CORPORATE POLICY **Subject:** Domestic Abuse Recognition and Management	Bedford Hospital NHS NHS Trust
Reviewed by: Named Midwife Safeguarding Vulnerable Families Midwife Lead Midwife for Domestic Abuse	**Key Reference:** Domestic Abuse Strategy 2016 – 2020 accessed via http://www.centralbedfordshire.gov.uk/Images/domestic-abuse-strategy_tcm3-19094.pdf Bedfordshire Domestic Abuse Partnership accessed via https://bedsdv.org.uk/ Bedford Borough Council Strategy to Tackle the Causes and Effects of Domestic 2017-2020
Date of Approval: March 2019	**Review Date:** March 2022

Purpose	To assist Health Care Practitioners in the support of adults and children who are subjected to domestic abuse
Objectives	Enable health workers to detect Domestic abuse and take appropriate action in the interests of adults, children and their families. To encourage & support routine enquiry Ensure availability of information and services on Domestic abuse for those that experience it
For Use By	All clinical staff
Related Policies *Any policies or guidelines that directly impact or are impacted by this Guideline*	• Missed appointments • Safeguarding Children and Young People • Teenage pregnancy • Care & treatment of pregnant women(and their babies) who use or misuse drugs and/or alcohol • Safeguarding vulnerable adults – raising concern • Mental Capacity Act 2005 Domestic Abuse Strategy 2016 – 2020 accessed via http://www.centralbedfordshire.gov.uk/Images/domestic-abuse-

Definitions *Any Acronyms or Abbreviations used in Guideline*	**1.** Domestic Abuse (DA) is defined as: *…Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members, regardless of their gender or sexuality.* *This can encompass but is not limited to the following types of abuse:* • *Psychological* • *Physical* • *Sexual* • *Financial* *(HMSO, 2018)*

	MARAC: Domestic Abuse Multi-Agency Risk Assessment Conferences
Status / Version Control *Previous versions of the Guideline should be stated here with former name if changed along with dates when they were approved.*	Version 5 2019-2022 Version 4 2016 – 2019 Safeguarding Midwife V3 2014 – 2016 V2 2013 – 2014 V1 2012 -2013

Contents

Guideline

1. INTRODUCTION

This policy aims to create a framework of action within the Trust to ensure a consistent and effective multi-professional response to tackle domestic abuse.

This policy recognises that identifying domestic abuse is a regular part of healthcare assessment and promotes routine enquiry which is timely and should occur at key times of contact with patients and parents/carers of children.

The purpose of this policy is to provide clear guidance supported by education and training which will enable staff to support the victims of domestic abuse. In accordance with the Mental Capacity Act 2005, we work from a presumption of mental capacity unless a person's apparent comprehension of a situation gives rise to doubt.

Domestic abuse (DA) is a criminal, social and medical problem with serious consequences. In the health of individuals it contributes to physical, psychological and psychiatric problems associated with depression, anxiety, suicide and mental health issues (MBRRACE, 2018).

The home office defines domestic abuse as:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Verbal

(see Appendix 1 for more information)

Controlling behaviour is defined as:
'A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'

Coercive behaviour is defined as:
'An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'

This definition, which is not a legal definition, includes so called honour based abuse, female genital mutilation (FGM) (Appendix 2) and forced marriage and it is clear that victims are not confirmed to one gender or ethnic group. (HMSO, 2018)

DA is rarely an isolated event and can begin and escalate in severity and frequency during pregnancy.

It is estimated that:

- One in four women experience domestic violence at some point in their lives, 25% (Bedfordshire Domestic Violence partnership, no date)
- A woman will experience an average of 35 episodes of violence before seeking help.
- Police in the UK receive a report of domestic abuse every 60 seconds (Women's A i d , 2018).

- Two women a week are killed in the UK by their current or former partner
- 30% of domestic abuse begins in pregnancy (DoH, 2017)
- Domestic abuse forms quarter of all violent crimes
- 52% is the percentage of child protection cases involving domestic abuse (DoH, 2017)
- 90% is the proportion of DA in which children are in the same or next room (DoH, 2017)
- £1.2 bn is the cost to the NHS of dealing with physical injuries alone caused by DA

1.1 Health Care Professionals are uniquely placed to offer support within their own speciality and by working in partnership with other agencies.

Health Care professionals detecting Domestic abuse and taking appropriate action can make an important contribution and in doing so improve the health and well-being of individuals and their families.

1.2 Domestic abuse can cause recurrent miscarriage, stillbirth and maternal deaths. Women who experience DA are more likely than non-abused women to use mental health services and children suffer as a consequence.

1.3 Bedford Hospital NHS Trust recognises the serious adverse effect that domestic abuse can have on babies and children who live in affected households and the potential for both short and long term damage to their health and development.

1.4 Bedford Hospital NHS Trust also has a responsibility to safeguard and protect adults and recognise that they may be victims of domestic abuse. Please follow the flow chart in appendix 3.

2. Domestic Abuse and Safeguarding Children

Working Together (HMSO, 2018) requires staff to be alert to the strong links between adult domestic violence and abuse, substance misuse and child abuse, and recognise when a child is in need of help, services or at potential risk of suffering significant harm.

Children may suffer both directly and indirectly in households where there is domestic violence and abuse.

Patients and/or staff may be victims of or perpetrators of domestic abuse. Hearing or seeing the ill treatment of another constitutes harm. Therefore a referral should be made to the Local Authority if a child lives in a household where domestic violence is believed to be a factor which may lead to them being in need of support or protection.

Unborn children are at risk as violence towards women increases both in severity and frequency during pregnancy often involving punches and kicks directed at the women's abdomen. Once born, the impact on the mother-child attachment process may be affected, as well as the child's capacity to develop normal responses to stressful situations. This can result in a fractious baby and place both mother and child at further risk from the abuser.

Domestic violence during pregnancy puts a pregnant woman and her unborn child in danger. It increases the risk of miscarriage, infection, premature birth, low birth weight, fetal injury and fetal

death.

3. Roles and Responsibilities

Chief Executive
Overall accountability for implementing the policy lies with the Chief Executive.

Director of Nursing
To ensure the implementation of all policies and procedures that are in place to maintain the safety of service users, staff and the public.

Associate Director of Nursing – Safeguarding
Lead the development and implementation of domestic abuse policy and procedure.

Safeguarding Adult & Children's Teams
Will provide the following the context of domestic abuse:

- An expert professional leadership role in relation to Safeguarding Adults and Children.
- Act as an expert resource on safeguarding adults and children issues, providing accessible, accurate and relevant information to staff.
- Deliver training relating to domestic abuse to clinical staff working with adults across the Trust. (Adult team)
- Deliver training identifying domestic abuse and the impact on children as part of level 2 & 3 safeguarding children training (Children team)

Independent Domestic Violence Advisor (IDVA)
Will be a victim's primary point of contact, working with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

Line Managers
It is the responsibility of all managers to ensure that this policy is implemented and that all employees comply with this policy.

Employees
All staff needs to be aware of the policy and how it impacts on their practice. It is the responsibility of staff to ensure they keep up to date with the contents of this policy and implement when relevant. Every member of staff owes a duty of care to protect all children and adults from domestic abuse, regardless of the setting in which the care takes place. It is every employee's responsibility to be aware of the content of this policy and how it applies to them.

4. What to do if domestic abuse is suspected or disclosed

Victims of domestic abuse are most at risk of increased life threatening abuse when they start to disclose abuse or try to leave an abusive relationship. The person who is experiencing the abuse is ultimately the only one who can predict the risk they face and the likelihood of further abuse.
A disclosure may be made or there may be indicators of domestic abuse:

- Frequent appointments for vague symptoms
- Injuries inconsistent with explanation of cause
- Patient tries to hide injuries or minimise their extent
- Partner always attends unnecessarily

- Patient is reluctant to speak in front of a partner
- History of repeated miscarriages / still births
- Repeat presentations of anxiety, depression, self-harm
- Multiple injuries at different stages of healing
- Partner is aggressive / dominant / refuses to leave room
- Recurrent sexually transmitted infections / Urinary Retract Infections (UTI)
- Early self-discharge from hospital
- Frequent missed appointments
- Non-compliance with treatments
- Burns / stab wounds / bruising / broken bones
- Eating disorders / eating difficulties
- Feeling of dependency
- Post-Traumatic Stress (PTS)
- Tiredness and sleep disturbance
- Enuresis
- Self-harm / suicide
- Gynaecological / urology problems
- Introverted / withdrawn
- Low self esteem
- Aggression
- Relationship difficulties
- Sexual precocity

Where possible patients should be unaccompanied when asked about domestic abuse.

If a disclosure of abuse is made please refer to Appendix 3 –What to do if a disclosure of Domestic Abuse is made.

- Allow sufficient time for the victim to make a disclosure fully. If the victim is interrupted they may not feel able to revisit the subject.
- Determine if there are any children, or if the woman is pregnant, and if so follow the Trust's safeguarding children procedures.
- Ask the victim if they would like to be supported by the Independent Domestic Violence Advisor (IDVA).
- Establish the level of further risk to the victim by carrying out a risk assessment. The DASH risk assessment form can be found on the safeguarding children section of the intranet under 'Domestic Abuse'.

Victims should be encouraged and supported to report incidents to the police, especially in the event of serious injury. However if they do not wish to do so, and you have assessed the case as high risk, a referral to MARAC may be made without the victims consent. You should inform the victim that you are making a referral to MARAC due to the level of risk.
Key individuals within the Trust will attend MARAC training in order to become confident in making a referral. However, advice can be obtained 9am-5pm, Monday to Friday from the Safeguarding Children and Adult Teams.

5. Multi Agency Risk Assessment Conference (MARAC)

A MARAC (multi-agency risk assessment conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
Bedford Hospital NHS Trust has a responsibility to share information in the Multi-Agency Risk Assessment Conferences (MARAC) and to implement safety plans as appropriate to the organisation. Referrals for MARAC and DASH risk assessments for CBC and BBC should be sent to; MARACenquiries@centralbedfordshire.gov.uk

6. ROUTINE ENQUIRY in Maternity

Routine enquiry is recommended at least once during pregnancy at booking or before 28 weeks gestation, and postnatally before the 10th day. The actual asking of the question is the most significant dimension of this sensitive issue and as with most sensitive issues it is the approach and manner in which enquiry is initiated that will secure the confidence of the women. Once an enquiry has been made it will be discreetly documented on the patient held green notes and also clearly recorded in the hospital records.

Some suggested openings for enquiring are offered below although opportunistic enquiry is more likely following a period of rapport building. By informing the women that all Health Professionals are being asked to routinely enquire about DA may provide an avenue to broach the subject.

Each Health Care Professional will be receptive to any cues outlined earlier and focusing on the pregnancy may provide a suitable opening at the outset, beginning with:

“Since you have been pregnant ……

- How are you feeling?
- Is everything alright at home?
- Are you getting the support needed at home?
- Because domestic abuse is so common, I have begun to ask all patients routinely if they have ever experienced any form of violence or abuse from their partner.
- Have you ever been in a relationship where you have been hit, punched or hurt in any way? Is this happening now?
- Are you in a relationship where you are treated badly? In what way?
- I am sorry if you have been asked this question before, according to research 1 in 4 women and 1 in 6 men, experience violence in their own home so now we are routinely asking about domestic abuse.

7. Recording and Documenting Domestic Abuse

It is important to keep accurate records detailing the allegations and any injuries due to abuse as disclosed by the victim. This ultimately may be used in any action taken against the perpetrator. The victims consent is not required to record a disclosure of domestic abuse however this must not be detailed in any patient held notes.

- Always seek the persons consent to share information. Information may be passed on without consent when there is a risk of significant harm to the victim, any children or another person if the information is not passed on.

- Pregnant women who disclose domestic abuse will have a record made within their hospital notes to make relevant healthcare professionals aware of the situation. It is important the records of domestic abuse are not made within her patient held file as the perpetrator may have access to the file.
- Review history to see if there has been a previous disclosure or evidence of Domestic abuse.
- In the course of clinical documentation be specific about marks or injuries to the body. Also record the patient's/victim's emotional state and record what you have seen and heard. Record verbatim what patient/victim says rather than using your words.
- It is also useful to note who is present, such as a partner, when a history of an injury is being taken. If there were children in the house, were they present at any time of the alleged incident and/or present at the history taking.

8. Confidentiality

Extreme care should be taken to protect the safety of victims of abuse and no information should be disclosed which may breach their safety. For instance, a third party may try and use the whereabouts of children to trace a mother. This would apply even if the enquirer was a professional member of staff, a partner or family member who works in the organisation.

However, it must be made clear to patients that there are limits to the extent of confidentiality where the safety of children and vulnerable adults is concerned. Where children are living in a domestic abusive household, information may be passed to other agencies in line with child protection procedures and similarly for adults, consistent with safeguarding adult's procedures.

9. STAFF SUPPORT

Staff may require emotional support after domestic abuse disclosures. Managers are responsible for making this available either through themselves or by negotiating clinical or safeguarding supervision as appropriate.

10. Local Services

For further information about domestic abuse & local services visit www.bedsdv.org.uk

Appendix 1 Definitions

Domestic Abuse

The following are examples of and are not an exhaustive list:

Physical Abuse
Shaking, smacking, punching, pushing, kicking, biting, starving, stabbing, suffocation, throwing things, using objects as weapons, female genital mutilation, honour based abuse. The physical effects are often on areas of the body that are covered and hidden (i.e. breasts and abdomen).

Sexual Abuse
Forced sex, sexual exploitation, pressuring an individual to participate in non-consensual sexual activities, sexual insults, stopping a woman from breast feeding, coerced nudity, taking explicit

photographs under duress, sexual violence, non-consensual acts during intercourse including strangulation, beating, restraint and marking. The perpetrator may refuse to use protection and knowingly expose the victim to infection.

Indicators can be unexplained bleeding from the vagina and/or anus, unexplained genital infections, bruising around the genital area, buttocks and thighs. There may be a reluctance to be physically examined; nervous reactions and withdrawal may also be indicators.

Psychological/Emotional Abuse
Intimidation, insulting, swearing, undermining confidence, making racist remarks, making the victim feel unattractive, calling them stupid or useless, and eroding their independence.
Isolating the victim from friends and family, criticising, denying the abuse, treating them as inferior, threatening to harm children or take them away, forced marriage, controlling behavior including obsessive checking of texts and whereabouts.
Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
In the LGBT community, sometimes the threat of 'outing' (threatening to divulge the nature of someone's sexuality to family friends or employers) is used to intimidate individuals.

Financial Abuse
Not letting a victim work, undermining efforts to find work or study, refusing to give money, asking for an explanation of how every penny is spent, making them beg for money, gambling, not paying bills. The victim may have no access to cash or cards and have their accounts or access to money tightly controlled.

Appendix 2

Forced Marriages and Honour Based Violence

What is honour based violence?

Honour based violence is a violent crime or incident which may have been committed to protect or defend the honour of the family or community. It is often linked to family members or acquaintances who mistakenly believe someone has brought shame to their family or community by doing something that is not in keeping with the traditional beliefs of their culture. For example, honour based violence might be committed against people who:
• become involved with a boyfriend or girlfriend from a different culture or religion
• want to get out of an arranged marriage
• want to get out of a forced marriage
• wear clothes or take part in activities that might not be considered traditional within a particular culture
• Honour is the perception of shame that can be the catalyst, and that 'honour' is vague and can be different things to different individuals.

Honour-based violence can include:

- Acid attacks
- Assault
- Blood feuds
- Disfigurement
- Domestic abuse
- Dowry - abuse of dowry arrangements
- False imprisonment
- Female genital mutilation
- Forced marriage
- Forced repatriation
- Harassment
- Honour killings (murder)
- Kidnap
- Stalking
- Self-harm, suicide as a result of these issues
- Rape and sexual assault

Forced Marriage

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. This is now legislated as an offence and is recognized in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights. An arranged marriage (not considered abuse) will become 'forced 'if either or both parties withdraw consent and are pressured to continue with the marriage.

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

Female Genital Mutilation

FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. The practice violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death. (World Health Organisation, Jan 2018).
Appendix 3

Domestic Abuse Disclosure

If someone discloses domestic abuse to you, you should speak to the individual concerned alone and in a confidential space where they have the opportunity to disclose the abuse and discuss the support they would like without fear of the perpetrator or other people hearing about the abuse.

Wherever possible you should try to complete a Domestic Abuse, Stalking & Honour Based Violence (DASH) risk assessment with them to help determine the risks to the individual and to guide any safety planning. Depending on the level of risk posed to the individual concerned you may need to make a referral to the Multi Agency Risk Assessment Conference (MARAC). You can download copies of the

risk assessment and MARAC referral form from: https://bedsdv.org.uk/marac/#useful

If you need support finding out about services or completing a risk assessment and/or MARAC referral you can contact the Hospital Independent Domestic Violence Advisor (IDVA) via the referral process on Bedford Hospital intranet:http://intranet/QualityHub/Safeguardingchildren/Pages/default.aspx

You may need to find out more about services available to support victims of domestic and sexual abuse, you can find more information about local and national services at: . www.bedsdv.org.uk

If you are aware of or suspect domestic abuse please be cautious about approaching the perpetrator and speaking to them directly, as potentially this may put yourself and the victim at further risk.

References *i.e. NICE guidance, externally recognised reports or research*	Bedfordshire Domestic Violence partnership (2017). Strategy and action plan (www.bedsdv.org.uk). Bewely, S., Morey, G,. Friend, J. (1997). *Violence Against Women.* London: RCOG. Department of Health (2017). *Responding to domestic abuse: A handbook for health professionals.* London: DoH. Domestic Abuse Strategy 2016 – 2020 http://www.centralbedfordshire.gov.uk/Images/domestic-abuse-strategy_tcm3-19094.pdf Hester, M., Pearson, C., Harwin, N (2000). *Making an impact: children and domestic violence***.** London: Barnardos. HM Government (2017). *Tackling Domestic Violence: the role of the Health Care Professional*. London: Crown. HM Government (2018). Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children. London: Crown. MBRRACE (2018). *Saving lives, improving mother's care*. Oxford: MBRRACE-UK. National Institute for Health and Care Excellence (2014). *Domestic violence and abuse: multi-agency working* (PH50). London: NICE. Nursing and Midwifery Council (2004). *Code of Professional Conduct.* London: NMC. (www.nmc-uk.org). Nursing and Midwifery Council (2004). *Midwives Rules and Code of Practice* London: NMC. (www.nmc-uk.org). Royal College of Midwives (1999). *Domestic Abuse in Pregnancy.* 2 (3) 84-85. London: RCM. (www.rcm-uk.org). Smith, L. (1989). *Domestic Violence: An Overview of the Literature*. London: HMSO. Women's Aid (2018). *Survival and beyond: the domestic abuse report*. Bristol: Women's Aid. World Health Organisation (Jan, 2018). Female Genital Mutilation.
Staff Involved In Development	Louise Dickson, Midwife Sharon Wheeler Named Midwife safeguarding

Monitoring / Audit Criteria

Aspect	Method	Frequency	Responsibility	Reporting Arrangements
Audit maternity notes for evidence of routine enquiry	Retrospective review of notes	Annually	Safeguarding Midwife	Via Multidisciplinary Safeguarding Team and Bedford Hospital W&C Quality meeting

Bedford Hospital NHS
NHS Trust

Equality Impact Assessment Screening Tool for Policies

AREA	NEGATIVE IMPACT		SIGNIFICANT Y/N?	
	Y ✓	N ✗	Y ✓	N ✗
1. Gender		N		
2. Religion/ belief		N		
3. Age		N		
4. Disability (includes: mental health, learning disability, physical, sensory		N		
5. Ethnicity (includes: travellers and gypsies)		N		
6. Sexual Orientation (includes: gay, lesbian, bisexual)		N		
7. Social / Economic		N		

For any boxes marked as 'yes' above please complete details below

Area	Issue	Further Steps to be Taken

Negative Impact

Q1. Will the policy create any problems or barriers to any community or group? N
Q2. Will any group be excluded because of the policy? N
Q3. Will the policy have a negative impact on community relations? N

If yes, a full equality assessment must be done.

WILL THE POLICY PROMOTE	positive IMPAC		State how, i.e. evidence used to reach this decision
	Y ✓	N ✗	
1. Equal Opportunities			
2. Get rid of discrimination			
3. Get rid of harassment			
4. Promote good community relations			
5. Promote positive attitude to disabled people			
6. Encourage participation by disabled people			
7. Consider more favourable treatment of disabled people			
8. Promote and protect human rights			

Assessed by (Name/s) Andrea Anniwell

Signed	S.Wheeler	Post:	Named Midwife for Safeguarding Children	Date:	18/02/2019
Signed		Post:		Date:	

Bedford Hospital NHS
NHS Trust

Approving Signatories

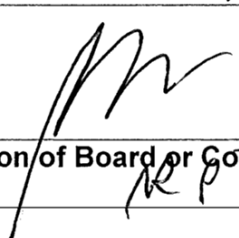
Name of Leading Sub-Committee / Business Unit Approving this Guideline: Women & Children Divisional Quality Meeting

Date: 12/03/2019	**Date:**
Signature: 	**Signature:**
(Chairperson of Board or Committee indicated above)	**(Chairperson of Board or Committee indicated above)**

Name of Other Sub-Committee / Business Unit involved in Approval of Guideline:

Date:	**Date:**
Signature:	**Signature:**
Print Name:	**Print Name:**
(Chairperson of Board or Committee indicated above)	**(Chairperson of Board or Committee indicated above)**

Ratification Signature
Approved by Quality Board

Date: 15/7/19	**Date:**
Signature: 	**Signature:**
(Chairperson of Board or Committee indicated above)	**(Chairperson of Board or Committee indicated above)**

Consultation List

A completed list should accompany **every** guideline/policy
(This gives evidence on who has seen this Guideline and any comments made)

Bedford Hospital NHS
NHS Trust

Name of Person	Department or Committee	Comments
Paul Tisi	Medical Director	Approved
O Purdy	Clinical Midwifery Manager /SoM	Approved
A Pachulski	Clinical Midwifery Manager for Delivery Suite and SoM	Approved
Team Managers delivery Suite	Midwifery Team Managers	Approved
Nichola Keer	Associate Director of Nursing - Safeguarding	Approved
Liz Lees	Director of Nursing	Approved
Cathy Pullen	Divisional Nurse Integrated Medicine	Approved
Shirley Jones	Head of Midwifery	Approved
Sharon Wheeler	Safeguarding Midwife	Approved
Claire Garratt	Maternity Matron	Approved
Sarah Reynolds	Consultant Obstetrician & Gynaecologist	Approved

Oseiwa Kwapong	Named Doctor for Safeguarding Children	Approved
Mandy Roberts	Matron for Emergency Department	Approved
Julie Sharpe	Riverbank Ward Manager	Approved
Carol Warden	Meadowbank Ward Manager	Approved
Joanne Andrews	ED Team Manager	Approved
Paediatric Consultants	Paediatric Quality Group	Approved
Consultant Obstetricians and Gynaecologists	Obstetricians and Gynaecologists Quality Group	Approved
Emergency Department Consultants	Emergency Department Quality Group	Approved