



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against Belfast Health and Social Care Trust

Report reference: 202400407

The Northern Ireland Public Services Ombudsman

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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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Appendix 1 – The Principles of Good Administration

Case Reference: 202400407

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint was about the care and treatment the Belfast Health and Social Care Trust (the Belfast Trust) provided to the complainant on 6 July 2022 when he attended a urology appointment.

The complainant felt the Consultant Urologist he saw did not take his concerns seriously and failed to provide him with any active treatment. The investigation established the care and treatment the complainant received from the Belfast Trust on 6 July 2022 was appropriate and in accordance with relevant guidance and good practice. I therefore did not uphold this element of the complaint. However, I found maladministration when the Trust failed to establish the complainant was under the care of a Consultant Urologist at the South Eastern Health and Social Care Trust (the SEHSCT) before he attended the clinic appointment on 6 July 2022

I therefore partially upheld the complaint.

I recommended the Belfast Trust provide the complainant with a written apology for the injustice caused as a result of the failure identified. I made a further recommendation to bring about service improvement and to prevent future recurrence. I recommend the Belfast Trust provide this Office with evidence of its compliance with these recommendations.

Notwithstanding this conclusion, I hope the findings of the report provide the complainant with the reassurance the care and treatment provided to him on this occasion was appropriate.

THE COMPLAINT

1. This complainant was about the care and treatment the Belfast Health and Social Care Trust (the Belfast Trust) provided to the complainant on 6 July 2022 when he attended a urology appointment.

Background

2. The complainant's GP referred him in February 2022 to Urology at the Belfast Trust as a routine referral. As the complainant's home address was outside the Trust's catchment area, his referral letter was triaged and discharged with advice to the GP to refer the complainant to the South Eastern Health and Social Care Trust (SEHSCT).
3. The complainant subsequently attended the Emergency Department at the Belfast Trust on 26 May 2022 as he had stopped passing urine completely. The Emergency Department referred the complainant to the Urology Service at the Belfast Trust on 30 May 2022. The complainant's GP subsequently referred him for a second time to the Urology Service at the Belfast Trust as an urgent referral on 10 June 2022. On this occasion, despite his home address being outside the catchment area, the Belfast Trust triaged the referral as urgent and added the complainant to the clinic list. The second referral from the complainant's GP was classed as a duplicate registration as a referral had already been received from the Emergency Department at the Belfast Trust and was therefore closed on 16 June 2022.
4. The complainant received a Urology outpatient appointment for 6 July 2022 which he attended. During this appointment the Consultant Urologist did not recommend any investigations or change the complainant's management, as he was already under the care of another Health and Social Care Trust in Northern Ireland, the SEHSCT, and was awaiting investigations with that Trust for the same symptoms at that time.

Issue of complaint

5. I accepted the following issue of complaint for investigation:

Whether the care and treatment the Belfast Trust provided to the complainant on 6 July 2022 at a Urology outpatient appointment was appropriate and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

6. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

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

- A Consultant Urological Surgeon, MD FRCS, with over 30 years' experience (IPA)

I enclose the clinical advice received at Appendix two to this report. I will address the key elements of this advice in the analysis and finding section.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA 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

9. 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 Principles¹:

- The Principles of Good Administration

10. 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.

¹ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council Good Medical Practice, 2014 (GMC Good Medical Practice).

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

11. 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.
12. A draft copy of this report was shared with the complainant and the Belfast Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered all of the comments received.

THE INVESTIGATION

Whether the care and treatment the Belfast Trust provided to the complainant on 6 July 2022 at a Urology outpatient appointment was appropriate and in accordance with relevant standards.

Detail of Complaint

13. The complainant believed the Consultant Urologist did not take his concerns seriously and he felt belittled. The complainant felt the Consultant should have provided him with treatment as part of the consultation, instead of only referring him back to his established healthcare team at the SEHSCT. He said this had a serious impact on both his physical and mental health.

The Belfast Trust's response to investigation enquiries

14. The Belfast Trust stated the complainant attended the Belfast City Hospital on 6 July 2022 under a Consultant Urologist. The Consultant Urologist was aware the complainant was already attending the Ulster Hospital, SEHSCT. A Clinical Nurse Specialist at the SEHSCT assessed the complainant at an appointment on 4 April 2022. At this appointment the complainant underwent flow rate and post-void

residual² assessment. The SEHSCT added the complainant to the waiting list for a routine flexible cystoscopy³. The SEHSCT was due to review the complainant again in July 2022. The Belfast Trust explained the Consultant Urologist did not wish to interfere with the complainant's ongoing care and treatment plan at the SEHSCT, or duplicate tests or investigations.

15. The Belfast Trust stated it completed a clinical record review on 15 November 2023. A clinician not involved in the case reviewed the complainant's treatment and care. This concluded the Belfast Trust was not required to carry out any additional investigations at the clinic appointment, given his ongoing treatment plan with the SEHSCT.

Relevant Trust records

16. The Belfast Trust provided a copy of the relevant medical records and the Consultant Urologist's comments.

Analysis and Findings

17. I reviewed the GMC Good Medical Practice Guidance and note in relation to continuity and coordination of care it states, '*You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers.* In addition, Standard 15 requires clinicians to provide a good standard of practice and care by referring patients to another practitioner when this services the patient's needs. Standard 16 also emphasises the importance of clinicians ensuring care and treatment they provide is compatible with any other treatment the patient receives at the time.
18. I reviewed the Belfast Trust outpatient clinic letter dictated on 6 July 2022 and note it states the complainant '*was referred from the Mater Hospital ED after going into retention. This in fact was in error. He has already been reviewed due to urinary symptoms and erectile dysfunction through the Ulster Hospital. He is awaiting a cystoscopy.*' The clinic letter concludes with '*I will leave his follow up with the Ulster Hospital.*' The Belfast Trust sent this clinic letter to the complainant's GP.

² A flow rate is a test that is used to show how quickly and effectively you empty your bladder. The post-void residual is the volume of urine left in your bladder after you have passed urine.

³ A test that allows the doctor to look directly at the lining of the bladder from the opening of the urethra.

19. I reviewed the Consultant Urologist's comments and note he stated *'I felt I was very clear at the time that his booking to and attendance at my clinic was an error, as he was already under the care of another Urology team in the South Eastern Health and Social Care Trust and was awaiting investigations with them for the same symptoms. I purposely did not want to interfere in his care, recommend any investigations or change his management in any way.'*
20. I reviewed the SEHSCT outpatient review letter for an appointment on 4 April 2022. This letter states the SEHSCT would refer the complainant for a cystoscopy and it would await the outcome of this procedure and organise a review if necessary.
21. The IPA advised *'The complainant was already under the care of a dedicated specialist centre at another hospital. There was nothing the Consultant could do on 6 July 2022 except attempt to explain that the GP's referral had been inappropriate and that his care would need to continue with the Urology Department at the South Eastern Trust.'* The IPA did not raise any concerns about the Consultant Urologist's decisions or actions at that particular appointment.
22. The records evidence the complainant's GP referred him to the Urology Department at the Belfast Trust, as opposed to the SEHSCT. Having reviewed the IPA's advice, the Consultant Urologist's letter, and the SEHSCT's letter, it is apparent this was an error. Despite this error, the Belfast Trust nonetheless provided the complainant with an outpatient appointment with a Consultant Urologist which he attended on 6 July 2022.
23. I acknowledge that at this appointment, the Consultant Urologist did not provide the complainant with any treatment, beyond referring him back to his GP for further onward referral back to his established healthcare team at the SEHSCT. I appreciate it was disappointing and frustrating for the complainant to have awaited this appointment, and then to not receive any active treatment from it.
24. However, I accept the IPA's advice that the Consultant Urologist's actions were reasonable and appropriate in the circumstances. On foot of his advice, I am satisfied the complainant was under established and specialist care in the SEHSCT. Having considered his advice, I find it was reasonable for the Consultant Urologist to decide he did not want to interfere in the existing treatment plan the SEHSCT had in place for the complainant, or to provide any treatment that might impact or change that plan. I consider this was in line with Standards 15 and 16 of the GMC Good Medical

Practice Guidance, set out above, which emphasise the importance of referring patients to another practitioner if it best meets a patient's needs, and ensuring doctors do not provide any care and treatment which may impact a patient's existing treatment pathway. I also note the complainant had another appointment scheduled with the SEHSCT later that month.

25. I consider the Consultant Urologist was clear about his rationale for his decision in his clinic letter to the GP. I am satisfied there is nothing in the available evidence to demonstrate or infer that the Consultant Urologist did not take the complainant seriously, or that he belittled him during the consultation.
26. Having reviewed all the relevant evidence to include IPA advice, I am therefore satisfied the Belfast Trust's decision not to recommend any investigations or change the management of the complainant's condition on 6 July 2022 was appropriate and in accordance with relevant guidance. On this basis I did not identify a failure in care and treatment. There was not a failure by the Belfast Trust consultant in not providing treatment at the clinic appointment on the 6 July. Therefore, I do not uphold this element of complaint.
27. However, as has been accepted, an error occurred when it was not identified during triage that the complainant was under the care of the SEHSCT Urology Service. Having received an appointment from the Belfast Trust the complainant had an expectation that he would receive further treatment at the Belfast Trust. I consider this expectation reasonable, and I find there was maladministration by the Trust in not identifying the complainant was under the care of a consultant Urologist at the SEHSCT prior to him attending the clinic appointment on 6 July 2022. I consider the complainant to have sustained the injustice of upset, annoyance and frustration that he attended the appointment and no treatment was provided. This also prevented another patient obtaining the appointment that the complainant attended.

CONCLUSION

28. I received a complaint about the care and treatment the complainant received from the Belfast Trust on 6 July 2022 when he attended for an outpatient appointment.

29. I partially upheld the complaint for the reasons outlined in this report. I found maladministration by the Belfast Trust in not identifying that the complainant was under the care of the SEHSCT Urology Service prior to his attendance at the appointment of 6 July 2022.
30. I recognised this failure caused the complainant to sustain injustice, as discussed in the report.
31. I hope this report has provided reassurance to the complainant the care and treatment provided to him on this occasion was appropriate.

Recommendations

32. I recommend the Belfast Trust provides to the complainant an apology written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified, within **one month** of the date of the final report.
33. I further recommend for service improvement and to prevent future recurrence that the Belfast Trust:
 - i. Brings the contents of this report to the attention of all relevant staff, emphasising the importance when triaging referrals to ensure the patient is not in receipt of treatment and care at another Trust, within **three months** of the date of the final report.

MARGARET KELLY
Ombudsman

9 December 2025

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.