Investigation of a complaint against the Belfast Health & Social Care Trust

Report Reference: 202005122

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Case Reference: 202005122

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint was about the actions of the Belfast Health and Social Care Trust (the Trust). The complaint concerned care and treatment the Trust provided to the complainant (the patient) and her twin babies following their premature birth.

The investigation established that the Trust failed to provide the patient with appropriate mental health support which could have helped her cope with managing the premature birth of her children and the subsequent transfer of one twin to the Northern Health and Social Care Trust (the Northern Trust).

The investigation did not identify any failings in how the Trust:

- performed Ultrasound scans;
- handled a review of the patient's blood pressure medication; and
- communicated with the complainant in respect of a brain scan.

The investigation also did not identify and failings in the Trust's decision to transfer one twin to the Northern Trust.

I recommended that the Trust apologises to the complainant for the failing identified. I further recommended that the Trust provides training to relevant staff on the provision of psychological support for parents from the time of admission, as well as providing ongoing support during the parents' time on the neonatal unit.

THE COMPLAINT

1. This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient and her twin babies between 13 May 2022 to 11 June 2022.

Background

2. The Trust provided pre-natal care for the patient including the administration of Ultrasound scans[1] (USS).

3. The Trust delivered the patient's children (Twin 1 and Twin 2) by caesarean section on 13 May 2022.

4. The Trust prescribed the patient with blood pressure medication prior to discharge on 14 May 2022.

5. The Trust transferred Twin 1 to the Northern Health and Social Care Trust (the Northern Trust) on 26 May 2022.

6. The Trust conducted brain scans of Twin 2 on 6 June 2022 and 8 June 2022.

7. The Trust transferred Twin 2 to the Northern Trust on 11 June 2022.

Issues of complaint

8. I accepted the following issues of complaint for investigation:

   Issue 1: Whether the care and treatment the Trust provided the patient was appropriate, reasonable and in accordance with relevant policies and standards.

   Issue 2: Whether the care and treatment the Trust provided the patient's children was appropriate, reasonable and in accordance with relevant policies and standards.

INVESTIGATION METHODOLOGY

9. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

[1] Ultrasound scans use sound waves to build a picture of the baby in the womb.

Independent Professional Advice Sought

10. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

    - A consultant with 31 years' experience in Paediatric and Neonatal Intensive care (C IPA); and
    - A midwife with 43 years' service (M IPA).

    I enclose the clinical advice received at Appendix two to this report.

11. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

12. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[2]:

    - The Principles of Good Administration

13. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council, - Good medical practice, March 2013 (the GMC Guidance);
    - The Nursing & Midwifery Council - The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, updated October 2018 (the NMC code);

[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- British Association of Perinatal Medicine, Service and Quality Standards for Provision of Neonatal Care in the UK, August 2010 (the BAPM standards);
- British Association of Perinatal Medicine, Enhancing Shared Decision Making in Neonatal Care, A Framework for Practice, , November 2019 (the BAPM framework for practice);
- The National Institute for Health and Care Excellence - Antenatal and postnatal mental health, NICE Quality Statement QS115, February 2016 (the NICE Quality Statement);
- The National Institute for Health and Care Excellence - Twin and Triplet pregnancy, NICE guideline ng137, 4 September 2019 (the NICE guideline); and
- The National Institute for Health and Care Excellence - Tobacco: preventing uptake, promoting quitting and treating dependence, NICE guideline ng209, 30 November 2021, (the NICE guideline, ng209).

I enclose relevant sections of the guidance considered at Appendix three to this report.

14. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

15. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. All the comments I received were carefully considered and, where appropriate, were included in the report.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Trust provided the patient was appropriate, reasonable and in accordance with relevant policies and standards.

In particular this considered:

- *The Trust's considerations around provision of mental health support.*

- *Ultrasound scans (USS) administered; and*
- *The Trust's handling of a review of blood pressure medication.*

Detail of Complaint

The Trust's considerations around provision of mental health support

16. The complainant said the birth of her children was "*traumatic*" and the Trust did not offer "*mental health support"*.

Ultrasound scans (USS) administered

17. The complainant said the Trust mixed up her twins during two UUS. This was admitted by a named doctor who later denied having said this.

The Trust's handling of a review of blood pressure medication

18. The complainant said the Trust prescribed her with blood pressure medication prior to discharge on 14 May 2022. She spoke with her General Practitioner (GP) who informed her the Trust should have scheduled a follow-up appointment. The complainant said the Trust failed to schedule a follow-up appointment.

Evidence Considered

The Trust's response to investigation enquiries

The Trust's considerations around provision of mental health support

19. The Trust apologised it did not adequately meet the patient's mental health needs as it did not offer "*help and support from the Trust's specialist teams"* during her admission.

Ultrasound scans (USS) administered

20. The Trust stated its lead sonographer reviewed the USS images and found the twins were "*labelled in accordance with the booking scan"*. The lead sonographer stated it can often take time at the beginning of the USS to "*orientate each baby*" and hopes that this "*did not cause confusion*" and lead the complainant to believe she had "*mixed up the twins*".

21. The named doctor stated she does "*not remember these interactions*" with the complainant.

The Trust's handling of a review of blood pressure medication

22. The Trust stated following discharge *"postnatal care is provided by the primary care team and community midwives".* It is the responsibility of the primary care team to *"organise a follow-up appointment".*

Relevant Trust records

23. I completed a review of the documentation the Trust provided in response to my investigation enquiries. I also reviewed the documentation I received from the complainant. I refer to the relevant records in the Findings and Analysis section of this report.

Relevant Independent Professional Advice

The Trust's considerations around provision of mental health support

24. The C IPA advised psychologists are "*essential members of the neonatal multidisciplinary team"*. They bring an "*understanding of the psychological impact of preterm delivery and serious illness on infants and families, supporting parents through the admission"*.

25. The C IPA advised they found no record demonstrating the Trust offered the patient the services of a "*perinatal psychologist or other mental health support"*. The C IPA further advised this could have helped the complainant cope with "*managing premature twins and their subsequent separation".*

Ultrasound scans (USS) administered

26. The M IPA advised the Trust's booking scan labelled the infants Twin 1 and Twin 2 in accordance with the NICE guideline.

27. The M IPA advised different members of the multidisciplinary team would undertake scans with the consultant obstetrician as the lead. A radiographer conducted the two scans in question.

28. The M IPA advised "*all imaging and labelling of the twins are consistent"* and the babies are "*accurately labelled"* in accordance with the booking scan.

29. The M IPA advised in a scan conducted on 27 April 2022, a good view of the babies was "*restricted by their positions"*. The M IPA further advised this may account for why it took "*longer to undertake the scan"*. The M IPA found "*no failings"* in the Trust's USS.

The Trust's response to the draft report

30. The Trust stated it currently does not have psychological services available to them to support parents with children in the NICU. It does facilitate a family support worker from the charity Tiny Life who offer support to parents whilst their baby is being cared for in the NICU and post discharge. In June 2022, at the time of the events raised, this support worker offered a virtual service, due to COVID.

31. The Trust stated in 2025 the NICU, in conjunction with psychological services, are launching a two-year project to offer psychological support for families with children in the NICU. The Trust hope this will offer the required support that the families need during this difficult time. The NICU have also set up a parent's advisory group to ensure we understand the needs and perspectives of parents.

Analysis and Findings

The Trust's considerations around provision of mental health support

32. I considered the GMC guidance which requires a medical practitioner to provide a *"good standard of practice and care".* They must *"adequately assess the patient's conditions"* which includes psychological factors and *"refer the patient to another practitioner when this serves the patient's needs".*

33. Having reviewed the clinical records, there is no evidence to suggest the Trust conducted any kind of assessment of the patient's mental health following the birth of her children. This is even when it took the decision to separate the twins and transfer Twin 1 to the Northern Trust.

34. I considered the C IPA's advice that psychologists are "*essential members of the neonatal multidisciplinary team"* who provide support to "*parents through the admission*". The provision of psychological support could have helped the complainant with "*managing premature twins and their subsequent separation*".

35. I note the Trust's initial response to my office apologising it did not adequately meet the patient's mental health needs as it did not offer "*help and support from the Trust's specialist teams"* during her admission.

36. I note the Trust's subsequent response to the draft report that the NICU does not have psychological service available to them to support parents with children in the NICU. In 2025 the Trust are launching a two-year project to offer psychological support. The Trust hopes this will offer the "*required support families need during this difficult time*".

37. I considered the BMAP framework for practice which states each Neonatal Unit should have "*dedicated psychological support*" embedded within the neonatal MDT, with psychological professionals working alongside their medical, nursing and AHP colleagues. I welcome the Trust are introducing this service to provide better support for parents within the NICU.

38. I considered the NICE Quality Statement which specifies that antenatal and postnatal mental health services should be "*commissioned from and coordinated across all relevant agencies encompassing the whole antenatal and postnatal mental health care pathway*". A person-centred, integrated approach to providing services is "*fundamental to delivering high-quality care to women with a mental health problem in pregnancy and the postnatal period*".

39. The NICE Quality Statement specifies women with a suspected mental health problem in pregnant or the postnatal period should receive a "*comprehensive mental health assessment*". Women referred for psychological interventions are to start treatment within 6 weeks of referral.

40. I note that in its response to the complainant, the Trust accepted it did not adequately meet the patient's mental health needs and did not offer "*help and support from the Trust's specialist teams"* during her admission. I welcome its recognition.

41. I consider that by failing to assess the patient's mental health and provide psychological support, the Trust did not act in accordance with GMC guidance/NICE Quality Statement. I am satisfied this constitutes a failure in care and treatment. I echo the IPA's advice that the provision of psychological support would have helped the complainant cope with managing the premature birth of her children and their subsequent separation. I consider the need for assessment of the patient was clear. I am concerned and disappointed that the Trust did not take such action.

42. I therefore uphold this element of the complaint. I consider the failure identified caused the complainant to lose the opportunity for earlier psychological support. It also caused the complainant to sustain the injustice of anxiety.

Ultrasound scans (USS) administered

43. I considered the NICE guideline which requires women with a twin or triplet pregnancy to be offered a first trimester ultrasound scan. The scan should "*assign*

nomenclature[3] *to babies*" and document this clearly in the woman's notes to "*ensure consistency throughout pregnancy*".

44. I reviewed the patient's clinical records and note the Trust labelled her children Twin 1 and Twin 2 on the scans and throughout the records. There is no indication in the records to suggest the Trust 'mixed up' the twins at any time during the patient's pre-natal care. The M IPA also advised that the Trust's booking scan labelled the babies "*in accordance with the NICE guideline*". All "*imaging and labelling*" of the babies was consistent and in accordance with the booking scan. They found "*no failings*" in the Trust's USS.

45. I note the Trust's lead sonographer stated it can often take time at the beginning of the USS to "*orientate each baby*".. I also considered the M IPA's advice regarding the scan conducted on 27 April 2022, that a good view of the babies was "*restricted by their positions*" which may account for why it took "*longer to undertake the scan*".

46. The patient said it was a doctor who told her the radiographer 'mixed up' the twins. However, in response to enquiries, the doctor stated they had no recollection of making this statement. I have no reason to doubt the patient's recollection. However, I have not found any documentary evidence of this conversation in the records.

47. Having considered the information available, there is no evidence within the Trust's records to demonstrate it incorrectly labelled the babies. The documentary evidence instead indicates that the Trust conducted the USS scans in accordance with the NICE guideline. I therefore do not uphold this element of complaint. I hope this brings the patient some element of reassurance.

The Trust's handling of a review of blood pressure medication

48. The Trust's discharge note records the patient was advised to "*stay as inpatient until good blood pressure (BP) control was achieved*" but the patient was keen to go home. The discharge note includes:

    - Labetalol[4] increased to 200mg;
    - Community midwife to monitor BP; and
    - GP to kindly follow-up in two weeks.

[3] The labelling of twins according to their location relative to the birth canal.

[4] Labetalol is a beta blocker medicine, used to treat high blood pressure (hypertension), including high blood pressure in pregnancy.

49. The Trust's records demonstrate it made a referral to the patient's GP for a "*review in two weeks regarding BP/labetalol*".

50. Midwifery records show a community midwife recorded the patient's blood pressure on four occasions in the first 11 days following discharge.

51. GP records show the Practice monitored the patient's blood pressure between 20 May 2022 – 19 August 2022 as follows:

    - The Practice recorded the patient's blood pressure on three occasions;
    - A GP conducted a consultation at the Practice on two occasions; and
    - A GP conducted a telephone consultation on one occasion.

52. I considered the Trust's response that it is the "*primary care team's responsibility to monitor the patient's blood pressure/prescription following discharge*". I am satisfied the Trust made a referral to the patient's GP, therefore fulfilling its duty to the patient.. I also note that following the referral, the patient's Practice monitored her blood pressure for a number of months following her discharge. As such, there was no requirement for the Trust to schedule a follow-up appointment. I therefore do not uphold this element of the complaint.

Issue 2: Whether the care and treatment the Trust provided the patient's children was appropriate, reasonable and in accordance with relevant policies and standards.

In particular this considered:

- *Communication in respect of a brain scan; and*
- *The decision to transfer one twin to the Northern Trust.*

Detail of Complaint

Communication in respect of a brain scan

53. The complainant said the Trust conducted a brain scan on one of her children "*without her knowledge*". She first became aware when a nurse informed her they wished to discuss the results. A consultant attended who informed her Twin 2 had a possible bleed on the brain.

54. The complainant said the Trust failed to properly explain Twin 2's possible bleed on the brain, which is an "*ongoing issue*" for her.

The decision to transfer one twin to the Northern Trust

55. The complainant said the Trust transferred Twin 1 to Antrim Area Hospital (the Northern Trust) due to the Belfast Trust "*not having bed space*". The complainant said as a result she had to travel between both hospitals for several weeks to visit her newborn children.

Evidence Considered

The Trust's response to investigation enquiries

Communication in respect of a brain scan

56. The Trust stated within the Neonatal Unit, it is "*normal practice to perform relevant non-invasive investigations in order to ensure the treatment pathway and care is meeting the baby's clinical needs*". When parents visit or telephone regarding their infants, an "*update will be provided*".

57. The Trust stated records show a registrar discussed the "*rationale behind why the scans are performed*" and documented the scans were "*reassuring but other factors needed to be considered and that a further scan would be required*".

The decision to transfer one twin to the Northern Trust

58. The Trust stated the Royal Hospital is home to the regional "*Neonatal Intensive Care Unit*" which is the only neonatal team in Northern Ireland that can provide "*care for certain conditions such as extreme prematurity, surgical cases and cardiac cases*".

59. The Trust stated it aims to return all babies to their home Trust as soon as they are *"clinically well enough to be transferred*". This is to ensure that cots are available for those babies who *"require specialist care, which cannot be provided elsewhere*".

60. The Trust stated its understanding was that at the time of the transfer of the first twin, the Northern Trust would be able to "*receive the second twin in a timely way*". Every decision regarding placement of infants is considered carefully and the "*care of all families is a priority*". In this case the Northern Trust were "*not able to accept the transfer of the second twin*". The Trust recognised the pressure this placed on the family which was never the *"expected or desired outcome*". The Trust apologised the twins were *"separated for such a long period of time*".

Relevant Trust records

61. I completed a review of the documentation the Trust provided in response to my investigation enquiries, and the documentation I received from the complainant. I refer to the relevant records in the Findings and Analysis section of this report.

Relevant Independent Professional Advice

Communication in respect of a brain scan

62. The C IPA advised brain ultrasound scans are "*routinely performed in neonatal intensive care units on preterm babies*" due to increased risk of "*bleeding in the brain in these babies*". It is also to detect "*evidence of damage due to low blood flow or oxygen to the brain cells*".

63. The C IPA advised the scans are usually performed at the bedside and "*parental consent is not usually required*", as it is part of the routine neonatal care and causes minimal disruption.

64. The C IPA advised clinical records demonstrate a doctor provided a "*clear explanation*" as to why they conducted the scan.

65. The C IPA advised it is "*not uncommon practice*" for parents to be given this information at their next visit so that appropriate explanations can be provided. In both instances, Twin 2's parents were informed of the results the "*day after the scans were done*".

The decision to transfer one twin to the Northern Trust

66. The C IPA advised the BAPM standards clearly state that "*Neonatal care should be provided under a network model to maintain skills for all members of the neonatal workforce, to optimise capacity, streamline flow and help manage the workforce*". As such, it would not be possible for "*all neonatal units to provide the same level of expertise and care*".

67. The C IPA advised the standards state the "*levels of care*" clinicians should provide in "*Neonatal Intensive Care Units*" (NICUs) and "*local Neonatal Units*" (LNUs). It was appropriate for the Trust to transfer the infants back to their local unit (the Northern Trust) when they no longer required the **"***specialist services provided by a tertiary NICU".*

68. The C IPA advised both infants were ready for transfer back to their local unit on 25 May 2022. However, the local unit only had capacity for one infant. The Trust hoped

a bed would become available for Twin 2 a few days after Twin 1 was transferred. Records demonstrated the Belfast Trust contacted the Northern Trust on a "*daily basis*" enquiring about a bed for Twin 2.

69. The C IPA advised permission from the parents is "*not generally required to transfer patients back to their local unit, and consent is not normally sought*". It would not be possible for "*tertiary NICUs to function if they kept all the patients that were referred to them when their specialist expert care is no longer required*".

70. The C IPA advised although it is stressful and an inconvenience for the family to have to travel between Belfast and Antrim to visit both twins, it is a practice that "*occurs frequently"* to many parents due to the *"shortage of trained neonatal nursing staff*". The C IPA advised they did not identify "*any failing in the handling of the transfer of the twins*".

Analysis and Findings

Communication in respect of a brain scan

71. It is not in dispute that the Trust performed a brain scan on Twin 2 without first seeking consent from the patient. The Trust stated that within the Neonatal Unit, it is "*normal practice to perform relevant non-invasive investigations in order to ensure the treatment pathway and care is meeting the baby's clinical needs*".

72. The BAPM framework states the important focus of neonatal care should be around "*doing the right thing for the baby*". Regarding consent, its states implicit (or implied) consent refers to clinicians proceeding with a "*non-urgent low-risk intervention without necessarily having specific prior discussion for the procedure at that time with the parents*". The C IPA advised that scans form part of the routine neonatal care and "*parental consent is not usually required*".

73. I consider it would have been preferable for the Trust to have spoken with the complainant before it performed the scan on Twin 2. However, it is clear it is common practice in these circumstances to proceed with necessary tests without first seeking parental consent. Therefore, I accept the decision to do so in this case was appropriate.

74. I also considered if the Trust appropriately explained its action, and its rationale for it, to the patient. The GMC Guidance requires clinicians to "*be considerate to those close to the patient and be sensitive and responsive in giving them information and*

support." The BAPM framework also requires healthcare professionals to engage in a dialogue with the parent(s) enabling information to be shared "*in a way that they can understand and use meaningfully*".

75. The C IPA advised it is "*not uncommon practice*" for parents to be given this information at their next visit. He further advised the clinical records in this case demonstrate a doctor provided a "*clear explanation*" to the patient as to why the scan was conducted.

76. Having considered the evidence available, I am satisfied the Trust provided the complainant with sufficient information to explain the results of the scans and the reasons why it conducted the scan without consent. In doing so, I consider the Trust acted in accordance with the GMC guidance and the BAPM framework. Therefore, I do not uphold this element of the complaint.

The decision to transfer one baby to the Northern Trust

77. The C IPA advised it was appropriate for the complainant to be "*transferred from her local unit for delivery of her twins"* as one twin was identified to be "*growth restricted*". It is safer for the twins to be transferred "*in-utero*[5] *, than to be transferred on delivery*".

78. The twins were delivered by the Belfast Trust as it is home to the regional NICU which is the only neonatal team which can provide "*specialist care*" for certain conditions such as "*extreme prematurity*".

79. The C IPA advised both twins were "*ready to be transferred back to their local unit"* on 25 May 2022. However, the Northern Trust only had capacity for one Twin. The Trust stated it aims to return all babies to their home Trust as soon as they are "*clinically well enough to be transferred*". This is to ensure cots are available within the NICU for babies who require "*specialist care*". On transfer of Twin 1 the Trust believed the Northern Trust would be able to receive Twin 2 in a "*timely way*".

80. The C IPA advised it is clear from the Trust's notes it contacted AAH daily enquiring about a bed for Twin 2. However, the Northern Trust did not have a bed available. Having reviewed the clinical records, I am satisfied the Trust made regular contact with the Northern Trust to enquire about the availability of a bed for Twin 2.

[5] Within the womb/uterus.

81. The BAPM standards recommend Neonatal care in the UK should be provided under a "*network model*", with "*centralisation of care for the smallest and sickest babies".* The C IPA advised it would not be possible for tertiary NICUs to function if they kept patients when "*specialist care is no longer required".* Therefore, the Trust's transfer of one infant was "*in line with the BAPM standards".*

82. Whilst I acknowledge how difficult it would have been for the parents to have to travel between two hospitals to visit their children, I also considered the Trust's requirement to comply with relevant standards and ensure beds are available within the NICU for babies who may require "*specialist care*". I am satisfied in its handling of the transfer of the twins the Trust acted in compliance with the BAPM standards. Therefore, I do not uphold this element of the complaint.

83. I welcome the Trust's statement that it was sorry the infants were "*separated for such a long period of time"* and its recognition of the pressure this placed on the parents.

CONCLUSION

84. I received a complaint about the actions of the Belfast Health and Social Care Trust. The complaint concerned care and treatment the Trust provided to the patient and her children.

85. I recognise the difficult circumstances the complainant and her partner experienced following the birth of their children. I did not find any failures in the care and treatment provided to the complainant's children. However, I found the Trust failed to provide the complainant with the psychological support she needed during this time. I am satisfied this represents a failure in her care and treatment. I uphold this element of the complaint.

86. I am satisfied the failure identified caused the patient to sustain the injustice of a loss of opportunity for earlier psychological support. It also caused the complainant to sustain the injustice of anxiety.

Recommendations

87. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration identified (within one month of the date of this report).

88. I further recommend that within six months of the date of my final report, the Trust provide evidence it has introduced it psychology services project and has provided training to relevant staff on the provision of psychological support for parents from the time of admission, as well as providing ongoing support during the parents' time on the neonatal unit.

MARGARET KELLY **July 2025**
OMBUDSMAN

Appendix 1 - PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances.
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.

- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.