METHODS USED BY HEALTH OMBUDSMAN IN THEIR SYSTEM IMPROVEMENT ROLE: A COMPARISON OF TWO INTERNATIONAL HEALTH OMBUDSMAN IN THEIR SYSTEM IMPROVEMENT ROLE AND THE RESPONSE OF SCOTTISH HEALTH BOARDS TO THE SYSTEM IMPROVEMENT ACTIVITIES OF THE SPSO

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Abstract

Academics and ombudsman claim that a key role for ombudsman is to contribute to the improvement of the system over which they have oversight. However, there is limited research to support this claim and, much of what exists, is equivocal. This research examines the thesis that health ombudsman make a significant contribution to the improvement of the healthcare system as a result of the roles and activities that they undertake together with the way that they work with bodies in jurisdiction. In conducting this research, an international comparative case study was undertaken, using the Office of the Health Ombudsman, Queensland (OHOQ) and the Scottish Public Services Ombudsman (SPSO) as cases. In addition, three Scottish health boards participated in the research. The OHOQ was found not to be an ombudsman but to be a health complaint entity which principally focused on the prosecution of health professionals that it considers have conducted serious professional misconduct. The SPSO is an ombudsman, which principally tries to contribute to system improvement through compliance from health boards with recommendations arising from upheld complaints. In its approach to complaint investigations, the SPSO adopts the positions of an accountability institutional logic and coercive model of administrative control. These positions adversely affect the relationship between the SPSO and health boards with health board participants complaining about the nature of the communication between themselves and the SPSO, the quality of the clinical advice relied upon by the SPSO in reaching its decisions, and the inability to challenge either the advice or the decision. Consequently, in many cases, compliance with SPSO recommendations was due to a fear of sanction rather than commitment. In implementing recommendations, health boards use a dominant informational mode of organisational learning. Together, these factors explain why learning is unsustained leading to repeated complaints about the same issue.

Keywords: *ombudsman, health complaints, institutional logics, administrative control, motivational postures, organisational learning, conceptual model*.

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Contents

Abstract.....ii

Acknowledgements.....iii

List of Tables.....x

List of Figures.....xi

List of abbreviations.....xii

Chapter 1 Introduction.....1

1.1 Situating the research.....1

1.2 Motivation behind the research.....4

1.3 Aim and scope of the study.....5

1.4 Significance of the study.....7

1.5 Overview of the thesis.....7

Chapter 2 Literature Review.....10

2.1 Introduction.....10

2.2 Health complaints.....11

2.3 Complainants.....12

2.4 The attitudes of health professionals towards complaints.....15

2.5 Learning from complaints.....19

2.6 Administrative justice.....22

2.7 Conceptual models of administrative justice.....26

2.8 The development of the ombudsman institution.....30

2.9 Ombudsman and system improvement.....36

2.10 Health complaints and the ombudsman.....40

2.11 Research on ombudsman ... 47
2.12 Conclusion ... 53

Chapter 3 Theoretical considerations ... 55
3.1 Introduction ... 55
3.2 Organisational learning ... 56
3.2.1 Accountability ... 57
3.2.2 Feedback ... 62
3.2.3 Learning ... 63
3.3 Institutional logics ... 71
3.3.1 Institutional logics and healthcare ... 77
3.4 Conclusion ... 80

Chapter 4 Methodology ... 81
4.1 Introduction ... 81
4.2 Research aims, objectives and questions ... 81
4.3 Developing a philosophical stance ... 83
4.4 Research paradigms ... 84
4.5 Positionality ... 89
4.6 Reflexivity ... 90
4.7 Methodology ... 92
4.7.1 Case Selection ... 96
4.7.2 Sampling Bodies in Jurisdiction ... 101
4.7.3 Data collection methods ... 105
4.7.4 Interview participant selection ... 109
4.7.5 Data analysis ... 111

4.8 Quality, Reliability and Validity 113
4.9 Ethical considerations........ 115
4.10 Situating the research 117
4.10.1 Australian and Scottish healthcare systems 118
4.11 Conclusion........ 130

Chapter 5 Research Findings – The Office of the Health Ombudsman, Queensland, and the Scottish Public Services Ombudsman 131
5.1 Introduction........ 131
5.2 Office of the Health Ombudsman, Queensland 131
5.3 Complaint numbers 134
5.4 Results 136
5.4.1 Objectives of the OHOQ 136
5.4.2 Complaint handling process........ 137
5.4.3 System improvement 150
5.4.4 Other activities undertaken by the OHOQ........ 153
5.5 The Scottish Public Services Ombudsman........ 154
5.6 Complaint numbers 155
5.7 The objectives of the SPSO 157
5.8 Results 158
5.8.1 Complaint handling process........ 159
5.8.2 Investigation reports and decision summaries 160
5.8.3 Recommendations 160
5.9 System improvement........ 162
5.10 The Complaints Standards Authority 168
5.11 Other activities undertaken by the SPSO 170

5.12 Working with partners 172

5.13 Conclusion 173

Chapter 6 Results – Scottish health boards 174

6.1 Introduction 174

6.2 Awareness and perceptions of the roles of the SPSO 175

6.3 Participants' views on SPSO investigations 177

6.3.1 Interactions 177

6.3.2 Challenging the ombudsman 179

6.3.3 Clinical Advice 182

6.3.4 How bodies handle SPSO investigation reports and decision letters 185

6.3.5 Recommendations 190

6.3.6 Learning 194

6.3.7 Prioritising recommendations 202

6.3.8 Obstacles to change 203

6.3.9 Analysis of reported cases 204

6.4 Conclusion 206

Chapter 7 Discussion on research findings 207

7.1 Introduction 207

7.1.1 The OHOQ 209

7.1.2 SPSO 211

7.2 Research Question One: What approaches do health ombudsman take to administrative justice? 212

7.2.1 OHOQ and administrative justice 213

7.2.2 SPSO and administrative justice 215

7.3 Research Question Two: What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement? 217

7.4 Approaches used by the OHOQ to improve the healthcare system . 219

7.4.1 Prosecuting health professionals 219

7.4.2 Systemic investigations.. 222

7.4.3 Local resolution... 223

7.4.4 Conciliation 224

7.5 SPSO and system improvement 225

7.5.1 Using recommendations from upheld complaints to improve the system 227

7.6 Research Question 3: How do those in the healthcare system receive and respond to these approaches? 233

7.6.1 Participants awareness of the SPSO 233

7.6.2 The conceptual model.. 234

7.6.3 Using the conceptual model... 240

7.6.4 Determining the dominant institutional logic within the SPSO.... 241

7.6.5 Hertogh's models of control and the relationship between the SPSO and health boards 244

7.6.6 Motivational postures 256

7.6.7 Types of change that result from SPSO recommendations 260

7.6.8 Organisational learning 261

7.6.9 Barriers to change 265

7.7 Conclusion.. 266

Chapter 8 Conclusion 268
8.1 OHOQ 268
8.2 SPSO 270
8.3 Strengths and limitations of the research 273
8.4 Scope for further research 275

References 277

Appendix 1 – Positionality statement of the researcher 296
Appendix 2 – Research memoire 298
The insider-researcher 298
Issues relating to research design 301
Determining the case 301
Identifying the research questions 303
Data collection 306
Data analysis 311
Conclusion 312

List of Tables

Table 1 Desired outcomes sought by complainants (Bismark et al. 2011)... 14
Table 2 Desired outcomes sought by complainants (Friele et al. 2013)....... 14
Table 3 Models of administrative control (Hertogh 2001)............................ 50
Table 4 Health ombudsman and the number of investigations (2014/15).... 99
Table 5 Number of complaints received by the SPSO relating to each individual health board (2016/17).. 104
Table 6 Number of complaints received by the OHOQ relating to each individual.. 105
Table 7 Average length of interview by participating organisation 112
Table 8 Case study actions for ensuring the case study validity and reliability (Merriam 1988) 115
Table 9 Number of complaints by type of organisation (OHOQ 2019, pp.89-90).. 135
Table 10 Number of complaints by practitioner type (OHOQ 2019, p.88).. 135
Table 11 Number of issues raised within complaints, by type (OHOQ 2019, p.97).. 136
Table 12 Number of complaints received by the SPSO by health sector (SPSO 2019f)... 156
Table 13 Subject of health complaint received by the SPSO (SPSO 2019b, p.4)... 156
Table 14 Number of closures at the different stages of the complaints process (SPSO 2019f) 157
Table 15 Demographics of participants from Scottish health boards 175
Table 16 Awareness by participants of SPSO's non complaint activities ... 175
Table 17 Number of participants identifying different SPSO non complaint activities 176
Table 18 Number of participants who identified differing SPSO roles........ 177
Table 19 Comparison of activities undertaken by the OHOQ and the SPSO 218

List of Figures

Figure 1 Pyramid of ombudsman regulatory mechanisms (Healy and Walton 2016, p.501) 42
Figure 2 Queensland's coregulatory health system (OHOQ 2019, p.59) ... 122
Figure 3 OHOQ complaints management process (OHOQ 2019, p.18) 132
Figure 4 Example recommendations from investigation report (SPSO 2020l) 168
Figure 5 Basic diagram demonstrating how ombudsman contribute to system improvement 235
Figure 6 Revised diagram incorporating the work of Stuhmcke (2006)...... 236
Figure 7 Relationship between phases and barriers (Hertogh 2001) 236
Figure 8 Revised model incorporating the work of Hertogh (2001) 237
Figure 9 Revised diagram incorporating the work of Braithwaite (2014).... 237
Figure 10 Revised model of how ombudsman outputs can lead to service improvements 238
Figure 11 Revised model highlighting the possible institutional logics dominant within health ombudsmanry 239
Figure 12 Relationship between the differing elements in the conceptual model 240

List of abbreviations

Abbreviation	Long form name
ABA	American Bar Association
ACHS	Australian Council for Healthcare Standards
AHPRA	Australian Health Practitioner Regulation Agency
ANZOA	Australian and New Zealand Ombudsman Association
CHP	Complaint Handling Procedures
CMO	Chief Medical Officer
CSA	Complain Standards Authority
DG	Director General
DOP	Director of Prosecutions (at the OHOQ)
HCE	Health Complaint Entity
HHS	Hospital and Health Services in Queensland
HIS	Health Improvement Scotland
IOI	International Ombudsman Institute
NHS	National Health Service
NSW HCCC	New South Wales Health Care Complaints Commission
OHOQ	Office of the Health Ombudsman, Queensland
QCAT	Queensland Civil and Administrative Tribunal
QHQCC	Queensland Health Quality and Complaints Commission
SPSO	Scottish Public Services Ombudsman

Chapter 1 Introduction

The purpose of this introductory chapter is five-fold. It starts by situating the overall thesis within the administrative justice tradition before detailing the motivation that underlay the research. Following this, the chapter explains the aims and scope of the research before providing an outline of the research study's significance and contribution to knowledge and theory in this area. There, lastly, follows an overview of the structure of the thesis. In this thesis, the term 'ombudsman' is used to denote both the singular and plural version of the term. This is intended to retain the term's Swedish origins yet remove the gendered connotation associated with the suffix 'man'.

1.1 Situating the research

The socio-legal tradition considers the place of law within wider society and examines how legal institutions operate within the real world. A significant part of socio-legal thought concerns itself with administrative justice and concerns itself with ensuring that people receive from public bodies that to which they are entitled. Where this has not occurred, the administrative justice system enables individuals to raise a grievance and receive redress where appropriate (see Gamble and Thomas 2010 and Buck et al. 2011). Administrative justice, therefore, concerns itself with at least two things: the correctness of the initial decision by public bodies and the availability of secondary redress mechanisms (see Buck et al. (2011), Thomas and Tomlinson (2016) and Harris and Partington (1999)). One issue that arises from this is the effectiveness of these redress mechanisms to correct wrongs at both an individual and systemic level.

There are three broad groups of redress mechanisms relating to the consideration of citizen grievances against public bodies: courts, tribunals, and public sector ombudsman. It was the failings of legal processes to protect the rights of individuals that led to the establishment of ombudsman (Buck et al. 2011, p.29), with Seneviratne (2002, p.2) arguing that the basic premise underpinning the establishment of ombudsman was that individuals should be able to make a complaint about their government or its agencies and that such complaints should be independently investigated. This includes individuals who receive public healthcare.

However, until recently, health professionals were largely responsible for their own professional regulation, including the determination of the appropriate standard of care (Beaupert et al. 2014), but, now, many countries have started to move away from self-regulation towards a system of greater external oversight and accountability, with the intention of exerting greater influence over health professionals (Carney et al. 2016). This extends to the consideration of healthcare complaints as, '… a complaint will achieve most effect in increasing accountability if it is backed by the authority of some external agency, independent of the provider' (Pollock and Kerrison 2001, p.118).

The reason for this move to an increasing role for independent scrutiny has been due to a number of factors, but, importantly, include a number of high-profile healthcare scandals (Beaupert et al. 2014). Both Smith-Merry et al. (2016) and Healy and Walton (2016) suggest that the impetus that lay behind the establishment of health care complaint commissions in Australia[1] had several factors: general levels of dissatisfaction concerning the handling of health complaints by hospitals and professionals, a lack of alternative means of securing redress other than through hospitals, a desire for greater

[1] Health care complaint commissions are broadly the equivalent of health ombudsman in the UK.

accountability from hospitals and professionals, and, a desire for a less onerous alternative to medical negligence claims. The functions of these commissions were to resolve complaints and to act as a public watchdog (Smith-Merry et al. 2016). These motivations are similar to the reasons behind the establishment of health ombudsman in the United Kingdom (Gregory and Giddings 2002).

British health ombudsman and Australian health care complaint commissions are second-tier bodies, that is, appellate bodies for complaints. They are established on a statutory basis to consider complaints against healthcare organisations and health professionals and are funded through taxation. Most of these complaint bodies are restricted to responding to complaints brought to them and usually have very limited powers to secure compliance with their recommendations, or to undertake systemic investigations (Healy and Walton 2016). Their purpose is to act as the pinnacle of the complaints system and, thus, provide final decisions on health complaints. Compared with courts and tribunals, public ombudsman operate in a less legalistic and formal manner, with the emphasis less on adversarial approaches and more on inquisitorial investigations.

There is an argument, made by academics and ombudsman, that ombudsman make a contribution to system improvement (see Seneviratne (2002), Kirkham (2012) and Healy and Walton (2016) for academic views on this topic and Neave (2014), O'Reilly (2015) and Abraham (2012) for views from ombudsman). Indeed, contributing towards system improvement is seen to be a core function of ombudsman schemes, with some health ombudsman having this as a strategic objective while, for other health ombudsman, this objective is identified as a statutory obligation.

In theory, ombudsman are well placed to identify failings and should be able to provide bodies with guidance on how to prevent similar failings occurring in the future. It has been suggested that ombudsman attempt to do this through the use of a variety of activities (see Buck et al. (2011) and Stuhmcke (2010a)). In this regard, the role of courts and tribunals in the securing of administrative justice through judicial review and appeal hearings is well known but there has been limited empirical research undertaken on public ombudsman which examines their role and the impact of their decisions on public bodies. Buck et al. (2011, p.55) complain that academics and lawyers often consider administrative justice to consist solely of the workings and decisions of courts and tribunals, with ombudsman marginalised to 'superficial treatment' on the part of academics. Healy and Walton (2016, p.493) claim that health ombudsman justify particular attention as their core responsibility is to consider complaints from the public, noting that the healthcare sector has been slow to respond to, and learn from, complaints. Research findings on ombudsman, such as they are, have been equivocal, at best, suggesting that public ombudsman exert limited influence on decisions made by bodies under their jurisdiction. There is no research on the impact of the work of health ombudsman.

1.2 Motivation behind the research

This thesis builds upon a previous pilot study, undertaken by the researcher, on the Parliamentary and Health Service Ombudsman's (PHSO) role in the regulation of healthcare. Health scandals in England, such as the Mid-Staffordshire and the Morecambe Bay public inquiries, highlighted the failure of healthcare organisations to take complaints about the delivery of healthcare seriously, resulting in significant harm to patients as opportunities to improve the system were missed (Francis 2013, Kirkup 2015). In the former inquiry, the PHSO was seen as peripheral, while, in the latter inquiry, the PHSO was subject to significant criticism for failings in its handling of

complaints made against Morecambe Bay NHS Foundation Trust. This research concluded that the PHSO's strategic aim of contributing to the improvement of the healthcare system was more aspiration than reality (McBurnie, 2013).

This, together with the assertion that health ombudsman contribute to the improvement of the healthcare system yet where there is no empirical evidence to support this assertion and significant anecdotal evidence which suggests otherwise provide the motivation for undertaking this research.

1.3 Aim and scope of the study

The underpinning thesis that this research examines is that health ombudsman make an important contribution to the improvement of the healthcare system as a result of the roles and activities that they undertake together with the way that they work with bodies in jurisdiction. The overall aim of the research is to describe the approaches used by health ombudsman that are intended to contribute to the improvement of the healthcare system and to understand how these approaches are received, and acted upon, by that system. The health ombudsman's role as system improver includes any, and all, of their actions intended to contribute to the improvement of the healthcare system. This overall aim was supported by more detailed research objectives:

1) To describe the approaches used by health ombudsman to administrative justice.
2) To describe the differing approaches utilised by health ombudsman with differing statutory functions, as they seek to secure system improvement.

3) To describe the response of bodies in jurisdiction to the approaches utilised by health ombudsman.

To meet these objectives, the following research questions were identified:

1) What approaches do the OHOQ and the SPSO take to administrative justice?
2) What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement?
3) How do those in the healthcare system receive and respond to these approaches?

In undertaking this research, the initial proposal was to undertake comparisons of the contribution of two health ombudsman with differing statutory responsibilities to the improvement of the healthcare system in which they are part of the regulatory network and, also, to review the attitudes and responses of bodies in both jurisdictions to their health ombudsman. Unfortunately, the researcher was unable to gain the agreement of Queensland Hospital and Health Services (bodies within the jurisdiction of the OHOQ) to participate. As a result, the research has resulted in two interconnected research elements. Firstly, there is a comparison of the system improvement activities between the SPSO and the OHOQ which have significantly different statutory roles and responsibilities within their own regulatory network. Secondly, there is a study of the responses by Scottish health boards to the approaches used by the SPSO when discharging its responsibilities and the impact of these approaches on system improvement within the healthcare setting.

1.4 Significance of the study

As indicated above, this is novel research. There is little empirical research on ombudsman in general, and very little at all on health ombudsman. This research attempts to provide evidence to address some of the gaps that currently exist in the academic research base. As ombudsman schemes develop, it is not uncommon for the schemes to take on new responsibilities. How these additional responsibilities interact with core ombudsman functions is unknown. A novel approach used in this research is an international comparative case study investigating ombudsman offices with differing statutory responsibilities. This comparative approach will allow for greater insight to be obtained on the interplay between ombudsman responsibilities and activities than a focus on a single ombudsman scheme.

This research, therefore, intends to increase knowledge about the contribution made by health ombudsman to the improvement of the healthcare system, including the identification of the methods used by health ombudsman to achieve this contribution and to understand how bodies in jurisdiction respond to these ombudsman activities. This research should also have practical benefit to health ombudsman. Through the identification of different activities used by health ombudsman in their attempts to secure system improvement, and, an understanding of how the system responds to these activities, health ombudsman will be able to refine their approaches in order to maximise their impact.

1.5 Overview of the thesis

The structure of this thesis is as follows. Chapter 1 is the introductory chapter and provides the background and motivation to the research as well as providing an overview of the thesis. In Chapter 2 there is a review of the

literature relating to both health complaints and to administrative justice. Complaints are the primary activity of health ombudsman, the resolution of which engenders the legitimacy of health ombudsman. The chapter, therefore, considers the literature concerning complaints from the perspective of the complainant and those complained against, as well as the ability of complaints to secure system improvement. The chapter then considers the literature relating to the administrative justice system and the ombudsman's place within that system, before considering the ombudsman's contribution to complaint resolution and system improvement. In Chapter 3 there is the exposition of theoretical constructs relating to both organisational learning and to institutional logics and which, together, provides the conceptual and theoretical framework for the research. If organisations are to make improvements following an ombudsman report or other ombudsman output, then, in response to that output, organisational learning has to take place. This strand of the chapter considers current academic thought on organisational learning. The second strand of this chapter concerns the metatheory of institutional logics. Institutional logics create a belief system within an organisation that guides the thoughts and actions of individuals within the organisation. Multiple institutional logics can exist within an organisation and whichever institutional logic becomes dominant will shape the behaviours of the organisation. This strand continues by considering institutional logics as they apply to alternative dispute resolution and to the regulation of healthcare. Chapter 4 outlines the research methodology and research methods used in the research. The chapter also provides contextual information relating to the two case studies used in this research: the Scottish Public Services Ombudsman (SPSO) and the Office of the Health Ombudsman Queensland (OHOQ). Chapters 5 and 6 presents the research results, beginning in Chapter 5 with the results of the research into both health ombudsman offices while Chapter 6 provides the results from the research into Scottish health boards. In Chapter 7 there is the discussion involving the results of the research linking it back into previous academic research and theoretical constructs considered earlier in this thesis. The

thesis ends with Chapter 8 in which the conclusions from the research are drawn, the strengths and limitations of the research are identified and recommendations for future research are made.

Chapter 2 Literature Review

2.1 Introduction

A major function of health ombudsman is to act as a second-tier health complaint handler, that is, to consider complaints made against healthcare organisations and/or health professionals but which the healthcare organisation or health professional concerned have not been able to resolve. Part of the thesis that this research examines, and which was detailed in the introduction, is that health ombudsman are able to make an important contribution to the improvement of the healthcare system as a result of the roles and activities that they undertake. This chapter contains a review of the literature which supports this part of the thesis by considering the literature relating to both complaints and to the ombudsman institution.

Complaints are the primary activity of health ombudsman and the investigation of which provides health ombudsman with their legitimacy. Health complaints are also central to a health ombudsman’s system improvement activities. This, first, strand of the literature review starts with a brief introduction to complaints, introducing ideas that will be considered later in the chapter. The chapter then considers health complaints from, firstly, the perspective of the complainant, and then, secondly, from the perspective of those who have received a complaint. The chapter continues by considering the ability of health organisations and professionals to learn from complaints.

The second strand of this literature review relates to the ombudsman institution and its place within the administrative justice system. This strand commences with an introduction to the concept of administrative justice together with the description of some of the administrative justice models developed by academics before considering the place of the ombudsman

institution within the administrative justice system. The chapter then continues by considering the role of the ombudsman in system improvement and in the handling of complaints, before concluding with a brief review of relevant research on ombudsman.

2.2 Health complaints

The number of complaints received by both public and private organisations has been increasing, due in part to rising expectations on the part of consumers and also as a result of changes made by organisations to make it easier for the public to complain (Simmons and Brennan 2013, p.7; Allsop and Jones 2007, p.233). Simmons and Brennan (2013, p.19) further suggest that this is particularly the case for public services which, they claim, reflects the affection that the public have for public services.

Some authors suggest that the number of healthcare complaints submitted represent only a fraction of those people who have suffered an adverse event (Walton et al. 2014, Bismark et al. 2006), or who are dissatisfied with the care received (Allsop and Jones 2007, Parliamentary and Health Service Ombudsman 2013, Jones et al. 2006). However, the claimed ranges of unsubmitted potential complaints vary widely, from a low of 0.5% of potential complaints (Bismark et al. 2006) to ‘fewer than half’ (Healthwatch 2014), although most reports tend towards the lower end (Walton et al. 2014, Bismark et al. 2006, Allsop and Jones 2007, Parliamentary and Health Service Ombudsman 2013, Jones et al. 2006). The most common reasons for not pursuing a complaint was the belief that it would be futile and that nothing would change, a lack of knowledge about the complaints process, a concern about the impact on their future care and a feeling that they would not be taken seriously (Jones et al. 2006, Beaupert et al. 2014).

It has been suggested that ‘complaints are best understood as sentinel events, and complainants as representatives of much larger groups of harmed or dissatisfied patients’ (Bismark et al. 2013, p. 6). However, another study, by Kroening et al. (2015), suggests that complaints are not effective predictors of serious patient safety incidents, creating a challenge for hospitals to identify which complaints reflect a serious concern about which they should act, although the authors also write that where a serious adverse event had occurred, retrospectively, it could be found that the department had received complaints about that subject. It would appear that it is difficult to use individual complaints to predict serious safety issues, although receiving multiple complaints on the same topic may be an effective predictor.

2.3 Complainants

When individuals are unhappy about a service or product, they have a range of possible responses available to them which can be categorised as exit, breaking the relationship between individual and product or service, voice, a verbal response aimed at achieving change from the ‘offending’ company or person, and, loyalty, where the individual hopes that things will improve without action on their part (Sharma et al. 2010, pp.164-165). Where there is little competition in any given market, many people may be motivated to complain by a perceived sense of public benefit rather than individual benefit (Crie 2003). The reasons that people may complain are complex and can range from ‘… expressing dissatisfaction, to seeking an explanation, holding service providers to account, wanting an apology, seeking redress or pursuing compensation’ (Allsop and Jones 2007, p.233, George et al. 2007, p.22). In situations where individuals believe that they are more involved with a product or service the more likely will it be that they complain (Lau and Ng 2001). It can be difficult to assess the performance of a service when it is

difficult to see, ambiguous in nature or is complex (Friele et al. 2015) as is the case with healthcare.

Friele et al. (2015, p.529) suggest that the public has high expectations concerning the management of health complaints and that these high expectations explain, in part, low satisfaction with the response to their complaints. Ensuring that all complaints received by organisations are handled effectively, and that an individual's right to any arising redress is upheld, are core features of good governance, and are important in ensuring the effective provision of services (Brewer 2007, p.549). With regard to healthcare, control over the complaints process by health bodies, deferential attitudes towards doctors, and limited complaint processes originally acted as barriers to patient complaints but changes in the complaints system, particularly in the NHS, has led to a more consumerist model (Allsop and Jones 2007, p. 233).

Bismark and Dauer (2006) suggest that people who raise a health complaint are not troublemakers but people who believe that they have suffered harm and want to ensure that any preventable harm does not befall other persons. Dissatisfaction from those complained against about the reasonableness of complaints is considered at 'odds with reality' after a study found that nearly two-thirds of complainants had suffered harmful events, of which '79% were preventable and 60% involved permanent injury or harm' (Bismark et al. 2006, p.20).

Various academics have tried to identify the outcomes sought by complainants from complaining and suggest that outcomes sought include the receipt of an explanation, the prevention of recurrence, and to hold people to account (Kent 2007, Jangland et al. 2009, p.202, and Cowan and

Anthony 2008, p.166). Research by Bismark et al. (2011) found the following desired outcomes sought by healthcare complainants, see Table 1:

Desired Outcome	% complainants
Restoration which is a desire to be put back into the position the complainant would be if the error had not occurred.	87
Communication – this includes an apology and explanation.	57
Correction – improvements to ensure an error is not repeated.	46
Sanction – disciplinary action taken against a health professional.	17

Table 1 Desired outcomes sought by complainants (Bismark et al. 2011)

Friele et al. (2013, p.293), in their research, found broadly similar desired outcomes from healthcare complainants, see Table 2:

Form of accountability	% complainants
Correction	95
Communication	60
Restoration	70
Accountability	34

Table 2 Desired outcomes sought by complainants (Friele et al. 2013)

However, while healthcare complainants had clear expectations about their desired outcomes it is not clear that they are achieved. Bismark et al. (2011) found that only one in three persons who sought restoration achieved it, only one in five persons who sought system improvement were reassured that such improvements had taken place, while fewer than one in ten seeking some form of sanction saw this occur. The authors go on to claim that their findings are replicated in other countries (Bismark et al. 2011, p.807). Friele et al. (2013, p.294) claimed that only half of complainants were satisfied with

the outcome of their complaint. They stated that good complaint handling is not a guarantee of satisfaction. While good complaint handling is important, complainants are seeking more than that, they want action to be taken, things to change, for them to feel validated and for individuals to be punished.

2.4 The attitudes of health professionals towards complaints

One theory that may assist in understanding why people and organisations behave as they do when the subject of a complaint is that of defensive organizational behaviour (Homburg and Furst 2007). This model suggests that individuals try to avoid criticism which may affect their self-esteem through a range of defence mechanisms, which include isolation, denial, projection, rationalisation of the events, and repression of the events. Individuals within organisations bring these defence mechanisms with them and when faced with ‘an issue that contains significant embarrassment or threat, they act in ways that bypass … the embarrassment or threat’ (Argyris 1990, p.25). In doing so, employees will adopt a position, which protects their self-esteem which they may do through attempts to block or distort information (Argyris 1990). At an organisational level this may result in three types of defensive behaviour: reduced efforts to receive complaints, either by not signposting how to make a complaint or hostility towards complainants, reduced effort in ensuring that complaints are effectively transmitted to those parts of an organisation that needs to be aware of them, and reduced efforts to learn from complaints, through the poor handling of complaints, limited analysis of complaints information, and an inadequate use of complaints data to inform policies and practices (Homburg and Furst 2007). The consequence of such organisational mechanisms is reduced consumer and complainant satisfaction and complaint-based service improvements (Homburg and Furst 2007).

Clinicians do not always respond positively when the subject of a complaint (Zengin et al. 2014), with many doctors questioning the legitimacy of complaints received (Cunningham 2004). Many clinicians perceive complaints to be personal attacks which should be resolved by some other person (Douglas and Harrison 1996). Such attitudes by professionals are described as a matter of concern 'representing 'a fundamental breach of patient-centred care' (Gallagher and Levinson 2017, p.521).

These attitudes may, at least in part, be explained by the reaction of clinicians to the receipt of a complaint. Claiming that the effects of a complaint upon an individual can be 'enormous', Siyambalapitiya et al. (2007, p.108) state that clinicians may exhibit a 'sense of indignation towards the patients, frustration, doubts about their competence and fear of litigation'. Cunningham (2004, p.1) suggests that clinicians exhibit both short- and long-term emotional responses which arise as a result of receiving a complaint. Short-term emotional responses include 'anger, depression, shame, guilt and reduced enjoyment of the practice of medicine' and, while long-term these responses are reduced, clinicians retained a degree of anger along with decreased trust and goodwill towards patients. In a qualitative study of health professionals in England in which clinician participants attempted to interpret patients' complaints, Adams et al. (2017) found that the clinician participants interpreted the complaints in ways that marginalised the issue(s) central to the complaint. Complainants were held to be 'inexpert, distressed or advantage-seeking' with clinicians unlikely to say that complaints were grounds for system improvement, contrary to what complainants' state is one of the key objectives when making a complaint (Adams et al. 2017, p.603). Adams et al. (2017) found that interpretations of complaints by clinician participants included a sense of mistrust by the patient or family, as disregarding staff and services, evidence of misjudgement on the complainants' part, a sign of distress over what had occurred, and advantage-seeking.

Jain and Ogden (1999) conducted research with British general medical practitioners and, as a result, describe a three-stage response to the receipt of a complaint. The first stage, or initial impact, provoked indignation, shock and/or panic. There then followed a second, conflict, stage where the clinician was involved in conflict with not only with colleagues and family, but also with their own sense of professional identity. This conflict stage was associated with the psychological issues of stress, depression and suicidal ideation. The authors claimed that in the third, and final stage of resolution, the general medical practitioners either practised medicine more defensively or left medicine altogether.

Receiving a complaint is associated with high levels of psychiatric morbidity. Bourne et al. (2015) found that compared to the baseline, twice as many doctors reported suffering from moderate/severe depression and/or anxiety following the receipt of a complaint. Reported levels of severe/moderate depression and/or anxiety were higher if the complaint was being investigated by the regulatory body. (See also Nash et al. 2004, Ullström et al. 2013, Nash et al. 2006 and Walton 2003). Being subject to a complaint can have such devastating consequences to an individual clinician that, over an eight-year period, 28 doctors committed suicide while subject to fitness to practice investigations by the General Medical Council (Casey and Choong 2016). The feelings experienced by doctors have been compared to post-traumatic stress disorder at which point doctors become what is referred to as a ‘second victim’ (Bourne et al. 2015). It is claimed that the second-victim phenomenon is akin to that experienced by the complainant, or ‘first victim’ (Ullström et al. 2013).

The consequences of such psychiatric stress and morbidity appears to have an impact on the conduct and practise of medicine by those affected. Far from being a trigger to improve clinical practice it appears that such an experience can actually negatively impact clinical practice where doctors

display a set of behaviours known collectively as defensive medicine. ‘While the complaints process is intended to improve healthcare, some doctors appear to practise defensive medicine after receiving a complaint’ (Cunningham and Wilson 2011, p.449, see also Siyambalapitiya et al. 2007). Bourne et al. (2015) report that over 80% of doctors who had received a complaint reported ‘hedging’ in their clinical practice, which is when a doctor is overcautious leading to overtreatment or over-referral, or ‘avoidance’, which occurs when doctors avoid practices or patients they view as complicated or difficult. Defensive medicine is aimed at minimising the risk to a doctor and Cunningham and Wilson (2011, p.449) claim that there is evidence that such practice is ‘low quality in terms of decision-making, cost and patient outcomes’. Nash et al. (2004, p.280) claim that 98% of general medical practitioners claimed to have made a ‘defensive change’ to protect themselves against a possible complaint. Nash et al. (2006) are not as negative claiming that complaints can lead to positive changes in clinical practice as well as negative changes. The positive changes include better record keeping and better communication with patients, as well as improved screening, audit and general patient satisfaction behaviours. Cunningham (2004) states that while ‘complaints should lead to improved medical practice – this assumption has never been tested’.

One issue which may worsen the experience for clinicians is the complaints process. Nash et al. (2015) claim that doctors want the complaints process to be transparent and for the complaints process to be overseen by competent staff. In a study by Ullström et al. (2013) it was found that doctors who had received a complaint felt that the organisational support that they received had been insufficient, particularly from managerial colleagues although peer support was viewed more positively. A lack of support for doctors who receive a complaint was also found by Bourne et al. (2016), with doctors reporting that they felt powerless, distressed and harboured negative feelings towards the complaint handlers. The authors found that particularly stressful, for doctors, was the uncertain duration of the investigation, poor

communication between clinician and complaint handler, the unpredictability of the complaints process and procedures, with many viewing the complaints process being biased in favour of the complainant. As a result, doctors ‘felt neglected and betrayed by complaints procedures’ (Bourne et al. 2016, p.2).

2.5 Learning from complaints

Complaints can be considered as patient identified significant events and Jones et al. (2006) suggest that if complaints are considered as means to improve services rather than to blame individuals, then there will be opportunities to improve the health care system. Complaints can indicate problems within the health care system (Zengin et al. 2013, Cunningham and Wilson 2011, Friele et al. 2015, Hseih et al. 2006) and in the last thirty years there has been interest in the relationship between complaints and the quality of care (Adams, et al. 2018, Beaupert et al. 2014, Gallagher and Levinson 2013). Some researchers believe that there is a clear correlation between complaints received and the quality of care (Kroening et al. 2015, Harrison et al. 2016, Born and Query 2004, Walton et al. 2012), while other researchers do not believe that this is the case (Cunningham and Wilson 2011, Bismark and Studdert 2010, Cunningham 2004). In support of the latter view, it has been argued that ‘complaints act as a distorting mirror magnifying problems in some areas while obscuring problems in others’ (Cooke 2006, p.983). If true, then this would question the utility of complaints to act as a potential service improvement tool and may be compounded if health organisations view quality assurance as the search for poorly practising professionals rather than systemic learning processes (Berwick 1989). Research by Jones et al. (2006) also casts doubt on the ability of complaints to be used as service improvement triggers which is consistent with research by Friele et al. (2013).

Complaints can be opportunities to learn if they are recognised by organisations as triggers for learning (Vos et al. 2008). Learning from complaints can be considered as an integral element of clinical governance (Haw et al. 2010). Complaints have been considered ‘windows of opportunity to improve health services’ (Bismark and Paterson 2006, p.281), ‘an important source of information for service improvements’ (Siyambalapitiya et al. 2007, p.107), are able to act as a driver to improve the quality of clinical services (Bennett and MacDougall 2007), can support the recognition of adverse incidents, act as an early warning system and help the identification of areas for improvement (Allsop and Mulcahy, 1995), ‘should lead to improved medical practice’ (Cunningham 2004, p.2), and ‘offer invaluable learning opportunities’ (Healthwatch 2004, p.8). Walton (2003, p.41) states that ‘medical mistakes mainly occur in isolation (one patient at a time)’ and this, therefore, makes it harder to recognise system errors. Hseih (2010, p.453) suggests that while ‘patient complaints should be part of a quality management system’ there is a lack of tools which would enable complaints to promote system improvement.

Gray and Williams (2011) argue that the learning culture associated with error is associated with sets of defensive behaviours which aim to pretend that learning has occurred, when in fact, there has been little understanding of what happened and why, potentially together with some degree of cover-up. Learning within the NHS depends significantly upon information obtained from the analysis of adverse events and complaints but, in doing this, the result is that the NHS focuses its learning activities on ‘low frequency events’ (Sujan and Furniss 2015, p.8). Sujan and Furniss (2015) continue that this focus on low frequency events brings with it negative connotations which lead to negative behaviours and a focus on safe events, thus limiting the utility of what learning can be gained. They continue, complaints often emphasise what has gone wrong which sets the tone of the investigation and creates a set of negative implications and, from this, a negative learning culture. If the NHS is to be able to learn fully from complaints then it is

important that health organisations and professionals recognise the negative behaviours that drive inappropriate responses to complaints (Cunningham and Wilson 2011).

Gray and Williams (2011, p.439) further suggest that the approaches from the NHS to organisational learning ‘include a surface approach to learning and a blame learning culture’ where surface learning is characterised by a transient gain of new learning and practise, while the latter becomes ‘ … “things that cannot be discussed”, which are in effect fear, shame and personal trauma’. The teaching of health professionals often ‘encourage[s] surface learning approaches which promote single loop learning’ (Gray and Williams 2011, p.445; Hseih 2011) while learning associated with blame cultures perpetuate ‘what’ is learned and not ‘how’ is it learned (Gray and Williams 2011, pps.446-447).

Gray and Williams (2011) propose that to break out of this negative culture requires a move from a focus on failure and blame to a re-framed focus which attempts to recognise the positive learning features contained within an adverse event. Based upon this idea, Gray and Williams (2011) successfully piloted an approach which sought to re-frame negative experiences involved in adverse events by focusing on what went right and, by doing so, increased learning from the adverse events. Bismark and Morris (2014, p.428) state that what is needed is a ‘paradigm shift [in culture] that allows health practitioners to see them [complaints] as an invitation to learn’. Braithwaite et al. (2005) suggest that the answer is the adoption of a ’no blame’ culture although they recognise that a shift from a no blame to a learning culture will not be simple or quick.

The literature review, so far, has considered literature relating to health complaints from the perspective of both a complainant and those complained

against, as well as considering the ability of complaints to contribute towards system improvement. The literature review now moves on to a consideration of the administrative justice system, the ombudsman's place within it and the ombudsman's contribution to service improvement and complaint handling.

2.6 Administrative justice

In recent decades, there has been a significant change in the extent and range of government and public administration affecting almost every citizen (Gamble and Thomas 2010, p.3). As a consequence of these changes, it has become more difficult for both politicians and citizens to understand the increasingly fragmented governing process, with Gamble and Thomas (2010 p.6) claiming that a distinguishing feature of modern governance arrangements is that, as decisions are taken by an extensive range of bodies, it is 'increasingly hard to pinpoint who has responsibility, who is accountable, or where policies come from'. They further suggest that as a result, individual citizens are, for the first time, unable to understand the governing arrangements under which they are situated (Gamble and Thomas 2010, p.3). The vast majority of legal decisions now made in modern democracies are not made by courts or tribunals but by a range of public administrative functionaries in areas such as tax, welfare benefits or immigration.

In parallel to this development of the state, there has been the development of what Gamble and Thomas refer to as the 'integrity arm of the government', that is the establishment of bodies with the express purpose of overseeing the conduct of public administration and referred to as the administrative justice system (Gamble and Thomas 2010, p.14, see also Buck et al. 2011). The development of this 'integrity arm' is intended to mediate 'the behaviour of civil servants, ministers, advisers and agencies' and 'hold Ministers to

account and to redress citizens' grievances' (Gamble and Thomas 2010, p.14).

Administrative justice has been defined in different ways by different theorists. For Mashaw (1983, p.24) administrative justice is 'the qualities of a decision process that provide arguments for the acceptability of its decisions'. Creyke and McMillan (2000, pps. 3-4) define administrative justice as 'a philosophy that, in administrative decision-making, the rights and interests of individuals should be safeguarded', although Creyke claims that McMillan later refined the definition to take account of 'the need for government agencies to balance justice in the individual case with other imperatives' (McMillan, cited by Creyke 2010, p. 274). This highlights one of the challenges facing public administrators – how do you balance the rights of the individual with those of the wider public in a publicly funded, and hence financially constrained, service?

Disagreements about the nature of administrative justice has led to claims that it is in 'a muddle' (Abraham 2012, p.91). Harris and Partington, (1999, p.2) picks up this issue of confusion surrounding administrative justice, arguing that there is disagreement about the meaning of the term 'administrative justice', suggesting that some consider administrative justice to be concerned with legal entitlements and the decisions of courts or tribunals, while others consider it more broadly, encompassing the concept of maladministration or poor service delivery. Despite this common agreement about confusion and disagreement with the concept of administrative justice, Ison (1999, p.26) suggests that there is a 'demand' for a 'common thread' or 'common overview'.

Mullen (2010, p.383) suggests that the term, administrative justice, can be used either prescriptively or descriptively. When used prescriptively it refers

to the principles used to determine the justice in any administrative decision, while, when used descriptively, ‘the term administrative justice denotes a field of study’ arguing that writers need to be clear about the definition used. Buck et al. (2011, p.54) claim that the term can be used descriptively or normatively. However, for them, when used descriptively, the term refers to the interface between government agencies and individuals or bodies such as courts tribunals or ombudsman while, when used normatively, administrative justice describes how administrative decisions ought to be made. Tomlinson and Thomas (2016) suggest that administrative justice can be considered as a network of systems such as courts, tribunals or ombudsman or as a set of principles and values that underpin administrative decisions. These principles include ‘fairness; participation; accessibility; accuracy; proportionality; transparency; finality; consistency; efficiency; effectiveness; and value for money’.

Part of the definition of administrative justice is the concept of citizen redress that arises when a mistake has been made in the delivery of public services. Dunleavy et al. (2010, p.421) suggest that redress includes the remedy of a harm (or reparation if that is not possible), in a way that is visible to the individual concerned but should also include the correction of contributory factors and a public apology for the error. In delivering these objectives, Buck et al. (2011, p.36) warn of the limitations in relying upon courts as a means of defending good administrative standards. They suggest that ‘the concept of good administration goes much further than legal standards alone and include non-legal rules that define the standard of conduct which ensures the proper functioning of public administration (Buck et al. 2011, pp. 32-33). They argue that, as a result, the concept of administrative justice has gone beyond courts and tribunals to include ‘the importance of the first-instance decision making process’ (Buck et al. 2011, p. 54, see also Thomas and Tomlinson (2016, p.4) and Harris and Partington (1999, p.2)).

Central to the concept of administrative justice is the idea of accountability: 'individuals affected by decisions should have the ability to call to account those responsible for those decisions' (Gamble and Thomas 2010, p.19). This accountability has two benefits: it enables individuals to receive that to which they are entitled and, if appropriate feedback mechanisms are in place, should lead to improvements in public services. However, due to the fragmentation of the delivery of public services and the confusion about who is responsible for what, Gamble and Thomas (2010, p.20) believe this combination leads to a decrease in the level of trust held by citizens in government and the state. Accordingly, one of the functions of the administrative justice system is to restore trust through the establishment of appropriate redress mechanisms.

Adler (2010, p.129) suggests that administrative justice has two dimensions: a procedural dimension concerned with the way individuals are treated and a substantive dimension concerned with what an individual receives or contributes. This is a development on the initial idea that administrative justice was concerned with individuals receiving that to which they are entitled. It now encompasses how individuals are treated and recognises that to individuals, how they are treated is important, whether or not they get the desired outcome, and that individuals assess the fairness of the process separately from the outcome received (Adler 2010, p.129). Thus, administrative justice is concerned with both procedural and substantive justice. Procedural fairness can be secured either through the imposition of principles by organisations external to the public body by organisations such as courts, tribunals or ombudsman, or the self-imposition of principles established by the body itself such as through quality control or audits and that both internal and external imposition of such principles co-exist (Adler 2010, p.141).

Initially, the external control centre would have been the courts or tribunals. Courts achieve this through the judicial review of the decision and, particularly, the processes used in reaching that decision. However, as Adler (2010) states, data on judicial review 'do not suggest that judicial review provides a very effective check on routine administrative decision making' and, that, as courts 'provide little procedural protection for administrative decisions', this led to the establishment of ombudsman. However, despite this, Adler (2010, p. 147) still believes that external means of control, including ombudsman, can provide little evidence of their effectiveness.

2.7 Conceptual models of administrative justice

Mashaw (1974) was responsible for seminal research on social welfare payments which, instead of focusing on external controls on administrative decisions, focused on the very large number of decisions made by first-instance decision-makers. In this research Mashaw (1974, p.24) defined administrative justice as 'those qualities of a decision process that provide arguments for the acceptability of its decisions'. From his research he developed three competing models of administrative justice: bureaucratic rationality, professional treatment and moral judgment. However, Mashaw's work has been criticised as it does not include consideration of the rights of citizen redress (Buck et al. 2011, p.58).

Mashaw's three models define three differing considerations of administrative justice. The bureaucratic model is concerned with the efficient and accurate implementation of decisions which reflect the legislature's will; the professional model is dominated by a professional culture which takes account of the incompleteness of information, the fact that no two cases are alike, and therefore professional judgment is required to make decisions; the moral judgment model is concerned with determining which side is to be

supported when the interests and values of two sides are in conflict (Mashaw 1983, pp.26-30).

Adler (2003) developed Mashaw's models of administrative justice in the light of changes in society and, firstly, recast Mashaw's moral judgment model as a legal model, as he suggested that Mashaw's moral judgment model, which was legitimated by 'fairness', was unhelpful as it implied that the other models were 'unfair' (Adler 2003, p.329). Instead, Adler felt that the model's legitimating value was the assertion of legal rights. Secondly, Adler identified three additional models: a managerial model, a consumerist model and a market model. Adler (2010, p. 333) defines the managerialist model 'in terms of managerial autonomy, the pursuit of efficiency gains, and the use of performance indicators to assess accountability' and the ability to highlight failure to hit performance targets as a means of pressurising management to improve. The consumerist model takes a view which holds that the individual is an active participant in the process unlike in Mashaw's three models, and thus is about meeting consumer satisfaction with services. Adler's third addition is the market model which, he states, combines elements of the managerialist and consumerist models and involves the matching of supply and demand through the use of price. Individuals choose the supplier who best meets their needs or wants (Adler 2010, p.334).

Mashaw (1983) suggests that his three models are in competition with each other and argues that, in any one particular organisation, one of the models will become pre-eminent. Adler (2010, p.150) highlights not only that these models may be in competition but also that what may appear in one model to be fair may appear to be unfair using a different model. One sees this in the delivery of health care in the United Kingdom where politicians, managers and health professionals are often in disagreement over the allocation of resources and how healthcare should be best delivered to patients. Adler (2010, p.153) argues that this competition between differing views regarding

a fair outcome indicates that there are no invariable principles of procedural fairness that apply in all administrative contexts. Adler (2006, p.621) notes that in the delivery of healthcare the dominant model is likely to be the professional judgment model. If true, it raises interesting issues about what happens when differing approaches to administrative justice clash, as may occur between health ombudsman and healthcare organisations, such as, which model will dominate and is the communication between the parties adversely affected?

As well as being in competition, as all models were legitimate but involved different approaches, both Mashaw (1983) and Adler (2003) also agreed that the dominance of one model necessitated trade-offs where aspects of the other approaches were diminished. Each of the three models, bureaucratic rationality, professional judgment and legal, can be associated with an external redress mechanism: administrative review, second opinion or complaint to a professional body, and, an appeal to a court or tribunal, respectively, (Adler 2003, p.330). However, Adler (2003, p.344) was cautious about the degree of impact that external bodies can have on administrative decision-making.

Carney et al. (2017) make a distinction between professional judgment, with its focus on the making of an appropriate decision drawn from a range of options designed to be in the best interest of an individual, and the legal model which they describe as ‘grounded in the application of rules after extending a fair hearing to any aggrieved party’ (Carney et al. 2017, p.75). The authors further note that proponents of the legal model may be critical of the professional model for being deferential to both peer and second opinions while also noting that the professional model may overcome ‘the rigidity, arbitrariness, and procedural straightjacket commonly associated with the legal model (Carney et al. 2017, p.75).

Buck et al. (2010, p.64) argue that together Adler’s six typologies ‘represent the underlying drivers of administrative justice which are in competition with each other for dominance’. The importance of the six typologies of normative models of administrative decision-making is that the three developed by Mashaw represent internal means of decision-making and accountability while, Adler’s three models, focus on external means of accountability. Adler (2003, p. 324) argues that his revised model is a theoretical framework through which administrative decision-making can be analysed.

Kagan (2010, p.168) identifies some factors which may influence which model of administrative justice is adopted by an organisation. These include the organisation’s legal mandate, its operating environment and, importantly, the beliefs and attitudes of the organisation’s senior management. While the underpinning legislation upon which an ombudsman office is founded will play a significant role in shaping the activities of an ombudsman office, the ombudsman post-holder will be the primary influence in determining which of these models its office adopts. Public sector ombudsman normally hold ‘corporate sole’ status which means that they have absolute authority over the running of their office, and formally accountable only to Parliament. In addition, ombudsman offices have limited resources and it is a matter for the ombudsman discretion as to where the balance of resources and hence activity are placed (Seneviratne 2002, p.17, Buck et al. 2011, p.91 and p.150).

Tomlinson and Thomas (2016) consider the utility of the different modelling approaches and conclude that there are three main benefits. The first claimed benefit which they identify is that they help people understand why public bodies operate and make decisions in the way that they do. A pluralistic approach enables differing normative views on how the administrative justice system ought to operate to be proposed. The second claimed benefit is that it aids the understanding of the tensions that arise

within the administrative justice system as the models are in competition. Thirdly, Tomlinson and Thomas claim that it enables an understanding of the trade-offs that need to be made in decision-making and allows for the consideration of whether these trade-offs are acceptable and desired.

2.8 The development of the ombudsman institution

The idea of the modern ombudsman is considered to date back to the establishment of the Justitieombudsman in Sweden in 1809, whose role was to consider complaints made by individuals against public officials (Abedin 2010, p.221), although it was another 110 years before another country, Finland, established its ombudsman in 1919 (Seneviratne 2002, p.2). However, it was the establishment of an ombudsman by Denmark in 1955 that led to world-wide interest in the ombudsman concept an interest which was reinforced when New Zealand became the first non-Nordic country to establish its ombudsman in 1962 (Seneviratne, 2002, p.3).

Since the establishment of these ombudsman there has been an exponential increase in the number of ombudsman with this growth described by commentators as 'spread[ing] explosively around the world (Gill et al. 2013, para 2.2), an 'ombudsman explosion' (Anderson 1980, cited in Abedin 2010, p.225) and 'ombudsmania' (Rowat 1985, p.83). The growth had been so exponential that, in 2002, Seneviratne (2002, p.2) felt able to declare that the ombudsman concept had 'conquered the world' with Buck et al. (2011, p.3) declaring the ombudsman to be 'one of the essential institutions that a constitution should possess'. Currently the International Ombudsman Institute (IOI) lists 222 members from 120 countries as well as the European Union Ombudsman (IOI 2020) which represents an increase of 23 members and nine countries from 2018 (IOI 2018).

Abedin (2010) considers the reasons that help explain the rapid growth in the ombudsman phenomenon and identifies three background factors: the establishment of new countries as a result of decolonisation, the collapse of the communist state system, and the development of the civil and human rights movement around the world. Upon these background factors Abedin (2010) then identifies specific factors which include the expansion of the role in government, the erosion of traditional institutions to protect individuals (exemplified by the court system becoming increasingly unaffordable to the average individual) and economic globalisation, where bodies such as the International Monetary Fund or World Bank increasingly insist on the use of ombudsman types institution to deal with 'bureaucratic and political inefficiency, ineffectiveness, corruption and lack of public accountability and transparency of administrative processes in return for investment' (Abedin 2010, pp. 226-229).

Gill et al. (2013, pp. 9-11) describe five phases of ombudsman development in the United Kingdom and make the important point that these developments were not planned in any orderly way, the process being described as 'blinkered and haphazard' by Merricks (2009, cited by Gill et al. 2013, p.11) and, ultimately, claim that the resulting landscape 'defies logic' (Gill et al. 2013, p.11). Buck et al. (2011) state that it would be a mistake to think of ombudsman 'as neatly fitting into any standard and fixed model'.

One issue that arises out of this flexibility and evolution is the difficulty that arises in defining what is an ombudsman. Gottehrer and Hostina (1998) try to circumvent this by describing the essential characteristics that a classical ombudsman should possess: independence, impartiality and fairness, credibility of the review process used by the ombudsman, and confidentiality. Rowat claims that ombudsman possess three characteristics: the ombudsman is an independent supervisor of public administration whose role is either provided for in a constitution or statute; the ombudsman considers

specific complaints concerning administrative injustice; and, has the power to investigate such complaints and to criticise but not to overturn the administrative decision (Rowat, cited by Abedin 2010, p.224).

However, those characteristics describing an ombudsman relate to classical public sector ombudsman and, with the spread and diversity of ombudsman in recent years, these definitions are increasingly outmoded. Gulland (2010, pp.470-471) asserts that ‘defining an ombudsman is difficult, as the name means different things in different countries and, even within the United Kingdom, there is a variety of different definitions’. Seneviratne (2002, pp. 7-10) states that there are many different definitions, arising from the ability of ombudsman to react to, and meet the needs of, local circumstances.[2] A common starting point in trying to define an ombudsman is the definition developed by the International Bar Association:

> An office provided by the constitution or by action of the legislature or Parliament and headed by an independent high level public official who is responsible to the legislature or Parliament, who receives complaints from aggrieved persons against government agencies, officials and employees or who acts on his own motion, and has the power to investigate, recommend corrective actions and issue reports (International Bar Association cited in Seneviratne 2002).

In recognition of the changing ombudsman world this definition was updated in 2001 by the American Bar Association to state:

> An ombudsman is a person who is authorized to receive complaints or questions confidentially about alleged acts, omissions, improprieties, and broader, systemic problems within the ombudsman defined jurisdiction and to address, investigate, or otherwise examine these issues independently and impartially (American Bar Association 2001).

As well as there being a range of definitions for the ombudsman concept, Stuhmcke (2010, p.162) states that ‘the [term] ‘Ombudsman’ … contains no

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[2] For a discussion on the definition and taxonomy of ombudsman see Carl (2012)

prescription to usage' and provides examples of ombudsman descriptors such as a 'watchdog' or a 'protector' with Abedin (2010, p.223) providing other examples, including 'grievance-man', 'mediator' and 'citizens' defender'.

Unsurprisingly, given that ombudsman have developed in ways to meet local circumstances, the exact means of service delivery used by ombudsman can vary between each scheme although Seneviratne (2002, p.12) claims that the different methods are underpinned by two concepts, that of informality and flexibility. Once an ombudsman accepts a complaint, they take responsibility for its investigation where the complainant and body concerned are participants rather than drivers of the process (Mullen, 2010, p.393). The ombudsman decides on the methods used, which are normally inquisitorial and informal, with the consequence that both complainant and body lack the procedural safeguards associated with the adversarial process (Mullen 2010, p.393). It is a low-cost model with the complainant incurring no costs at all (Mullen 2010, p.402). Adler (2003, p. 327) states that the methods used by ombudsman are effectively instrumental in so far as an upheld complaint is used to justify redress including service improvement.

Abraham, the former Parliamentary and Health Service Ombudsman, while recognising that an ombudsman is an alternative to the court system, differentiates the means used by ombudsman in their complaint investigations role from both courts and systems of mediation highlighting that it is still a decision-making forum and 'not an alternative to decision-making' (Abraham 2008, p.3). Abraham claims that the distinguishing feature between ombudsman and courts is that it makes adjudications by different means from those used by courts, based on informality, a 'common-sense' approach to evidence, inquisitorial processes with a focus on the individual case, unbound from precedent (Abraham 2008, p.4).

Mullen (2010 p. 417) states that it is important to maintain this separation of the court and tribunal systems from ombudsman as the former consider legal rights and duties while ombudsman deal with ‘administrative defects’. Indeed, he goes onto assert that a key reason behind the establishment of public sector ombudsman in the United Kingdom was their intended ability to consider such administrative failings. The consequence of this was that ombudsman could use tests of maladministration or injustice rather than illegality and utilise different means of to investigate the issues presented (Mullen 2010, p.417).

As discussed above, it is clear that the ombudsman institution has developed, altered and, arguably mutated, from its classical origin. Classical ombudsman originally focused on the resolution of individual complaints but, over time, ombudsman began to also focus upon system improvement and, more recently, on functions such as auditing and monitoring which are not normally considered to be within the purview of classical ombudsman (Stuhmcke 2012). Stuhmcke (2012) advances three principal reasons for this growth and diversity of ombudsman models.

Firstly, such changes are a reflection of the political environment in which the ombudsman institution exists. Public ombudsman are creations of the state to resolve some current political issue. Therefore, the construct of the ombudsman institution will be determined by both the nature of the political issue and the view held by politicians about the ombudsman institution and its role. The second reason for the growth and diversity of ombudsman relates to the willingness of the postholder to accept additional responsibilities. The third reason concerns the ‘acceptance and trust of the institution within … [their] jurisdictions’ (Stuhmcke 2012, p.92).

In the above paragraph it was noted that the growth and diversity of the ombudsman office lies in part in the willingness of the postholder to accept additional responsibilities. With public sector ombudsman, the postholder often holds what is known as corporation sole status. A corporation sole is a specific individual who embodies an official position which is a separate legal identity and can only be established via statute. While an ombudsman will, necessarily, employ staff to enable her to discharge her responsibilities, the ombudsman is responsible for all decisions made in her name. Thus, the ombudsman postholder is able to individually determine the priorities of the office as long as their decision is compliant with the offices underpinning legislation. This provides the ombudsman postholder great influence upon the balance of activity between individual complaint handling and system improvement. This is unlike the situation that occurs with traditional organisations and private sector ombudsman where there is likely to be a board which will agree the overarching policy approaches and strategies. In this regard, this research should be regarded as a snapshot in time. Different ombudsman postholders are likely to have differing priorities. This was the situation found by Stuhmcke (2006) in her research on the Commonwealth Ombudsman where a change in ombudsman postholder was linked to a change in the balance between individual complaint handling and systemic investigations. In making such a decision, the postholder will need to take into account the views of their Parliament to which they are accountable, their underpinning legislation, relevant case law and other political and contextual developments.

These changes in the range and scope of ombudsman institutions has led to attempts by academics to categorise them into different models of modern ombudsmanry with Stuhmcke's (2012) model one of the more renowned. In her model, Stuhmcke (2012) identified three broad categories or models of ombudsman: the reactive, variegated and proactive models of ombudsman. The reactive ombudsman model is based upon the classical ombudsman idea and has a primary focus on resolving individual complaints, although it

may undertake proactive system improvement work, through activities such as recommendations to resolve specific failings, and even systemic investigations. The variegated ombudsman model ‘is characterised by an increasing scale and scope in jurisdiction’ (Stuhmcke 2012, p.86) although this model of ombudsmanry retains its primary focus on the resolution of individual complaints. Stuhmcke (2012, p.86), suggests that this represents a move by ombudsman away from bodies in jurisdiction’s policies and processes, into a role of ‘verification and examination’. A final identifier for the variegated ombudsman model, identified by Stuhmcke (2012), is that of education, where ombudsman participate in educating bodies in jurisdiction on good practice complaint handling. The third, and final, ombudsman model is the proactive ombudsman model, where the ombudsman makes a conscious decision, to move away from a primary focus on individual complaint handling into proactive activities such as training and major systemic activities although it may continue to undertake some individual complaint handling. Caution should be taken not to think of these categories as absolute. For example, a reactive ombudsman may undertake some system improvement activities but its primary focus will remain on individual complaint handling.

2.9 Ombudsman and system improvement

It is clear that ombudsman are seen as an integral part of the administrative justice scene, with their own *modus operandi* and approach to remedying injustice. But, Harris (1999, p.134) poses the question of what is the role of the ombudsman within the administrative justice system? When the Australian Government was considering whether to establish its Commonwealth Ombudsman, it posed the question of whether the role of an ombudsman was to ‘swat flies or to hunt lions’, that is to be concerned with individual complaints or have a wider more systemic role, before deciding it was the former (Snell 2007).

However, this approach adopted by the Australian Government is not a view shared by ombudsman, or one that has been undertaken in practise. Emily O'Reilly, the European Ombudsman described the role as being like 'the canary in the coal mine' 'checking the health of a democracy by checking the air of the administration' (O'Reilly, 2015). Abraham (2012), the former Parliamentary and Health Service Ombudsman, makes a claim for an 'ombudsman dividend' that is a role greater than individual dispute resolution. Through the publication of case reports and documents offering guidance to public bodies, the ombudsman role expands from investigating complaints to system improver.

The role of an ombudsman has been of interest to academics and a broad consensus has developed. The initial role of the ombudsman was to investigate individual complaints. However, over time, as ombudsman made use of the large degree of discretion available to them in determining the activities they undertook, that role has grown. Colin Neave, the former Australian Commonwealth Ombudsman, stated that viewing an Ombudsman as an individual who investigates individual complaints against public bodies is a

> very old-fashioned notion. In reality, we are leaders in building public administration. We have a critical place between government and the public, and we are a safety net for members of the community … We promote good governance, accountability and transparency through oversight of government administration and service delivery. (Neave 2014, p.1-2).

Both Seneviratne (2002), and Healy and Walton (2016) state that ombudsman have two roles, that of individual complaint handling and to improve standards of public administration. Kirkham (2005, p.745) suggests that the early Parliamentary Ombudsman saw its role as having two functions: to right individual injustices and to ensure that lessons learnt from their complaint investigations was used to improve public administration more generally thus preventing errors occurring in the first place (see also Kirkham

2012, p.2; Behrens 2015, p.3 and Gulland 2010, p.475-476). Stuhmcke (2010, p.163) suggests that it is now an expectation of ombudsman that their activities lead to system improvement. Neave (2014, p.2) suggests that the system improvement is achieved in two ways. The first is that information from upheld complaints is fed back directly to the body concerned, allowing for the body to learn from the complaint, and, indirectly, where he asserts, that the existence of an ombudsman that has oversight over the body is an incentive for the body to improve their administrative actions.

In an influential paper on the role of ombudsman, Harlow and Rawlings (2009, pp.537-542) developed the concept of 'fire-fighting' and 'fire-watching' roles of ombudsman. The 'fire-fighting role' refers to individual dispute resolution function of ombudsman, while 'fire watching' refers to an ombudsman role in system improvement. This categorisation was developed further by (Snell 2007)[3] with the addition of a 'fire-setting' function which takes account of a trend by ombudsman to take on additional audit type functions and where the ombudsman activities are no longer driven by complaints. Buck et al. (2011, pp.19-21) refer to these three fire related categories as 'putting it right' relating to the handling of individual complaints, 'getting it right' relating to ombudsman system improvement roles where they help bodies to get it right first time, and 'setting it right', which places the ombudsman within a larger network of organisations aimed at improving the overall administrative system.

Despite widespread academic and practitioner agreement that ombudsman have at least a dual role of resolving individual grievances and contributing to system improvement, Carney et al. (2017, p.82) make the point that balancing both a focus on system improvement and individual complaints

[3] The Snell reference appears to predate the Harlow and Rawlings reference on the same subject. This is due to the author citing the latest edition of Harlow and Rawlings while the Snell paper has not yet been updated. Thus, Harlow and Rawling's concept of fire-fighting and fire-watching predates Snell's development.

resolution is problematic ‘both conceptually and in the overall governance system’.

In public sector ombudsman, recommendations arising from findings are normally non-binding. Despite this, Steyvers et al. (2009, p.18) claim that the lack of power does not imply a lack of influence. The authors claim that ombudsman have significant ‘moral authority’ arising from the quality of their investigations and their relations with both the public and bodies in jurisdiction means that ‘the office can have influence without power’. Buck et al. (2011, p.126) make a similar argument that it is the power and depth of an ombudsman investigation that creates legitimacy to the resulting recommendations creating influence.

Hertogh (2001) compared the impact of the Netherlands’ ombudsman and courts. He found that the impact of courts arose through their powers of coercion while, for ombudsman, he found that an ombudsman’s impact arose from their cooperative approach with bodies in jurisdiction. Hertogh (2001) concluded that the degree of impact achieved by either courts or ombudsman related to their operating style. Hertogh (2001) further concluded that the cooperative approach adopted by ombudsman led to better communication and better understood and accepted decisions. The result was that Hertogh believed it likely that ombudsman had more policy impact than courts (Hertogh 2001, p.63).

Buck et al., (2011, p.149) recognise the importance of the cooperative approach between ombudsman and bodies but caution that a more active role may appear threatening to a body, resulting in lower levels of cooperation and, ironically, increased difficulty for ombudsman in undertaking their work. Counterposing this view, Bizjak (1999) asserts that ‘While [an] ombudsman cannot turn hell into heaven, he can at least make life in hell

more bearable' (Bizjak 1999) by which he means an ombudsman can support bodies in jurisdiction in improving the system, a view in keeping with that of Hertogh.

By what methods do ombudsman make 'hell more bearable'? Stuhmcke (2010a) identified the following range of broad activities: complaint handling, the production of formal reports, submissions, meeting with agencies, publicising its activities, audit, compliance, conducting major projects and own motion investigations. Not all the listed activities are available to all ombudsman and the prioritisation of the available range of activities will depend upon the views of the incumbent ombudsman. Buck et al. (2011, pp. 132-146) identified a broadly similar range of activities undertaken by ombudsman in their system improvement roles: the production of thematic reports, undertaking systemic investigations, the production of follow up reports, undertaking own initiative investigations, widening the scope of an investigation, the production of guidance, the production of submissions, the delivery of training, and undertaking audit, inspection and monitoring.

John McMillan, the former Commonwealth Ombudsman, identified a range of activities that ombudsman could use to improve public administration. These include seeking publicity for the work of the office, and being constructive with the development of recommendations (McMillan 2010). Kirkham et al. (2008) claim that an ombudsman's ability to enforce their reports arise through a combination of an ombudsman powers of persuasion, the ability to publicise its activities and the access it has to the political process.

2.10 Health complaints and the ombudsman

Health ombudsman are a source of external scrutiny over health organisations. Continued public confidence in such external scrutiny bodies

depends in part on them retaining public confidence and trust in their operation (Brewer 2007). Kent (2007), considers such external scrutiny bodies as secondary targets of trust – that is independent bodies responsible for ensuring continued public trust in primary targets of trust, which are people or organisations with which the public have direct contact. Trust in the system depends upon these secondary targets of trust ensuring that breaches of trust between the public and primary targets of trust are condemned and remedied. Carney et al. (2016) warn that, if external agencies focus on individual complaints and redress, this may be achieved at the price of insufficient emphasis on overall system improvement. Walton argues that some health professionals exhibit negative feelings towards independent complaint authorities including ombudsman, but claims that there is significant evidence demonstrating the benefit that accrues to the medical profession from the existence of independent complaint authorities, going so far as to say that independent complaint bodies help 'sustain medicine as a profession' (Walton 2001, p.75).

Healy and Walton (2016, p.503) suggest that health ombudsman will manage most complaints at the 'softer base of a regulatory pyramid' (see Figure 1 below) using activities such as advice, referring the complainant back to the body in question or securing a rapid apology and explanation. In some cases, more interventionist actions will be undertaken, such as conciliation, investigation, the publication of reports, and in the case of certain Australian health commissions, the imposition of sanctions or prosecution.

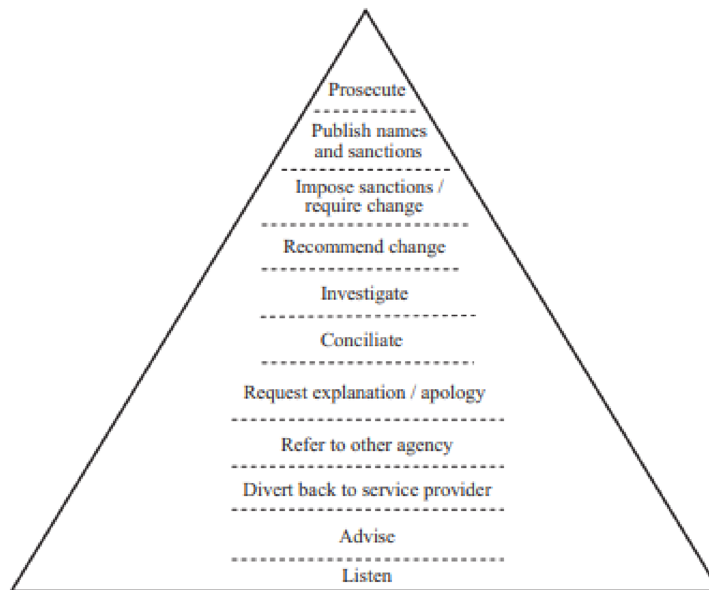

Figure 1 Pyramid of ombudsman regulatory mechanisms (Healy and Walton 2016, p.501)

Carney et al. (2017) claim that the matters dealt with by ombudsman-type bodies differ significantly from other administrative type tribunals. These insights were summarised by Carney et al. (2017) as follows:

1. The decisions made by health ombudsman are not normally simple binary decisions. Despite the fact that United Kingdom ombudsman tend to pronounce complaints as being upheld or not upheld, Carney et al. (2017) note that health complaints are normally multifaceted making simple upheld/not upheld outcomes problematic. They further note that health complainants are often interested in the quality of services, thus making upheld or not upheld outcomes for their complaints less than satisfactory.
2. Health complaints raise particular issues as they may require the consideration of multiple interests concurrently, and complainants may not all be wanting identical outcomes.
3. Ombudsman that use a range of approaches in their attempt to resolve disputes may create uncertainty and discomfort in complainants (Carney et al. 2017).

There are two broad approaches to improving the healthcare system. The first approach is to focus on improving practice, whether through activities such as personal education and development or activities that improve clinical effectiveness. The second approach is to focus on reducing poor practice though activities such as clinical audit which focuses on clinical

performance or though sanctions against poorly performing health professionals.

In the health ombudsman environment, these two approaches become, firstly, an emphasis on recommendations which encourage health organisations and professionals to review and improve their practice, seeking solutions based on activities such as education and training, the rewriting of a policy or protocol or change to a patient environment, and, secondly, sanctioning sub-standard performance from health professionals through naming and shaming, disciplinary action or financial redress. Although the English Health Service Ombudsman awards financial redress in most upheld investigations, this is an atypical consequence of an ombudsman investigation while sanctioning health professionals is an even more atypical action for a health ombudsman. In that regard, the ability of the Office of the Health Ombudsman, Queensland (OHOQ) to commence disciplinary action against health professionals makes it unusual in the health ombudsman world[4].

Walton (2001) suggests that health ombudsman can improve health care through, improvement in practice, the maintenance of standards, reduction in the level of litigation, the maintenance of trust between patients and clinicians, the encouragement of reflection by clinicians, the protection of the public, and act as reminder to doctors of their ethical and professional responsibilities. Pollock and Kerrison (2001, pps.123-124) suggest that health ombudsman do find failures by health bodies and that changes do arise as a consequence, but suggest that, overall, it is a weak system by which to enforce change, concluding that the ombudsman's ‘influence and

[4] In addition to the OHOQ, the New South Wales Health Care Complaints Commission is the only other health complaints entity that can prosecute clinicians.

persuasion' have had little effect on bringing the NHS to account (Pollock and Kerrison 2001, p.128).

Writing in the Australasian context, Bismark and Studdert (2010) also suggest that complaints received by healthcare complaint commissions can act as a driver to system improvement noting that each year the eight Australian and New Zealand healthcare complaint commissions receive over 10,000 complaints, claiming that many highlight preventable adverse events. They further claim that for each of these known adverse events there are 'dozens more [that] lie below the waterline' (Bismark and Studdert 2010, p.12). Asserting that healthcare complaint commissions have adopted the ethos of quality improvement, Bismark and Studdert (2010) note that commissioners recognise that complaints can be a source of learning which can be used to facilitate improvement to the healthcare system. Having acknowledged this intent, Bismark and Studdert (2010, p.12) note that commissioners have not published many comprehensive analyses of complaints implying that this is due to the fact that such analyses have not occurred.

Walton et al. (2012) claim that the commissions play an important role in the overall health governance framework, holding health services and professionals accountable, and provide redress to those who have been found to have been failed. Walton et al. (2012) suggest that the commissions are important for six reasons, and, which it is suggested, are equally applicable to health ombudsman in the United Kingdom: firstly, they are independent watchdogs able to hold health bodies and professionals to account; secondly, they enable patient voices to be heard; thirdly, as alternative dispute resolution bodies, commissions offer a quicker, less stressful avenue for redress; fourthly, unlike courts which can only provide financial remedy, commission normally have a range of potential remedies available to them; fifthly, they are an independent route by which patients can

complain about their health care; and, finally, the complaints received, singly, or in aggregate, can shine a light on the quality of healthcare.

Smith-Merry et al. (2016) researched the response of complaint managers to the recommendations for system improvement from two Australian health complaints commissioners (effectively ombudsman type organisations). The researchers carried out semi-structured interviews with 17 complaints managers from 11 hospitals and the data was subject to thematic analysis using Braithwaite's typology of motivational postures (2014).

Braithwaite (2014) described the responses from organisations to the outputs of overseeing bodies as 'motivational postures' and suggests that these motivational postures provide an important insight into the organisation's attitude to its controller and its willingness to accept the controller's rules and processes (Braithwaite 2014, p. 915). Braithwaite (2014) described five motivational postures which are firstly, commitment, which indicates a willingness to accept the authority and recommendations of the external controller, secondly, capitulation, which indicates acceptance of the authority's conditions as a means of avoiding trouble and having a quiet life, thirdly, disengagement, which indicates the body views the authority as irrelevant, fourthly, game playing, which indicates the body will try to appear as if it is accepting of the controller's authority while actively trying to circumvent its authority, and, fifthly, resistance, which indicates opposition to the controller's authority. It is important to note that individuals and organisations can adopt more than one posture and that several can coexist. If authorities understand the motivational postures adopted by organisations then they will be able to engender cooperation from the bodies concerned thus improving their own effectiveness (Braithwaite 2014, p. 918). In a review of the literature on the applicability of motivational postures, Braithwaite (2014) notes that they are applicable in a wide range of scenarios including

the compliance of farmers with environmental laws, taxation, the regulation of care homes, policing and child protection.

Smith-Merry et al. (2016) found that these motivational postures were applicable to the responses by hospital managers to the findings and recommendations made by their health complaint entity. In this research, Smith-Merry et al. (2016) found that three sets of postures, commitment, disengagement and resistance, were demonstrated. The researchers found that the complaint managers interviewed, as a group, displayed commitment to their complaint entity's recommendations. The hospital managers saw the commissioner's recommendations as helpful in improving services. Interestingly, the respondents, echoing Hertogh's (2001) cooperative control, indicated that recommendations were more likely to be implemented if there had been discussion of the proposed recommendations prior to their finalisation (Smith-Merry 2016, p. D**).** Some complaint managers indicated disengagement, suggesting that many complaints should be referred back to the hospital for consideration while in cases where the hospital managers felt the recommendations to be unreasonable actively, demonstrated potential resistance by considering the risks of not implementing the recommendations citing issues around resources or other policies, which echoes Hertogh's (2001) barriers to change.

Smith-Merry et al. (2016) also found that complaint managers generally supported the intervention of their health care complaint commission when a serious complaint had been submitted, recognising the authority of their complaints commission. Smith-Merry et al. (2016, p.530) were informed by complaint managers that the findings of investigations into serious complaints by commissions were rarely different from internal hospital investigations but, nonetheless, complaint managers found their commission potentially helpful as 'another pair of eyes'. In addition, Smith-Merry et al. (2016) were informed by complaint managers that the recommendations made by commissions

could be used by complaint managers to encourage otherwise disinclined staff to accept the need for change. Despite this apparently positive view of recommendations, complaint managers argued that, while committed to the process, commissions should undertake greater negotiations with complaint managers on the content of the specific recommendations, suggesting that recommendations 'were more likely to be implemented if the commission discussed options with the hospital before finalising recommendations' as this would allow discussion of what was possible, including time-scales for action (Smith-Merry et al. 2016, p.530). Smith-Merry et al. (2016) make the point, however, that complaint bodies may wish to maintain a circumspect relationship with the body in jurisdiction to avoid regulatory capture and conclude that commissions should consider the potential for negotiating final recommendations for change while recognising that bodies could use the opportunity to raise potential barriers to implementation, which if accepted could prevent necessary change.

Smith-Merry et al. suggest that regulators 'should take note of the views of those that they regulate in order to be an effective and responsive regulator' (Smith-Merry et al. 2016, p.B) which is a similar finding to that of Hertogh with his cooperative control model. Merry-Smith et al. (2016) concluded that the relationship between the health commissioners and the hospitals was positive indicating general commitment to implementing recommendations although the hospital managers wanted greater discussion and negotiation during the investigative and recommendation process.

2.11 Research on ombudsman

Empirical research into the impact of ombudsman is scarce (Hertogh 2013; Bizjak 1999; Siemaitycki et al. 2015; Stuhmcke 2012a; Gill 2011) with Hertogh claiming that that the research which is available is either juridicial or

descriptive in approach (Hertogh 2013, p.2). Part of the reason for this may be that measuring the effectiveness of ombudsman is difficult. Danet, who was one of the first to attempt to evaluate ombudsman, notes that many ombudsman goals are 'intangible', including aims such as making bureaucracies humane or reducing alienation from government and concludes that ombudsman are concerned with justice and 'what can be more intangible than "injustice"' (Danet 1978, pp.341-342). Bizjak (1999, p.1) suggests that the difficulty in assessing the effectiveness of an ombudsman is due to a combination of lack of clarity over the role of ombudsman, and that some of the functions are reactive while others are proactive. Siemaitycki et al. (2015, p.85) suggest that it is the landscape in which ombudsman operate that creates barriers to research and this landscape includes the fact that ombudsman work is wide ranging, which means that the way ombudsman operate varies according to the office, along with differences in ombudsman jurisdiction, socio-economic and political context. Stuhmcke (2012, pp.3-4) suggests that 'the "natural" obstacles' to research include: firstly, the fact that the ombudsman is part of a wider system in which it plays only a limited part, secondly, an ombudsman often works informally, thirdly, asks whether a reduction in complaints received by an ombudsman a sign of success or not, and, fourthly, the objectives of an ombudsman is not to make citizens happy but to reduce maladministration in administrative decision-making.

A significant element of ombudsman research focuses on the effectiveness of an individual ombudsman office rather than examining the impact of the ombudsman office on the policies and processes of bodies in jurisdiction. An ombudsman is normally only one part of a complex set of regulatory bodies and sorting out who is responsible for which change can be challenging (Stuhmcke 2012, p. 3). Ombudsman recommendations are only one set of demands for change that a body in jurisdiction may face at any one time which, inevitably, leads to prioritisation by the body. As Smith-Merry et al. (2016) and Hertogh (2001) identified, and supported by a PHSO/IFF

Research (2010) study, recommendations by ombudsman may lead to direct change or act as a catalyst for other changes already under consideration. As Ayeni (1999, p.184) claimed, ‘evaluating programs like the ombudsman institution is an exceedingly difficult and uncertain endeavour. It is impossible to come up with a framework that is foolproof’.

Not only is there limited empirical research on the impact of ombudsman, and very little on health ombudsman in particular, there is also disagreement among academics about the level of impact, if any, that ombudsman can claim to have made on administrative decision making beyond the level of the individual complaint. Kirkham (2005) has noted that observers are unconvinced as to whether ombudsman are effective or not, a view to which Steyvers and Reynaert (2009) are in agreement. Adler (2003) believes that they do have a positive impact as does Seneviratne (2002). To help close this gap of empirical independent research into their effectiveness, ombudsman offices have started undertaking such research themselves (Stuhmcke 2012; Gill 2011). Gill (2011) concluded that the available evidence demonstrates a ‘mixed picture of the influence that the ombudsman may have in this area’.

In this next section of the literature review, the focus of the review is on research relevant to this thesis, either through its focus on health ombudsman or because of its relevance to the discussion later in the thesis.

Hertogh (2001) conducted an exploratory study examining the policy impact of the Netherlands courts and ombudsman investigating whether the degree of impact by courts and ombudsman was related to their respective models of administrative control those of coercive and cooperative control. Table 3 below identifies the key features of the coercive and cooperative models of administrative control. The starting point for Hertogh is that he suggests that

three important differences exist between courts and ombudsman. Courts consider administrative decisions, whether the administrative decision was lawful, and their decisions are legally binding; for ombudsman the position is that they are concerned with administrative behaviour, whether the body acted lawfully and their decisions are non-binding.

	Coercive Control	**Cooperative control**
Central goal	impose control	confer about control
Central quality	authority	interaction
Nature decisions	obligatory	facilitating
Relationship	vertical	horizontal
Orientation	reactive	proactive

Table 3 Models of administrative control (Hertogh 2001)

Hertogh (2001) suggests that the administrative decision-making process consists of three consecutive phases, the information, transformation and processing phases. In the information phase, the body asks what is the ruling of the ombudsman? During the transformation phase, the body asks itself what does the decision mean for it, what is the underlying normative value within the decision and how is that related to the goals and operations of the body? The body, thus, internalises the external decision. In the processing phase, the body asks itself what it should do with the decision, that is, should it implement the decision (Hertogh 2001, p.58).

Hertogh then builds upon this model by identifying, for each of these three phases, a barrier to implementation which, respectively, are clarity, policy tension and defensive reactions. To maximise policy impact, firstly, the decision has to be written in such a way that the normative rule within it can be discerned, secondly, the acceptability of the ombudsman's decision is determined by the difference between the decision and the existing organisational program and the level of commitment to that program by the

body so that the greater the change the less likely it will be implemented, and, thirdly, the degree of defensiveness by the body to the decision of the ombudsman. The degree of impact is related to the strength of these barriers and how well the ombudsman's decision can navigate them (Hertogh 2001, pp.58-59).

Reviewing the available evidence, Hertogh (2001, p.52) noted that the courts in the Netherlands have little impact on administrative decisions. Hertogh then contrasted that with available evidence on the impact on policy of the Netherlands Ombudsman and found there to be some evidence of substantial impact concluding that legal force does not automatically translate to policy change (Hertogh 2001, p.53). Instead, Hertogh postulated that the impact of ombudsman and courts is related to their style of control, being either coercive in the case of courts, or cooperative in the case of ombudsman (Hertogh 2001, p.53).

Stuhmcke (2006) undertook a case study of the Australian Commonwealth Ombudsman in which she established the concept of 'thick' and 'thin' impact where thick impact related to change in policy while thin impact related to changes in procedures (Stuhmcke 2006, p.30). Stuhmcke then developed the idea of direct impact, which she defined as impact that is measurable, and indirect impact, that is impact which is immeasurable. Examples of immeasurable impacts of an ombudsman is its existence, which may act as a means of encouraging public confidence in the overall system, or the ombudsman in its advisory role (Stuhmcke 2006, p.31).

The Parliamentary and Health Service Ombudsman (PHSO 2010), working with IFF Research, undertook research to assess the impact of the PHSO in 2010. IFF Research conducted the research but the findings are in the format of a PowerPoint presentation with little information on methodology. The

information provided indicate that interviews with 45 individuals involved with the implementation of the recommendations of 21 upheld investigations took place. No information is provided on the 21 investigations including the sector of the body complained about. For those staff involved, they stated that the intervention of the PHSO brought a complaint to an end, that the recommendations led directly to improvements, which may be single in nature, or to a 'far-reaching change [in] culture]', which broadly translates to Stuhmcke's thick and thin impacts discussed above. These changes can be the direct consequence of the PHSO recommendations or provide leverage to accelerate changes that the organisation was already planning, or at least, added to other evidence of which the organisation was aware and furthered the case for change. Of the 21 investigations, the informants claimed that the recommendations led to significant improvement in 17 cases. As such, the PHSO was described as 'a partner in improvement' (PHSO/IFF Research 2010, p.23).

Silva et al. (2014) undertook a qualitative case study of a municipal health ombudsman, following its establishment in Minais Gerais, South-Eastern Brazil in 2009, and found that the existence of this new ombudsman had had a positive impact in monitoring the public health system and the identification of common problems in healthcare delivery.

This brief review highlights the following points: there is limited empirical research on the impact of ombudsman; the empirical research that does exist demonstrates a mixed picture with the balance slightly in favour of ombudsman offices having a positive impact; there is no one single model on how one should evaluate the impact of an ombudsman office although several have been proposed. There are good reasons for the existence of this situation. As discussed above, the nature of ombudsman, their roles and functions can vary significantly between offices and even within an

ombudsman office, the role and functions are liable to change dependent upon the priorities of the ombudsman currently in post.

Stuhmcke (2012, p.3) raises the argument that the success of an ombudsman should not be measured in terms of customer satisfaction but rather in terms of the absence of maladministration. This situation could result in fair decisions yet dissatisfied complainants. Stuhmcke (2012, p. 6) concludes

> the measure of success of [an] ombudsman in delivering justice (or good administration) may be proven through efforts of an office to create a shared knowledge amongst stakeholders as to where the edge of injustice lies. Ombudsman offices build a just administrative culture based on a shared understanding of principles such as integrity and accountability and while the data evidencing this may not be obvious many of the examples given above – such as training and speeches may contribute to the cataloguing of efforts made by an ombudsman institution to define the edge of injustice. These efforts should not be sidelined in any evaluation of impact.

This makes the assessment of ombudsman offices very challenging.

2.12 Conclusion

This chapter reviews the academic literature relating to both complaints and to the ombudsman institution. The underpinning thesis for this research, which is claimed by both academics and ombudsman, and is being tested in this research, is that health ombudsman contribute to the improvement of the healthcare system as a result of their roles and activities. Complaints are a regular feature of life within healthcare systems and their number has been increasing in recent years. One key outcome sought by health complainants is to ensure that lessons are learned and that the system is improved but there is disagreement within the academic community on whether complaints

do achieve this outcome. Health ombudsman type institutions were established in the United Kingdom, Australia and New Zealand to provide second-tier resolution on unresolved health complaints and, as with complaints, there is the hope that they contribute to the improvement of the healthcare system. There is, however, little research which demonstrates that they do make a significant contribution. This chapter also considered the development of thought around the administrative justice system. The role of the ombudsman institution as part of the administrative justice system was introduced and a discussion on its proposed contribution to system improvement undertaken. Finally, a summary of ombudsman research, relevant to this thesis, is discussed.

Chapter 3 Theoretical considerations

3.1 Introduction

The impact of an ombudsman institution, by which it is meant in this thesis is the institution's ability to contribute to system improvement, lies in the degree to which it is able to engender change in an organisation over which it has oversight. In this thesis, two theoretical constructs are used to provide the conceptual and theoretical framework for the research, and are those of organisational learning and institutional logics.

This thesis is based upon the premise that the reports and recommendations produced by an ombudsman are potential triggers for organisational learning by bodies in jurisdiction. To make an appropriate change in response to an ombudsman's output, a body in jurisdiction has to undergo the process of organisational learning, during which it needs to understand what is the appropriate response that it needs to make. In understanding the response of bodies in jurisdiction to these external triggers, this first strand of the chapter considers three constructs which affect the willingness of health organisations to implement recommendations from their health ombudsman and are accountability, feedback and learning. For organisational learning to occur there has to be an acceptance of an accountability relationship between an ombudsman and body in jurisdiction, there has to be recognition that the output of an ombudsman is a source of feedback to an organisation, and an organisation has to be willing to learn from that feedback. The analysis begins by considering accountability and the nature of the accountability arrangement that exists between ombudsman and bodies in jurisdiction, then examines how organisations seek and react to feedback, before considering how organisations can use this feedback to improve its performance through organisational learning.

The second strand of this chapter concerns the metatheory of institutional logics. The metatheory of institutional logics has been developed to explain the behaviours and actions of organisations and their staff. It will be argued that institutional logics create a system which influences the thinking and actions of individuals within an organisation.

Organisational learning and institutional logics provide the theoretical background to the underpinning thesis of this research, presented in the introductory chapter, that health ombudsman contribute to the improvement of the healthcare system as a result of the roles and activities that they undertake together with the way that they work with bodies in jurisdiction. Together, they assist in the understanding of how ombudsman contribute to system improvement as their activities act as a trigger for organisational learning within bodies in jurisdiction and explains how the responses of bodies in jurisdiction of bodies in jurisdiction are facilitated by the nature of their relationships with their ombudsman and which are mediated by the dominant institutional logic that exists within the ombudsman.

3.2 Organisational learning

Public bodies are responsible for millions of decisions every year and it is important that as many as possible are correct, not only for reasons of individual justice but also to ensure that democratic decisions taken through parliament are appropriately implemented. Concerns have been raised about the errors made by administrative bodies and this has led to a focus on a ‘right first-time agenda’ (Thomas 2015, p.111). Thomas argues that to improve decision-making public bodies should engage with organisational learning which he defines as,

> … when individuals within an organisation experience a problematic mismatch between expected and actual results and inquire into it on the organisation’s behalf. Organisations learn when they identify

> appropriate lessons from history which are then encoded into routines that guide future behaviour (Thomas 2015, pp.111-112).

Vos et al. (2008, p.8) consider that complaints present an opportunity from which organisations can learn. However, they argue that organisational learning has not been integrated with complaint management despite complaints being an opportunity for gaining insights about the services delivered (Vos et al. 2008, p.9). For Vos et al. (2008), the learning experience begins with an unexpected event that triggers the learning process and ends when the learning has taken place and change occurred. In between these start and endpoints are the activities which relate to the process of learning.

In this thesis, the start begins when a body receives feedback in the form of an ombudsman report and is recognised as establishing a tension which '… comes from seeing clearly where we want to be, our vision, and telling the truth about where we are, our current reality' (Senge 1990, p.9). Such tensions are necessary for organisations to learn (Senge 1990, p.9) and act as a trigger for action. Following this trigger, learning activities can take place. For Vos et al. (2008, p. 15), the appropriate response to feedback from an ombudsman investigation would be an interactive learning approach as the response is not concerned with the analysis of the complaint but how to resolve the tension between current and recommended changes. The result of the learning is cognitive or behavioural change leading to service improvements.

3.2.1 Accountability

The idea of accountability can be considered in two ways. Firstly, it can be considered as a virtue, where it relates to the normative standards used to assess the behaviour of individuals. This translates to the idea of 'being

accountable' to someone or some body and is seen as a positive characteristic and often viewed as a public-sector value along with being transparent or responsive to customers. The alternative way of considering accountability is to see it as a mechanism where a person or body has to clarify and justify their conduct to another body (Schillemans and Bovens 2011). To Lindberg (2013), accountability is the relationship between, firstly, a principle and, secondly, an agent to whom power has been delegated where the agent is held accountable for the decisions that they make and, where, if necessary, the principle can apply sanctions for any failure by the agent. For an accountability relationship to exist the agent must have discretionary power.

Bovens (cited in Frees et al. 2015, pp. 30-31) considers the issue of accountability in terms of who is accountable to whom, why and for what? He states that the 'who' can be at the level of an individual, as with professional accountability, hierarchical, as occurs with a Chief Executive being held responsible for the actions of staff within their organisation, or corporate, as with the example of corporate manslaughter. The 'whom' can be considered in five different ways: firstly, political towards politicians and voters, secondly, legal towards courts and tribunals, thirdly, administrative towards auditors and ombudsman, fourthly, professional to professional bodies, and, fifthly, societal towards citizens, the media or special interest groups. The 'why' can be considered in three dimensions; vertically, horizontally and diagonally. The first of these, vertical accountability, occurs where a person or organisation holds formal power over another person or body and can hold the latter to account. Secondly, there is horizontal accountability where there is no formal obligation to give account of oneself but where it is given voluntarily. Finally, there is diagonal accountability which exists where there is no formal hierarchical nor voluntary accountability which reflects an accountability which has both horizontal and vertical elements Bovens (2005). Frees et al. (2014, p.31) claim that administrative accountability mechanisms, such as ombudsman are an example of diagonal

accountability. In this model, there is no hierarchical relationship between ombudsman and body but the relationship is more than voluntary as ombudsman may be able to use the courts or parliament to support its recommendation(s). The 'what' relates to the aspect of behaviour the agent is accountable for. It can vary according to the office but for bodies in jurisdiction to ombudsman it is normally about the implementation of administrative or other parliamentary policy.

Another way of categorising accountability mechanisms relates to the nature of the bodies to which one is accountable. Romzek and Dubnick (1987) identified four such types of bodies, bureaucratic, legal, professional and political. The four types of accountability mechanisms are derived from whether the agency control is internal or external and the degree of control the accountability mechanism has over the body in jurisdiction. The authority in internal control can be drawn from either formal hierarchical relationships or more informal social relationships. External sources of control can be drawn from either a formal legal relationship such as a contractual relationship or from the informal exercise of power by an interest outwith the body. In bureaucratic accountability relationships, the controller has a high degree of control and operates internally. This occurs in organisational hierarchies where junior staff are accountable to more senior staff. Professional accountability is associated with an internal locus of control and low degree of control. The classical types of professional accountability are with health professionals, lawyers and teachers to their regulatory bodies. Legal accountability mechanisms have an external locus of control which can exercise a high degree of control. Courts and tribunals are characteristic of this model. The fourth model is the political accountability mechanism which is where a person or body is accountable to a Minister, parliamentary committee or the local government equivalents dependent upon the level of political control.

Bovens (2005) suggests an additional fifth model, that of administrative accountability for independent external bodies such as by ombudsman or auditors, which exercise administrative or financial oversight on public bodies. Using Romzek and Dubnick's model, this administrative accountability model is located externally to the body in jurisdiction and, with their statutorily based, but rather limited, powers, is situated between the legal mechanism with significant control and the political with their more limited powers of control.

Aucoin and Heintzmann (2000, p.45) suggest that accountability mechanisms have three purposes. These are to control for the abuse and misuse of public authority. The second is to provide assurance in respect to use of public resources and adherence to the law and public service values. The third is to encourage and promote learning in pursuit of continuous improvement in governance and public management.

Reflecting on these three purposes, one can map them to the putative roles of an ombudsman. The initial role of ombudsman was to investigate complaints about public administration and this would include the first two of Aucoin and Heintzmann's purposes. Over time, as ombudsman developed their system improvement role, they have been trying to deliver more fully on the third purpose. It is this third purpose that is of relevance to this thesis which considers the means by which ombudsman contribute to the improvement of the healthcare system.

The central purpose of public accountability mechanisms is to hold public bodies to account. One of the reasons behind the establishment of ombudsman was to assist parliament in holding public administrations to account and, for Bovens (2005) this is the main purpose of public accountability schemes, that is to support the democratic control of public

services. Bovens (2005) suggests that a second function of accountability mechanisms is to promote trust and legitimacy in public services, as the existence of the accountability mechanism supports quality improvement activities and discourages the misuse of delegated powers. A potential third function of the accountability mechanism, and linked to the second, is that the accountability mechanism supports improvement of the system by encouraging learning from errors that it has, in turn, identified (Van Loocke and Put 2010, cited in Frees et al. 2015).

While it is clear that accountability mechanisms exist between ombudsman and bodies in jurisdiction, are these mechanisms able to fulfil the belief that they can encourage organisational learning? Frees et al. (2015) suggest that there are five potential mechanisms that can be used to achieve this aim and which can be split into two categories, firstly, that of information reflection and debate, and, secondly, the ability to sanction the body. In the former category, the ombudsman provides feedback information which should provoke a period of reflection by the body concerned on the service provided which in turns provokes discussion about how the body should correct an identified error. In the second category lies the ability for ombudsman to make their reports public. This acts as a form of moral suasion on the body to cooperate with ombudsman recommendations lest it bring public disapprobation. Finally, sanctions can act as a motivator to managers in public services to improve their services (Bovens, Schillemans and t'Hart 2008).

However, the potential for adverse publicity and sanctions can be seen as a double-edged sword. It may encourage the defensive reactions identified discussed by Hertogh (2001) such as lack of cooperation with an ombudsman investigation or indeed resistance to accept findings and was discussed in the previous chapter. The risk of adverse publicity and sanctions may also encourage public service managers to avoid risk taking which is a

necessary element to organisational change and improvement (Van Loocke and Put 2011, Bovens 2005).

3.2.2 Feedback

For Frees et al., 'feedback information allows an organisation to correct its errors, to adjust its goals, to restore its performance levels, and to align itself with its environment' (Frees et al. 2015, p.4). The authors have identified four sources from which public sector organisations can obtain feedback. These are from staff employed by the organisation, other organisational stakeholders such as customers or partner organisations, from internal monitoring systems or organisations involved in policy evaluations and from ombudsman or other administrative accountability mechanisms (Frees et al. 2015, p.24). The focus of feedback can be considered in two different ways: goal-seeking feedback considers the degree to which stated goals, and policies are achieved without questioning the validity or rightness of these goals or policies while goal-changing feedback seeks to challenge the appropriateness of the goals or policies. (Frees et al. 2015, p.26).

Inherent within the concept of organisational feedback is the idea that the organisation is open to receiving it. Academic thinking on this issue is focused on system thinking and is founded upon the idea that organisations are systems and, in particular, are open systems (Frees et al. 2015, p.15). An open system is one that is able to interact with its environment and adapt to changes within its environment (Katz and Kahn 1978) and actively seeks feedback in order to maintain an equilibrium with its environment.

Some authors suggest that organisations have limits to their openness and that organisations may be more or less receptive to signals and feedback from their environment (Frees et al. 2015, p.20). Frees et al. (2015, p.21)

describe this openness as a ‘perception filter’ which varies in thickness. The thicker the filter, the less likely an organisation will respond to feedback and the feedback to which it does respond must be more consistent with its internal culture and polices. This is similar to Hertogh’s (2001) view that a barrier to the impact of ombudsman depends on the degree of policy tension which the ombudsman recommendations has with internal policies. To complicate matters, subsystems within the organisation may have different perception filters meaning that different parts of the organisation may respond differently to the same feedback leading to confusion and problems of communication within the organisation as a whole (Katz and Kahn, 1978). There are advantages to operating a relatively closed system. It limits the complexity of interaction with their environment, decreases turbulence and stops the organisation responding to every piece of feedback (Frees et al. 2015). Organisations need to be able to filter the feedback that they receive and this filtering may vary at differing points of an organisational life.

Feedback is a key element of an ombudsman’s system improvement role and the underpinning premise is that if an organisation receives feedback about its performance then it will be able to learn from it.

3.2.3 Learning

Assuming that an organisation is open to feedback then it can learn from that feedback in different ways. The simplest means is through ‘single loop learning’ (Argyris and Schön 1978). In single loop learning the organisation will attempt to correct the problem by the simplest means possible, which is by attempting to effect change through alterations within the same policies or procedures. In this sense, it is learning which takes place with a goal-seeking focus. There is no attempt to change anything beyond the immediacy of the identified error. For Frees at al (2015, p.7) it can lead to a gradual

improvement of existing approaches but will ignore the question of why the problem arose in the first place. However, if the organisation does ask itself, why did the error or failing arise in the first place, this may lead to a deeper consideration of the organisation's underpinning polices or procedures. That is, to question the appropriateness of the policy or procedure. In turn, this may lead to a change in the organisation's operating models or principles. This is 'double loop learning' which occurs with goal-changing behaviour and involves changing an organisation's underpinning assumptions, policies and goals leading to discontinuous change (Frees et al. 2015).

Gnyawali and Stewart (2003, p.69) introduced the idea of 'modes' of organisational learning by which they mean the process through which learning is shared in organisations and suggest that there are two dominant modes of learning, the informational and interactional learning modes. The informational learning mode is the 'systemically based structural processes used in organizations to collect, analyze, and distribute information' where 'organisations develop systems to acquire and share information, and to store the information in organizational memory' (Gnyawali and Stewart 2003, p.69). One weakness of the informational approach to organisational learning is that organisational learning also requires the development of shared 'schemas', a development not included within the informational learning mode (Gnyawali and Stewart 2003, p.69). The creation of such schemas requires an interactive learning mode defined as a 'systemically based social process used in organizations to develop shared schemas through the actions and interactions of various individuals and units in the organization' and is viewed as essential in the development of shared understanding (Gnyawali and Stewart 2003, p.70). Organisations will not use only an informational learning mode or an interactional learning mode but will combine the use of both approaches to differing degrees (Gnyawali and Stewart (2003). Where there is a higher degree of interactional learning the resultant changes will be more fundamental and the creation of new learning, while, where the informational learning mode is dominant, the resultant

learning will be incremental in nature, with changes to, but the retention of, the existing knowledge base and approaches used by the organisation (Gnyawali and Stewart (2003). Informational learning is a simpler process and tends to be used in large, hierarchical organisations (Gnyawali and Stewart (2003, p.81). Gnyawali and Stewart (2003) liken informational learning to single loop learning and interactional learning to double loop learning.

While organisational learning has received significant academic focus, there is no generally accepted theory or model and even the term organisational learning has no agreed single definition (Frees et al. 2015). One of the debates surrounding organisational learning is whether organisational learning relates to learning by individuals or learning by organisations. Frees et al. (2015, p.8) summarise the debate as a 'focus on the learning of individuals in the organizational context' as opposed to a focus on an 'organization-level process that is distinct from individual learning'. Simon (1991, p.125) states 'all learning takes place inside individual heads' and suggests that that the learning of an individual is influenced by the organisation to which the person belongs and has effects on the organisation that extend further than can be inferred by observing the individual's learning (Simon 1991, pp.125-126). Knight (2002), meanwhile, argues that organisational learning is more than the combined learning of people within that organisation and that organizations have the capacity to learn albeit with the caveat that 'learning is a notion that can be usefully applied at different levels, provided that we accept that the detailed conceptualization of learning and associated constructs, such as memory, are not identical across the levels' (Knight 2002, p.436).

For example, Lam (2006, p.124) argues that organisational memory is 'the accumulated knowledge of the organization, stored in its rules, procedures, routines and shared norms'. Thus, organisational learning occurs at a higher

level than what an individual learns and involves group learning. Schilling and Kluge (2009, p.338) articulate this group level of learning and its relationship with an organisation's rules, procedures and culture with their definition 'We define organisational learning as an organisationally regulated collective learning process in which individual or group learning experiences concerning the improvement of organisational experience and/or goals are transferred into organisational routines'. Frees et al. (2015, p.10) summarise the academic debate and consider organisational learning to be 'the combination of individuals and groups learning in an organisational context, and the organization learning through intra-organizational interaction'.

Fiol and Lyles (1985) suggest that organisational learning arises as a dynamic relationship between cognitive and behavioural development. Cognitive learning refers to the development of new insights as a result of filtering, interpreting and processing new information about performance (Fiol and Lyles, 1985). The behavioural element refers to those changes in behaviour that reflect the insights and changes arising from the cognitive element, what van Ackers et al. (2015, p.26) refer to as 'the institutionalization of the lessons learned'.

Academics have also considered the process that organisations utilise during organisational learning. One approach was described by Huber (1991), who has detailed a four-stage process of the acquisition of knowledge, the distribution of knowledge, the interpretation of the information and the storage of this information in the organisational memory.

Acquiring knowledge is the start of the resolution process and organisations need to be able to seek the information which will assist resolve the creative tension. Greve (2003) describes 'problemistic search' where organisations seek information to help them resolve their immediate problem. For Gilson et

al. (2009) this is common with single loop learning. Where double loop learning is undertaken the key organisational focus will again be problemistic learning, but the organisation will undertake a wider search (Gilson et al. 2009, p. 18). An alternative approach to search for information is ‘slack research’ which occurs when the organisation devotes sufficient resources to allow for a wide-ranging reflective approach to problem-solving and which may involve trials of new ways of working to identify new ways of doing things (Gilson et al. 2009, p.18).

The acquisition of knowledge by an organisation can either be a deliberate activity where the organisation notes a gap in its knowledge and wants to improve what it does or when knowledge acquisition arises unconsciously. There are a wide range of potential sources of knowledge from which an organisation can draw. These include ‘internal resources and experiences’ such as staff expertise, ‘citizens and consumers’ such as customer feedback, ‘partners, rivals and comparators’ and which includes the use of consultants and secondments, ‘top down direction and control’ which for public-sector organisations could include Treasury Notes, Cabinet Office or Departmental advice, ‘critiques, advice and media’ such as parliamentary select committees, pressures groups, the media, academia or think-tanks, and ‘testing interactions, crises and review’ such as audit, capability or serious incident reviews (Gilson et al. 2009, pp.30-31).

Once information has been acquired, the second phase is for its distribution across the organisation. Mariotti (2012) claims that organisational learning is a collective endeavour involving a series of relationships within the organisation. These relationships further the distribution of information. Organisations will facilitate this information distribution through a range of mechanisms. Without such mechanisms organisational learning would not be possible. Huber (1991, p.105) suggests that this is ‘a determinant of the occurrence and breadth of organizational learning’. The degree of sharing of

information (its breadth) is a determinant for how successful an organization will learn. For Huber (1991, p.108), there are five factors that can affect the extent of information sharing and are firstly, the degree of conformity of belief systems among individuals within the organisation which will affect their interpretation of new information, secondly, the way the information is framed will affect its interpretation, thirdly, the 'richness of the media used to convey the information' where media richness is defined as the 'capacity to change mental representations within a specific time interval' (Daft and Huber 1987, p.14), fourthly, the information load placed upon individuals or organisational units, and, fifthly, and the degree of 'unlearning' that must take place before the new learning can be generated and internalised.

There is then a need for the information to be interpreted. Crossan et al. (1999) describe this as the process that occurs when that part of the organisation, whether an individual or group, which has obtained the relevant information, share, and explain the relevance of this information, to others within the organisation. This step is intended to create a shared understanding of the information and its relevance in addressing the creative tension that has been noted to exist. Daft and Weick (1984, p.286) describe this as 'the process of translating events and developing shared understandings and conceptual schemes'.

The final phase is organisational memory which is where the new learning is routinised into the standard operating procedures of the organisation (Crossan et al. 1999). Fiol and Lyles (1985) argued that this was a cognitive process although the generally accepted position is that it involves both cognitive and behavioural elements (Vos et al. 2008, p.12). Thus, it leads to changes in both the way individuals think and behave. Huber (1991) notes that organisation memory can be affected by the turnover of personnel, failure to anticipate information needs in the future means that information useful in the future but of no immediate need is not retained, and even if the

information is retained individuals may not know where that information is stored.

Organisations do not always learn in isolation. Of increasing academic interest is inter-organisational learning. Knight (2002) defines inter-organisational learning as the learning of organisations within an inter-organisational network. Van Acker et al. (2015, p.27) note that inter-organisational learning can refer to the ‘sharing and transferring of knowledge from one network partner to another’. Van Acker et al. (2015, p.27) go on to state that it would be wrong to think of inter-organisational learning in terms of the transfer of explicit knowledge. ‘Instead, knowledge is continuously reviewed, recreated or reappreciated as it is taken into different settings or is rediscovered in relation to new purposes or alongside existing “old knowledge”’ (Hartley and Bennington 2006, p.104). Thus, the transfer of organisational learning is commonly a process of adaption and not of adoption (Van Acker et al. 2015, p.27).

According to van Acker et al. (2015 pp.27-28), for inter-organisational learning to take place it needs to be supported by institutional arrangements, such as learning networks that allow organisations to share their experiences. However, these opportunities can be undermined as organisations may see it as counter-productive to share information with potential or actual competitors. Although the public-sector is often seen as being based on collaboration and not competition, there is the risk of free loading, where people and organisations can gain knowledge through participation in the learning network but make little contribution in return, while a third potential problem relates to the composition of the network. Should the network be composed of similar or dissimilar organisations? Heterogeneity among members can allow learning from a wider range of experiences while homogeneity among members promotes the transfer of

tacit knowledge due to a shared language and knowledge base (Mariotti 2012).

Thomas (2015) provides further causes that inhibit public bodies from becoming true learning organisations. These include bureaucratic structures, the reality that many public organisations have complicated subsystem structures each of which may only be aware of part of the issue or its solution, that simple changes in large organisations may necessitate significant change programmes and the associated organisational capacity to manage too many change programmes at any one time, and ineffective resources and mechanisms to encourage learning.

Van Ackers et al. (2015, pp.15-16) consider why public-sector organisations have problems with change and innovation and identify four principle reasons for this. The first is the lack of true competition that most public-sector organisations face means that they have less reason to improve. The second is that change always involves risk and uncertain results and public-sector organisations are generally risk averse as, if things goes wrong, they will be accused of wasting public money, and the general political climate means that failures are heavily associated with blame with associated risks to career. The third is that the public-sector tends to be affected by short-termism due to the fact that they are under the influence of government and parliaments who need to respond to the electoral cycle. Politicians need results before the next election not failures. The fourth, and final, reason for low levels of public-sector change is the rule obsession that is innate within the public-sector bureaucratic culture.

Vos et al. (2008) do not criticise the bureaucratic culture, rather, recognising that this approach provides legal certainty and guarantees which are important values to the general public. They highlight that the problem arises

when the rules become the ends and are insufficiently questioned or challenged. Reschenthaler and Thompson (2001, p.53) go so far as to say the public administrative bodies are ‘seriously disadvantaged as learning organisations’. The result of these barriers is that public-sector organisations have limited ability and desire to conduct interactional learning. Instead, it is mainly focused on informational learning aimed at improving what they already do. It is only when significant problems arise that necessitate interactional learning will a public body engage in it.

The chapter, thus far, has considered how organisations learn. The response from bodies will be guided, in part, by the approach to their role adopted by their ombudsman. To understand this, the metatheory of institutional logics is used to help explain how organisations develop a shared understanding of thought and behaviours.

3.3 Institutional logics

As discussed in the literature review, ombudsman attempt to undertake two distinct roles, both of which have an intrinsic logic: firstly, they investigate complaints, trying to identify what happened and what should have happened, using normative standards such as guidelines and policies (accountability logic), and, secondly, seek to contribute to the improvement of the system over which they hold jurisdiction (learning logic). Dodds and Kodate (2011) state that these twin approaches of an accountability logic and a learning logic, are forms of institutional logics which have been defined as a ‘set of material practices and symbolic constructions’ (Friedland and Alford 1991, p.248) and which are used by organisations to ‘guide behaviour’ (Dodds and Kodate 2011, p.329).

The underpinning premise of institutional logics is that ‘the interests, identities, values and assumptions of individuals and organisations are embedded in dominant institutional logics’ (Thornton et al. 2011, p.6). Institutional logics create a belief system which shapes the thinking and behaviours of individuals within the institution. Institutional logics can be important as they can ‘help tease out the ways in which institutions influence actors’ room for manoeuvre’ (Dodds and Kodate 2011, p.329) and shape their reasoning (Thornton et al. 2013). Institutional logics act as a framework to influence the decisions and behaviours of organisations and organisational actors.

The metatheory of institutional logics has four underpinning principles: firstly, the duality of agency and structure where structures and individual agency both constrain and enable each other; secondly, institutions are both material and symbolic, where material represent structures and practices while the symbolic refers to organisational ideals and meaning and both the material and symbolic are interrelated in a form of dialectical relationship and, therefore, are not necessarily stable; thirdly, institutions are historically contingent where the historical environment and situation in which an organisation faces itself will impact upon the institutional logic that is dominant; and, fourthly, institutions are amenable to multiple levels of analysis where individual actors are nested within higher levels of organisations such as individual, team, organisation, field and societal levels all of which are likely to impact upon the actions and behaviours of individuals.

As indicated above there are more than one institutional logic and each institutional logic demonstrates ‘unique organizing principles, practices and symbols that influence individual and organizational behaviour’ (Thornton et al. 2013, p.2). Within institutions there may be different institutional logics that co-exist and compete for dominance (Dodds and Kodate 2011, p.329,

Thornton et al. 2013). The dominant institutional logic will guide how individuals respond to a given situation as the individual will be embedded within a broader cultural structure that will both enable and constrain the individual's agency (Thornton et al. 2011). Differing institutions will hold different institutional logics and these, will in turn, result in different practices. The practices of organisations which interact may result in both sets of practices being affected.

While differing organisations may hold differing internal institutional logics, there tends to be consistency in institutional logics among organisations operating in the same area and where this occurs this is known as an institutional field. An institutional field has 'collectively agreed upon rules, norms and practices to which their members adhere' (Purdy and Gray 2009, p.357). One such institutional field is that of healthcare which was long dominated by a professional institutional logic but which, since the introduction of new public management in the 1980s, has seen the introduction of managerialist and market-oriented logics. As this indicates institutions may borrow logics from other areas to create new logics (Purdy and Gray 2009). The development of new logics requires the introduction of a new logic, competition between this new logic and the existing logic for dominance, and once dominant for the new logic to be structurated into behaviours and actions (Purdy and Gray 2009, p.357).

The relationship between individuals and institutional logics, especially where there are competing institutional logics, provides both opportunities and constraints. Intrinsic to institutional logics is the idea of agency, which is the ability of individuals to have some effect on the environment and world that they inhabit, whether through altering rules, changing relationships or distribution of resources (Thornton et al. 2011, pp.6-7). Opportunities arise when internal institutional contradictions create space for individual agency and can result in institutional change. However, as institutional logics shape

the preferences, interests and behaviours of actors, these will act as a constraint on actors to support the existing institutional logic – here the dominant institutional logic will establish an underpinning schema for action (Thornton et al. 2011). How institutional logics shape the actions of actors as referred to as 'embedded agency' – here actors are embedded within an institutional logic which constrain their choices and actions (Thornton et al. 2011).

The ability of individuals to exercise agency allows for the pursuit of self-interest and the concomitant fulfilment of personal desires but these are also mediated not only by the dominant institutional logic but also by the social identity adopted by the individual. Social identities are derived from a person's sense of attachment with other categories of persons. Therefore, people have multiple social identities. For example, people can identify with a range of social identities which could include their work team, employing organisation, profession, political party, religion, or ethnic group among others. Individuals will hold some social identities more strongly than others.

Which social identity informs the individual's agency will depend upon the situation and this combination of interests and identity is referred to as 'individual intentionality' (Thornton et al. 2011). Not all goals may be congruent with a person's identity – the threat of a penalty may lead individuals to take actions that are not consistent with an individual's desired goals. Most individuals seek approval and try to avoid negative consequences. In this way normative processes may act as a substitute for social identity. Taking this together we see that individuals are both embedded within an institutional logic and exercise individual intentionality which are likely to be congruent with personal identities and interests (Thornton et al. 2011).

Organisations and individuals may assume multiple roles and identities which may result in a conflict which impacts upon their actions and behaviours (Thornton et al. 2011). At an organisational level this conflict may result in differing parts of the organisation adopting different practices, described by Meyer and Rowan (1977) as 'loose coupling'. Loose coupling enables organisations to conform with environmental pressures for change while, at the same time, protect the core operations of the organisation – people or organisations may thus decouple who they are from how they act (Thornton et al. 2011, p. 58). Thornton et al. (2011) claim that the literature identifies two types of loose coupling: defensive loose coupling which occurs when organisations attempt to maintain their internal consistency, and strategic loose coupling where organisations use loose coupling to create an impression of change to external actors in the expectation of receiving certain benefits.

Some organisations will be under the jurisdiction of multiple institutions, and each of these latter institutions may set normative standards with which the organisations in jurisdiction must comply. For example, in health there may be health ombudsman, professional regulators, healthcare quality commissions, the courts and governmental departments, all of which are able to influence how health professionals and organisations conduct their work. If a body is under the jurisdiction of multiple organisations then there may be competition between these organisations for influence and the bodies in jurisdiction may select which overseeing body has most influence (Heimer 1999). Those bodies which are able to influence and work through internal organisational practices have the most influence (Heimer 1999, p.18). In other cases, organisations may adopt changes for 'symbolic' purposes, that is, without making substantive operational changes, rather than for 'instrumental' purposes, that is, using recommendations to make substantive operational changes, and organisations achieve this through decoupling, although if the decoupling becomes too pronounced it could result in organisational confusion (Heimer 1999, p.22). Making symbolic changes may

be the result of organisations seeking to maintain legitimacy in the eyes of the overseeing body (Heimer 1999).

One other risk is that if a body adopts changes recommended by an overseeing organisation then these changes may create internal problems for these initial bodies – how will they conform with existing institutional logics and organisational policies and practices? Will they alienate staff or other stakeholders? Ultimately, what is decided depends upon who is involved in the decision-making, which problem facing the organisation is held to be the most urgent to resolve, what solutions are being advocated and by whom, and do participants in the decision-making processes have other competing issues with which to contend. As a result, some decisions may be selected for opportunistic reasons rather than because they are the best fit to the problem (Heimer 1999, p.23).

Effective regulators are those which strike a careful balance between logics (Ayres and Braithwaite 1992). However, the institutional logics adopted by regulators and ombudsman are likely to be strongly influenced, in turn, by the expectations of the ombudsman's key stakeholders. Health ombudsman have to accommodate the expectations of the public, clinical and non-clinical staff within health organisations and, finally, governments and other regulatory and accountability bodies (Carney et al. 2017, pp. 70-71).

Purdy and Gray (2009) researched the development of a new institutional field, that of alternative dispute resolution within the United States of America. The scholars claim that the development of alternative dispute resolution was driven by two competing logics: firstly, a judicial logic, which saw alternative dispute resolution as a means of improving the USA's justice system, and secondly, a social change logic, as a means of improving decisions and of empowering participants in disputes. The judicial logic is

characterised by language such as rights, disputes and justice leading to better, quicker, cheaper for the user, services, while the social change logic is characterised by the ideas of harmony and satisfaction of needs leading to better services and reduced litigation (Purdy and Gray 2009).

Purdy and Gray (2009) do describe a third model, that of a model that tried to combine both the judicial and social change logics but they noted the fundamental differences in the logics and that research indicates that where organisations have differing logics, one will eventually dominate. Alternative dispute resolution offices utilised different approaches to dispute resolution dependent upon which of the logics was dominant (Purdy and Gray 2009). Not only does this research demonstrate that institutional logics strongly influence the actions and behaviours of organisations and staff, it also indicates that the dominant logic within an alternative dispute resolution office will determine how the office conducts its dispute resolution processes. That is, either with a focus on accountability, the judicial logic, or learning and improvement, the social change logic. This is of importance to the ombudsman institution which is a form of alternative dispute resolution.

3.3.1 Institutional logics and healthcare

In a review of research into institutional logics that have been ascribed to healthcare, Dodds and Kodate (2011) advance an argument that three differing institutional logics can be identified within policy approaches towards patient safety. The authors state that the first, and traditional logic, is that of professional judgment as evidenced by the historically dominant self-regulatory approach to medical regulation. However, due to failings in this approach, as evidenced by numerous health scandals, two new logics emerged relating to patient safety, firstly, a logic of accountability and, secondly, a logic of learning.

As the names suggest, the accountability logic focuses on allocating responsibility and is seen in the new regulatory framework which includes revalidation and increased oversight of clinical competency though mechanisms such as health ombudsman or the Practitioner Performance Advice service in England. It is predicated upon the idea that clinicians are accountable for their actions and should be able to justify their actions by comparing their practise with that of their peers. It is, thus, focused upon the individual and notions of responsibility and accountability.

Meanwhile the learning logic places an emphasis on organisational learning and places importance on learning from patient safety incidents. In this logic health care organisations and professionals should use patient safety incidents as opportunities from which they can learn. Intrinsic to this approach is the reduction of a 'blame culture' which is seen to be a disincentive to openness from clinicians – clinicians are concerned that admitting errors could affect their careers and/or reputations. It is predicated on the basis that, if health professionals routinely reported adverse incidents and they were properly investigated, then learning from these adverse events could be obtained and which could be used to improve health care. For Dodds and Kodate (2011), such a logic supports the idea of clinical 'perfectability'. This approach is much more focused upon the system and often adopts a 'no blame' culture to encourage openness and learning (Dodds and Kodate 2011, Allsop and Saks 2002, p.85).

Dodds and Kodate (2011) assert that learning and accountability logics are in conflict: the emphasis on blame reduction inherent in the learning logic is seen to be in conflict with the apportioning of responsibility inherent in the accountability logic. 'The new focus on creating a "blame-free" culture directly goes against the notions that individual clinicians should be accountable for their mistakes' (Dodds and Kodate 2011, p.335). In a further complication, Dodds and Kodate (2011) note that much information collected through

approaches to support the learning logic are then used to support the accountability logic. For example, data collected on patient falls to understand why they occur and how they can be prevented is used to pass judgment on the safety of the NHS (Dodds and Kodate 2011, p.341).

Both Allsop and Saks (2002) and Dodds and Kodate (2011) state that there is a lack of agreement over which of the two logics should dominate in the patient safety arena, potentially leading to ‘a health care sector enjoying reduced legitimacy and organisational confusion’ (Dodds and Kodate 2011, p.342). Dodds and Kodate (2011, pp.342-343) conclude that, in the health service, ‘two differing logics are being promulgated as policy, and applied in practice, to the same organisational field simultaneously, with no escape for those who work in the service, and little official recognition of the conflicts between these alternative policies’. Dodds and Kodate (2011, p.341) consider whether this is ‘more a matter of emphasis than a significant cause for concern’ before concluding that when it comes to patient safety such a conflict is harmful to patients.

Dodds and Kodate’s (2011) suggestion that the two dominant logics in the sphere of patient safety are the accountability and learning logics are in conflict may have implications for health ombudsman as they will also be faced with this conflict as they attempt to reconcile their dual roles of adjudicating on individual complaints, which will involve the accountability logic, and contributing to the improvement of the system, which implies a learning logic. It is suggested that the dominant logic within the ombudsman is likely to affect the nature of the relationship between ombudsman and body in jurisdiction.

3.4 Conclusion

While ombudsman reports and recommendations are intended to act as triggers for organisational learning, their ability to do so depends upon three constructs: accountability, feedback and learning. There needs to be an acknowledged accountability relationship between ombudsman and body. The body also has to accept that the reports and recommendations produced by their ombudsman are a form of feedback which should act as triggers for learning. Finally, the mode of organisational learning that results from this feedback can be either informational learning, where the organisation tries to resolve the immediate problem though incremental change, or interactional learning, where the organisation undertakes a deeper reflection of the issue looking for underlying causes and which may necessitate changing to prevent recurrence. Organisational learning is a multi-faceted, complex process that needs to be actively managed by organisations for it to be successful.

There was also consideration of the metatheory of institutional logics. Institutional logics shape how organisations and individuals behave and act. It was noted that, within organisations, there are likely to be multiple institutional logics present, although one will become dominant. Within healthcare and alternative dispute resolution there are two dominant logics that exist, those of accountability and of learning. Which logic dominates will determine how organisations and individuals make decisions and how they respond to problems. In situations, such as exist between health ombudsman and health organisations, the logic of the ombudsman will strongly influence how health organisations respond.

Chapter 4 Methodology

4.1 Introduction

This chapter presents the methodology used to research the approaches adopted by health ombudsman in their contribution to system improvement and how bodies in jurisdiction respond to these approaches. When undertaking such research, researchers must decide, from the outset, on their methodological approach which will inform the nature of their work and their view of the world (Pansiri 2008, p.84). This chapter, therefore, starts by considering the research aims, objectives and questions that drove the research process. It continues with a general discussion on research philosophies before explaining and justifying the philosophical and personal stances that have been adopted. The chapter then details and justifies the methodology that has been used in this research before providing details on the approaches used in case selection, data selection and data analysis and concludes with the consideration on the methods utilised to ensure the quality of the research.

4.2 Research aims, objectives and questions

Savin-Baden and Howell Major (2013, p.87) state that ‘Choosing “who” or “what” to study is one of the most important decisions that researchers will make …’ as to answer this question determines the research question and subsequent research approach. They call this the ‘phenomenon of study’ (Savin-Baden and Howell Major 2013, p.87). Patton (2002, p.229) states, ‘The key issue in selecting and making decisions about the appropriate [phenomenon] is to decide what it is you want to be able to say something about at the end of the study’. In this research the phenomenon of study is

the means by which health ombudsman attempt to bring about improvements in the health system and how bodies in jurisdiction respond.

The overall aim of the research is to explore the approaches used by health ombudsman that are intended to contribute to the improvement of the healthcare system and to understand how these approaches are received and acted upon by that system. The health ombudsman's role as system improver includes any, and all, of their actions intended to improve the overall system.

This overall aim was supported by more detailed research objectives:

1) To describe the approaches used by health ombudsman to administrative justice.
2) To describe the differing approaches utilised by health ombudsman with differing statutory functions, as they seek to secure system improvement.
3) To describe the response of bodies in jurisdiction to the approaches utilised by health ombudsman.

To meet these objectives, the following research questions were identified:

1) What approaches do the OHOQ and the SPSO take to administrative justice?
2) What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement?
3) How do those in the healthcare system receive and respond to these approaches?

The underpinning hypothesis that this research examines is that health ombudsman make an important contribution to the improvement of the healthcare system as a result of the roles and activities that they undertake together with the way that they work with bodies in jurisdiction.

4.3 Developing a philosophical stance

When undertaking research, a researcher’s ontological and epistemological approach influences their key decisions in both designing and conducting the research and analysing the outcomes. Thus:

> Two scholars who hold different beliefs on ontology and epistemology may be interested in examining the same phenomenon, but their beliefs will lead them to set up their studies differently because of their different views of evidence, analysis, and the purpose of research (Potter 1996, pp.35-36).

This next section provides a review of ontology, epistemology and the more common research paradigms before explaining why this research adopts a philosophical stance based on critical realism.

Ontology considers questions concerning the nature of reality (Flew, 1984). Gray (2009 pp.17-18) suggests that the concept of ontology dates back to 6th century B.C.E. Greece where two competing models on the nature of reality developed: one of ‘becoming’ and one of ‘being’. Gray (2009, p.17) argues that the development of Western philosophy has been based upon the model of ‘being’ which suggests that there is a ‘permanent and unchanging reality’. According to this model, ‘clearly formed entities with identifiable properties’ exist and ‘can become represented by symbols, words and concepts’ as they are stable (Gray 2009 p.17). In contrast, the ‘becoming’ model emphasises the changeable nature of the world where meaning is ‘imposed on an object’ by an individual. The individual therefore creates meaning but does so from a ‘collective unconsciousness’ such as ‘dreams … [or] … religious beliefs’ (Gray 2009 p.18).

Meanwhile, Savin-Baden and Howell Major (2013 p.57) describe an ontological continuum between two extremes of realism and idealism upon

which qualitative researchers place themselves. Realists contend that there is an ‘objective external and knowable reality that exists independent of individual means of apprehending it’ (Savin-Baden and Howell Major 2013, p.57). This view argues that reality is a matter of the physical universe, and separate from human experience and perception (MacKay 1997). The implication of this view is that both physical and social realities must exist. Meanwhile, idealism ‘is the view that suggests reality is subjective and is constructed by individuals and groups’ (Savin-Baden and Howell Major 2013, p.57). This perspective implies that reality is the product of thinking and the meaning that individuals ascribe to their lives (Schuh and Barab 2008).

Epistemology is concerned with knowledge, where knowledge is the information obtained by humans and held to be true and considers questions such as: what is knowledge and how is it gained? And, does knowledge represent reality (Savin-Baden and Howell Major 2013, p.58)? A researcher’s epistemological position will affect how the researcher understands and interprets the matter being researched. Gray (2009 p.17) argues that there are three epistemological positions: firstly, an objectivist position which believes that there is a reality which exists independently of our own awareness. This position is linked to an ontology of ‘being’ in which meaning is discovered, secondly, a constructivist approach which believes that truth is not independent of our awareness but is created by our interactions with the outside world. While this approach is also associated with an ontology of ‘being’, this constructivist position views meaning as being constructed, and, thirdly, a subjectivist position which assumes an individual imbues an object with meaning and has close associations to a ‘becoming’ ontology.

4.4 Research paradigms

A researcher’s ontological and epistemological beliefs will inform their research paradigm which has been defined as:

> … world views that signal distinctive ontological (view of reality). epistemological (view of knowing and relationship between knower and to-be known), methodological (view of mode of inquiry) and axiological (view of what is valuable) position (Sandelowski 2000 p.247).

Researchers, generally, approach their work from different perspectives because of their personal ontological and epistemological beliefs and the subsequent adoption of a research paradigm consistent with these beliefs. However, this is not absolute and some researchers change their research paradigm when undertaking different research investigations. This suggests that, rather than there being a deterministic approach whereby ontology determines epistemology which together create a fixed research paradigm and, in turn, determines the research methodology, research design and, lastly, the research instruments used (see, for example, Sarantakos, 2005, p.29), some researchers adopt different philosophical stances at different times, potentially indicating a willingness to adopt different views of themselves and the world that they inhabit. For example, Savin-Baden explains how she may use different philosophical stances according to the planned research (Savin-Baden and Howell Major 2013, p.29). In addition, Savin-Baden and Howell Major (2013, p.65), describe how 'situationalist' researchers 'believe that different philosophies should be applied to different situations and contexts' although they will ensure that the chosen philosophical stance guides the remainder of the investigative process. One can conclude that for some researchers their chosen research paradigm is not fixed but informed by the question 'What to study?' as discussed above.

Pansiri (2008, p.84) describes two broad social science paradigms: positivist and interpretive and that 'many authors have identified a number of different paradigms which largely depend upon this positivist/interpretive dichotomy'. Within this broad dichotomous split, Savin-Baden and Howell Major (2013, p.3) similarly claim that researchers are 'faced with an overwhelming number of [paradigms]'. Lincoln and Guba (2005) identify four principal paradigms:

positivism and post-positivism, both of which are associated with a quantitative methodology, and critical theory and constructivism, which are associated with a qualitative methodology. Walliman (2006, p. 20), however, describes a fifth philosophical stance, that of critical realism. These five stances are briefly discussed below following which the explanation for adopting a critical realist approach to underpin this thesis is provided.

A positivist philosophy has been traditionally associated with the natural sciences and holds that there is an external reality independent of human thought and that knowledge is something that is discovered through scientific enquiry. Researchers are interested in establishing facts and integral to a positivist approach are the principles of objectivity, rationality and neutrality (Savin-Baden and Howell Major 2013, p.19). A positivist approach is intended to establish causal relationships (Walliman 2006, p.15) and ideas can only become knowledge if able to be tested empirically (Gray 2009, p.19).

Positivism and its application to the social sciences has come in for significant criticism. Sarantakos (2005, pp.33-36) provides a summary of the critique of positivism which includes disagreement that reality is objective but is subject to interpretation, hypotheses developed before the conduct of the research bias the subsequent conduct of the research, an over-importance on measurement, and, a misplaced belief that positivist research is objective which ignores the fact that the personal stance of the researcher influences the research.

Post-positivism developed as a response to the criticisms of positivism yet retained some of positivism’s central tenets such as the existence of an external reality which may be discovered through logical investigative techniques and a belief in objectivity. However, in contrast to positivism, post-

positivists believe that this external reality can only be imperfectly known. Thus, post-positivists believe that no human viewpoint can be fully correct but, instead, should be tested. Knowledge can never really be fully established but only refuted (Savin-Baden and Howell Major 2013, pp.19-21).

The third philosophical approach, that of constructivism, holds that ‘there is in practice neither objective reality nor objective truth’ but that ‘reality is constructed’ (Sarantakos 2005, p.37). That is not to suggest that the world is not real but that it has no meaning before an individual interacts with that world (Sarantakos 2005, p.37) or as Walliman (2006, p.20) puts it ‘we can only experience it personally through our perceptions which are influenced by our preconceptions and beliefs’. Therefore, reality is being perpetually constructed and reconstructed based upon a person’s interpretations of the world in which it interacts and therefore leads to multiple views of reality.

Critical theory offers a different perspective to those discussed above. Critical theorists challenge extant values, assumptions and social structures (Gray 2009, p.25) with the intention that the outcome of the research process should be a guide for action. Savin-Baden and Howell Major (2013, p.23) suggest that it is held by researchers interested in social justice and change. Marx is associated with this paradigm hence the view that describing the world is not enough, the intention must be to change it.

While critical theory is a philosophy that offers a different perspective to those of positivism and constructivism, critical realism is seen as a ‘reconciliatory approach’ between positivism and constructivism (Walliman 2006, p.20), although Savin-Baden and Howell Major suggest that it is, in fact, a development of post-positivism (2013, p.21). Critical realists, while recognising an external world in common with positivists, do not accept that it can be understood solely through observation but that there must also be the

process of interpretation, an approach in common with constructivists. Critical realists do not argue that the concepts which they construct need a direct link with observable phenomena, but that ‘concepts and theories about social events are developed on the basis of their observable effects and interpreted in such a way that they can be understood and acted upon’ (Walliman 2006, p.20). Critical realists differ from constructivists in that they believe that pre-existing social structures exist which create social action and understanding while constructivists would argue that there is no general social structure separate from the experienced event (Walliman 2006, p.22).

Critical realists view reality as ‘a *stratified, open system of emergent entities”* [authors’ emphasis] (O’Mahoney and Vincent 2014, p.6). This statement can be broken down to three constituent parts. ‘Open’ which means that that the events under study cannot be separated from their context. ‘Entities’ are things ‘which ‘make a difference’ in their own right, rather than as mere sums of their parts’, can be either physical or conceptual, and are made up of different layers (or strata) to create an organised hierarchy (O’Mahoney and Vincent 2014, p.6). Thus, to comprehend fully one part of the system one must place it, and understand it, within its context. An example given by O’Mahoney and Vincent is that one could not fully understand the function of a heart without placing it within its context of both the circulatory system and the whole body (2014, p.7). Emergence occurs when an entity has properties which are more than the sum of its parts. So, another example from O’Mahoney and Vincent, would be that the entity water has physical properties that are different from equivalent amounts of hydrogen and oxygen (2014, p.7). The third element of the definition is that of ‘stratification’. Critical realists may observe a phenomenon, and from these observations a set of ‘rules’ or repeated actions may appear to emerge. Critical realists would not accept these observations as being the totality of the phenomenon but would seek to look beyond the events observed to understand what is happening at different layers of the system and the interaction(s) which brought about that

repeated behaviour. This focus on the different layers of the system is referred to as a 'depth ontology' (O'Mahoney and Vincent 2014, pp.9-11).

Its relevance to empirical research is that critical realists are 'interested in looking for and establishing as correct particular causal relationships and for understanding the necessary connections between [them]' (O'Mahoney and Vincent 2014, p.13). Thus, a critical realist researcher 'seeks to provide a theoretical explanation for the social world' accepting 'that some views of the world are more accurate than others' (O'Mahoney and Vincent 2014, p.13).

For the author a critical realist approach is held to be appropriate because of his belief that there is an external observable reality independent of the observer yet the reality that is drawn from the observation(s) of it is undoubtedly constructed to some degree by the observer.

4.5 Positionality

Sarantakos (2005, p.13-14) discusses the potential of researchers to deliberately manipulate research for political ends and cites three potential sources: the researcher; the consumer of research; and what he refers to as the 'controller of knowledge', a term which covers those individuals or groups who have the power to control the production or distribution of knowledge, for example, research committees, interest groups, or publishers. Beyond this risk of deliberate manipulation of research, sub-conscious bias on the part of the researcher could affect the results as a result of their personal stance.

The researcher's personal stance towards their work is derived from their core beliefs and values (Savin-Baden and Howell Major 2013, p.68). These beliefs will impact the entire research process including its design, the

analysis of the data collection and the writing of the final report. It is important, therefore that researchers understand how their personal stance may impact their research.

This is particularly the case in my own situation. I have long previous experience as a general medical practitioner, and in director roles in both a range of health organisations and at the Parliamentary and Health Service Ombudsman. In all these roles I have had active involvement in the resolution of complaints and the intended use of complaints to improve services. I have developed a positionality statement which clarifies my position in relation to this research and which is attached as Appendix 1.

Despite being aware of my declared position I have to recognise the impossibility 'of disentangling the positionality of the researcher from his/her methods and values' and that 'researchers are part of their research' which are both risks to bias (Clough and Nutbrown 2012, p.63). According to Gray (2009, p.183) researchers need to develop 'theoretical sensitivity' which is the ability to understand the research process and its outputs while being able to appreciate the difference between the important and unimportant. An example Gray cites is being sensitive to the risk of bias. Gray states that researchers should, therefore, adopt a reflexive approach, which involves reflecting upon, and being sensitive to, the many ways that bias may subconsciously affect their research because of their positionality.

4.6 Reflexivity

Reflexivity is 'the process of a continual internal dialogue and critical self-evaluation of positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome'

(Berger 2015 p.220) and is recognised as a ‘major strategy for quality control in qualitative research’ (Berger 2015 p.219).

Reflexivity is based upon the premise that ‘the researcher is not a neutral observer’ and ‘the researcher … is someone whose observations are by their very nature, selective, and whose interpretations of results are partial’ (Gray 2009, p.498). This partiality is particularly the case when much of the data gathering is through interviewing (Ryan and Golden 2006). Gray (2009, p,498) recognises two forms of reflexivity: epistemological and personal. The former relates to the researcher’s beliefs about the source and nature of knowledge. The latter refers to a researcher’s personal beliefs and values. This reflection is bidirectional: the personal beliefs and values of the researcher impact the research process but the research process will, in turn, impact the researcher’s personal stance. The researcher’s position has already been recognised as an issue in this research. It may also affect the nature of the relationship between researcher and the willingness of participants to grant access and share their opinions and information. Finally, the researcher’s world view, originating in a health ombudsman, could affect how information is collected, analysed and the subsequent derived conclusions.

The researcher undertook reflexivity during the research process to manage issues arising from my positionality. I utilised the following reflexive strategies based upon the work of Savin-Baden and Howell Major (2013, p. 80):

- Developing a positionality statement.
- Identifying the preconceptions that I hold about: health ombudsman; their role within administrative justice; the participants at both organisational and, where relevant, individual level.
- Noting reflections that occur during the research and keeping them in a reflexive journal.
- Being aware of, writing down and reflecting upon any worries, ideas or issues that arise during the research.

Attached as Appendix 2 is the research memoire for this research. This memoire details the reflexivity of the researcher during the research.

4.7 Methodology

The research paradigm adopted by a researcher informs their methodology. For Silverman and Marvasti (2008 p.134), a methodology details how a researcher will undertake the investigation of the phenomenon of study. Clough and Nutbrown (2012, p.46) describe the essential task of a methodology as persuading 'the reader of the *unavoidably* triangular connection between *these* research questions, *these* methods used to operationalise them and *these* data so generated' [their emphasis]. Yin (2009, p.24) states that 'Research design is the logic that links the data to be collected (and the conclusions to be drawn) to the initial questions of the study'.

As detailed above, the research paradigm underpinning this research is that of critical realism. Ackroyd and Karlsson (2014, p.23) argue that only a limited number of research designs lend themselves to an approach based on a critical realist paradigm. Even within this limited number there are two that they consider the most appropriate and commonly used by critical realists – case studies and comparative case studies. Indeed, they argue that the case study could be held to be the basic design of critical realist research as a case study allows for the study of a mechanism or process in whole or in part within its specific context. Using abduction, a researcher may then be able to develop new theories about the causal mechanisms.

This thesis adopts a qualitative case study approach as the research aims to explore the approaches used by health ombudsman to improve the healthcare system and how these approaches are received and acted upon

by the system. To undertake this means taking account of the complexity of the contextual situation of both health ombudsman and their respective health care system together with the many influences that impact upon both. A qualitative approach was chosen as an in-depth understanding and description of participants' thoughts, attitudes, intentions and reactions was felt to be needed to deliver the thick description required to fully answer the research questions. The research questions focus on understanding, perceptions, actions and behaviours. To address them fully needs a focus on cognitive processes which are not easily gained through quantitative methods but are likely to be achieved through qualitative approaches such as interviews and the review of documents.

Hancock and Algozzine (2011, p.15), state that 'Doing case study research means conducting an empirical investigation of a contemporary phenomenon within its natural context using multiple sources of evidence'. For Stake (1995, p.xi), it 'is the study of the particularity and complexity of a single case, coming to understand its activity within important considerations' and 'is expected to catch the complexity of a single case'. Merriam (1988 p.2) highlights the versatility of the case study approach arguing that the 'case study [method] is a basic design that can accommodate a variety of disciplinary perspectives, as well as philosophical perspectives on the nature of research itself'. The case study is therefore a popular approach among qualitative researchers (Savin-Baden and Major 2013, p.151).

Hancock and Algozzine (2011, pp.15-16), identify a number of important characteristics that are integral to a case study: a focus on a representative of a group or phenomenon; the research must take place within the group or representative's natural context and is bounded by space and time; and, the output of the research is 'thickly descriptive'. Meanwhile, Merriam (1988, pp11-13) identifies four different characteristics of the case study approach. Case studies are: particularistic, in that they focus upon a particular

phenomenon, descriptive, as case studies describe the phenomenon of study in detail, heuristic, as case studies enlighten the reader's appreciation of the research subject possibly leading to new insights, and, inductive, as new generalisations or theories will emerge from the data. Savin-Baden and Howell Major (2013, p.154) identify five salient characteristics as the case: exhibits clear limits to what is being studied, describes the whole of the case as well as constitutional parts, is particularistic, outlines the context in which the phenomenon is situated to allow a true understanding, and is firmly based on the underlying data to convey the resulting meaning.

Different authors have categorised case studies in different ways. Stake (1995, pp.3-4) suggests three categories: intrinsic (where the choice is guided by the researcher's particular interest in that phenomenon), instrumental (where the choice is guided by a desire to develop a better understanding of a theoretical issue. The issue being researched is thus instrumental in developing a better understanding of the underlying theoretical proposition), and, collective (where the researcher undertakes several instrumental case studies to enable the researcher to reach broader conclusions and more generalizable theoretical propositions).

In contrast, Yin (2009, p.6) identifies three different design categories: exploratory designs which seek to explore an issue with the aim of generating potential future research, explanatory designs which seek to show a cause and effect relationship between events and their outcomes, and, descriptive designs which aim to provide an accurate description of a phenomenon within its own environment. Merriam (1988, p.27-28) also details three design categories: descriptive designs, interpretive designs which are based upon description but are used to either develop new, or challenge existing categories, concepts and theories; and, evaluative designs which adds an element of judgement to the analysis of the first two categories.

A number of advantages and challenges have been identified with the case study approach. For example, Savin-Baden and Major (2013, pp. 162-163) outline the following advantages with a case study approach. The method is inherently flexible; allows for a depth of investigation and perspectives meaning a well-produced case study is thorough; a case study is able to respond to changes within the phenomenon or its context during the research period; and, researchers can write case studies in ways that appeal to their intended audiences.

On the other hand, Yin (2009, pp.14-16) outlines the following 'prejudices' against case studies: there is a lack of rigour in case study methodology (but this is a challenge with all research), a case study provides little basis for wider generalisation but, here, Yin differentiates between 'statistical generalisations' for which a case study approach may be inappropriate and an 'analytic generalisation' where the goal is to 'expand and generalise theories'. Flyvberg (2004, p.243) refutes the assertion that one cannot generalise from a single case stating that 'it depends upon the case one is speaking of, and how it is chosen' citing 'Galileo's rejection of the Aristotle's law of gravity' as an example. In a well-argued case study, the link between data analysis, conclusion and generalisation should be clear thus affording a view on the reasonableness of any generalisation claimed. Yin (2009, pp.14-16) continuing his analysis of prejudices against case studies lists: case studies take too long, but this need not be the case; and, case studies do not meet the requirements of 'true experiments' such as randomised controlled trials. Finally, Merriam (1988, p. 32) raises a significant concern that due to the nature of the research, the case study may over- or under-play reality leading to inaccurate conclusions.

This research will be a case study that is: exploratory, as it seeks to understand the beliefs, attitudes, actions and reactions of those involved in the use of health complaints as catalysts to improve the health system;

collective, as it investigates two cases; instrumental, as it aims to provide a better understanding of the role, functioning and effect of health ombudsman as system improver; and, holistic, as it analyses both the participant ombudsman's approaches to system improvement and the response of bodies in jurisdiction to these approaches.

4.7.1 Case Selection

Once the decision has been made to undertake case study research the question of which cases to investigate becomes paramount. A common view is that the first criterion in the selection of a suitable case is that it should 'maximise what we can learn' (Stake, 1995, p.4) and a similar view is articulated by Sarantakos (2005, p.213), and Merriam (1988, p.48). Stake (1995, p.4) provides further detail when he suggests identifying 'cases [which] are likely to lead us to understandings, to assertions perhaps even to modifying of generalizations'. When identifying the cases to be selected Sarantakos (2005, p.213) suggests that 'The minimum parameters to be considered … are whether the case or cases are suitable, accessible, researchable and methodologically adequate and whether the study is ethically permissible'. The cases should define 'a relationship between parts of systems and wholes' (Savin-Baden and Major 2013, p.152).

Researchers conduct some form of sampling in order to identify appropriate cases. Merriam describes 'two basic types of sampling: probability and non-probability sampling' and 'non-probability sampling is the method of choice in *qualitative* case studies' [her emphasis] (Merriam 1988, p.47) for, as Stake states, 'Case study research is not sampling research' (1995, p.4).

The usual approach in non-probabilistic sampling is 'purposive' sampling which is where you select a case based on the intended purpose and

outcomes of the case study (Merriam 1988, p.48). Sarantakos (2005, p.213) suggests that in multi-case research the typical case is the first chosen, and that even with single case research typicality is often the determinant. However, Stake (1995, p.4) suggests that it may not necessarily be the typical case and that 'many … caseworkers feel that good instrumental case study does not depend on being able to defend the typicality of [the case]'. Sarantakos (2005, p.213) does suggest that case selection may be guided by other factors such as theory, convenience, the interest of the researcher or accessibility.

One form of purposive sampling is criterion-based sampling where the researcher identifies the criteria to be used to select cases and produces a 'recipe of the attributes essential to one selected [case] and proceeds to find or locate a [case] that matches the recipe' (Goetz and LeCompte, 1984, p.77). It was the approach used in this research to identify the two ombudsman schemes. Three criteria were used to select the case health ombudsman for this research:

1) The research questions include the comparison of health ombudsman with different jurisdictional responsibilities therefore the chosen cases must have differing jurisdictional responsibilities.
2) There must be evidence that the health ombudsman consider that they have a system improvement role.
3) The number of healthcare complaints each health ombudsman investigated. It was felt that there had to be a reasonable number of complaints investigated by ombudsman to collect meaningful data on all approaches utilised by ombudsman to effect change.

To begin the case selection process, the researcher prepared a list of all ombudsman that consider complaints relating to the delivery of healthcare but had to exclude all non-English speaking ombudsman from the sample due to language barriers. Accordingly, the sample effectively included the British and English-speaking ombudsman in Australasia. It should be noted

that while there are a larger number of English-speaking ombudsman services they do not have healthcare complaints within their jurisdiction. The researcher then undertook desktop research which consisted of reviewing the websites of each of the remaining health ombudsman examining their Annual Reports, Strategic Plans, Business Plans and other corporate information. From this information, the following features were identified:

- Each health ombudsman's jurisdictional responsibilities
- Each ombudsman's statutory obligations and strategic objectives
- The healthcare sectors over which the health ombudsman held jurisdiction
- The number of healthcare complaints each ombudsman investigated.

It was difficult identifying the number of health investigations undertaken by each of the health ombudsman as they each report the information in different ways, with some ombudsman talking of complaints considered but without detailing which of these underwent a full investigation. Other ombudsman speak of 'decisions' without it being clear whether an investigation had actually taken place. This lack of clarity is the consequence of health ombudsman having significant discretion as to how they conduct their work and reflects the different approaches adopted.

Table 4, p.99, lists the ombudsman and the number of health complaints that each body received and investigated in 2014/15. From this list a revised pool of potential cases was identified and two bodies finally selected. These were the Scottish Public Services Ombudsman and the Office of the Health Ombudsman, Queensland. With regards the selection of the UK and Ireland based health ombudsman, Ireland was ruled out as it does not have the powers to investigate the clinical actions of clinicians. As this is where most system improvement work by health ombudsman is focused, the inability of the Irish Ombudsman to investigate these issues suggested its usefulness as a case would be limited. At the time the research commenced. I was a

Ombudsman	Number of complaints received (2014/15)	Number of complaints investigated (2014/2015)
Australia and New Zealand		
New South Wales Health Care Complaints Commission	5266	194
Norther Territory Health and Community Services Complaints Commission	198	4
South Australian Health and Community Services Complaints Commission	1808	117
Victoria Health Commission	3436	842[5]
Western Australia Health and Disability Services Complaints Office	2419[6]	1754[7]
Queensland Health Ombudsman	3109	358
Tasmania Health Complaints Commission	320	4
New Zealand Health and Disability Commission	1880	100
United Kingdom and Ireland		
Parliamentary and Health Service Ombudsman	6815	4280
Scottish Public Services Ombudsman	1542	394
Public Services Ombudsman of Wales	769	151
Norther Ireland Public Services Ombudsman	337	74[8]
Ombudsman of Ireland	634	51[9]

Table 4 Health ombudsman and the number of investigations (2014/15)

[5] Described in the Annual Report as Formal Resolution. This may include other methods to resolve complaints such as conciliation.
[6] Includes complaints about disability services
[7] The Annual Report does not provide a breakdown on closure type – e.g. closed after enquiry, assessment or formal resolution including conciliation, investigation or negotiated settlement. It does not break closure by complaint type e.g. health or disability service
[8] In Northern Ireland the bodies are combined health and social care providers. It is impossible, from the data contained within the Annual Report, to separate which proportion of the complaints' figures relate to healthcare and which relates to social care.
[9] The Irish Ombudsman is unable to investigate complaints about clinical decisions.

director at the Parliamentary and Health Service Ombudsman. Conducting this research while holding that position would have increased the issues surrounding my insider status, and is likely to have had some effect upon participants from within both the Parliamentary and Health Service Ombudsman and participating health organisations, potentially affecting the accuracy and openness of responses from participants. Because of previous links with the SPSO between both Queen Margaret University and also from the researcher, the SPSO was approached and agreed to participate.

In respect to the Australia and New Zealand Health Ombudsman offices, the New South Wales Health Care Complaints Commission, the OHOQ and the New Zealand Health and Disability Commission all have powers to prosecute healthcare professionals, thus making them co-regulators within their healthcare system. The remaining HCEs do not have such powers. As one of the criteria was to select health ombudsman with differing statutory responsibilities, the significant differences in powers and responsibilities held by the New South Wales Health Care Complaints Commission, the OHOQ and the New Zealand Health and Disability Commission identified these three health ombudsman as of particular interest. The researcher felt that the smaller number of investigations undertaken by the New Zealand Health and Disability Commission made it less than ideal for inclusion. As a result, the researcher approached both the New South Wales Health Care Complaints Commission and the OHOQ asking if they were willing to participate. The New South Wales Health Care Complaints Commission failed to respond to the request while the OHOQ responded positively to the request. Thus, the OHOQ was included as a case.

Both ombudsman selected appeared to consider a similar number of complaints each year and both were variegated ombuds offices, that is, they both have the core ombudsman duty of investigating individual complaints but, in addition, they have additional statutory responsibilities. The Scottish

Public Services Ombudsman is responsible for the Complaints Standards Authority which undertakes standard setting and auditing of the handling of complaints by bodies in jurisdiction. The OHOQ has regulatory responsibilities as it is responsible for prosecuting serious complaints concerning registered individual health professionals.

While both the OHOQ and the SPSO share some common features, as above, which provides a basis for comparison, they also exhibit significant differences. Unlike the SPSO, the OHOQ has the responsibility to prosecute health professionals it suspects has committed serious professional misconduct. The OHOQ is also able to attempt to resolve complaints using methods such as conciliation or mediation rather than solely relying upon investigation which is the case with the SPSO. The OHOQ, unlike the SPSO, is empowered to undertake systemic investigations or inquiries on its own volition. These differences are of interest to this research as they may significantly affect the results to the research questions: What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement? And, how do those in the healthcare system receive and respond to these approaches?

Further details on both schemes are provided at the end of this chapter, where contextualising information about the SPSO and the OHOQ offices is presented along with details about their respective healthcare and healthcare regulatory systems in the relevant chapters.

4.7.2 Sampling Bodies in Jurisdiction

Tables 5 and 6 provide data on complaints received by the respective ombudsman about health bodies in their jurisdiction. This research aims to establish how bodies in jurisdiction respond to the approaches used by

health ombudsman to affect change in the system. Opportunistic sampling was used to identify bodies to investigate. The researcher looked at health bodies in the jurisdictions of the both the Scottish Public Services Ombudsman and the Queensland Office of the Health Ombudsman respectively, to identify potentially bodies to invite to participate. Although the approach to sampling was generally opportunistic in nature, the researcher ignored the five Scottish health boards and four Queensland HHS with the lowest number of complaints on the basis that the health board may have such limited exposure to their Ombudsman as to make it difficult for participants to answer questions fully and knowledgeably.

Several health boards in Scotland were asked to participate and three health boards in Scotland agreed to do so. They have each been used in this research. For Queensland the situation was different as the researcher was unable to secure agreement from any HHS to participate. The researcher undertook a number of steps to try and secure agreement from HHS to participate. The steps included: obtaining ethical approval for the study which was granted in June 2018. While the ethical approval process was undertaken, the researcher made direct contact with HHS via email, including in the email documents which included a brief summary of the proposed research, the actual research protocol submitted for ethical approval and copies of the patient information sheet and the consent form. This approach was adopted to provide potential participating organisations with full information. The researcher also, during a trip to Queensland, visited one HHS to discuss the proposal with a Director of the HHS. In other HHS's there were telephone conversations and email communication. Unfortunately, no HHS ultimately agreed to participate.

It is known that it can be difficult to obtain participants in research. Even in obtaining the agreement from Scottish health boards to participate, where the researcher had previously been a director in a Scottish health board, some

health boards chose not participate. It becomes even more difficult to secure participation from organisations which are literally half way around the world and where there is no link or history and the difficulties in communication are challenging. For many busy organisations, the research is one more unnecessary activity and this results in reluctance to participate.

In the absence of any HHS agreeing to participate, the researcher undertook desk research on all 15 HHS looking for information relating to complaints, the OHOQ, and the use by HHS of complaints to improve the healthcare system. The researcher found very limited information on all three of these areas of interest and not enough to make any meaningful contribution to the research.

This inability to obtain meaningful data from HHS in Queensland had a significant impact upon the research. Initially, the proposal was to compare the approaches used by both health ombudsman and the responses of bodies in their jurisdiction. It would have been interesting to see how the differing roles and responsibilities of the two health ombudsman participating in the research affected the perception of staff from bodies in jurisdiction on their respective approaches to working with the body in jurisdiction and contributions to system improvement. Instead, the research became two interconnected comparisons: firstly, between two health ombudsman with differing roles and responsibilities on their approaches to working with bodies in jurisdiction and their contribution to improvement of the healthcare system; and, secondly, a case study involving the SPSIO and health boards that focused on the awareness by health boards on the activities of the SPSO, the relationship between the SPSO and health boards and the willingness of health boards to learn from the recommendations of upheld SPSO investigations.

Scottish Public Services Ombudsman

Health Board	**Number of Complaints**
Ayrshire and Arran NHS Board	74
Borders NHS Board	14
Dumfries and Galloway NHS Board	25
Fife NHS Board	56
Forth Valley NHS Board	59
Grampian NHS Board	85
Greater Glasgow and Clyde NHS Board	282
Highland NHS Board	87
Lanarkshire NHS Board	109
Lothian NHS Board	179
Orkney NHS Board	4
Shetland NHS Board	4
Tayside NHS Board	90
Western Isles NHS Health Board	5

Table 5 Number of complaints received by the SPSO relating to each individual health board (2016/17)

Office of the Health Ombudsman, Queensland

Hospital and Health Service	Number of Complaints
Brisbane[10]	2885
Central West	9
Darling Downs	207
Far North[11]	326
Gold Coast	710
Mackay	160
North West	31
Sunshine Coast	357
Townsville	170
West Moreton	61
Wide Bay–Burnett	381
South West	28

Table 6 Number of complaints received by the OHOQ relating to each individual HHS (2016/17) (OHOQ 2017, p.146)

4.7.3 Data collection methods

Case study research can use a number of potential data collection methods. Merriam (1988, p.68) and Stake (1995, pp. 60-68) identify three such methods: observation, interviews and document reviews. With observation, the researcher observes the phenomenon of interest. Stake (1995, p.62) advises that during the research the researcher keep ‘a good record of events to provide a relatively *incontestable description* for further analysis and ultimate reporting’ [his emphasis]. A second approach is the use of interviews which aim to capture the ‘observation and interpretations of others’ (Stake 1995 p.62). Different individuals will observe and interpret the same

[10] The Brisbane category consists of Metro North, Metro South and Children’s Health Queensland Hospital Health Services. The Queensland Health Ombudsman in his Annual Report does not break Brisbane into its constituent Hospital and Health Services.
[11] Far North category consists of Torres and Cape and Cairns and Hinterland Hospital and Health Services

event differently. Collecting these multiple interpretations is important in case studies. Stake's third method is document review. There are a wide range of documents that may be available to a researcher ranging from formal publications produced by organisations to minute of meetings and press releases. These documents may provide useful data that aid data collection and analysis.

To these three methods, Yin (2009, pp.98-113) adds three more: archival records, participant-observation and artefacts. Participant-observation is where the researcher potentially plays a variety of roles including an active role in the phenomenon being researched. Participant-observation is often used in anthropological studies (Yin 2009, p.112). Yin's final method is the study of artefacts including objects such as technological devices, tools, work of art or, other, similar physical evidence (Yin 2009, p.113).

This research uses documents, interviews and a review of the selected bodies' responses to significant ombudsman investigations as sources of data for analysis. This research does not involve direct observation because of the many practical problems associated with this method such as: time, cost, permission, and the intrusive nature of the approach which may in fact impact upon the events being observed. Most importantly, a researcher 'cannot observe feelings, thoughts and intentions' (Patton 1980, p.196). As this research is interested in the approaches used by health ombudsman in relation to their system improvement role observation was not considered to be a suitable method. Further, the complex nature of the bodies being investigated means that it would have been fortuitous if the observer actually observed something of relevance. This research ruled out using participant-observation as a result of the practical problems that the method entails and the lack of justification for the researcher to participate in the events being researched.

Initially, available website documentary evidence was collected and analysed prior to the fieldwork being undertaken. For the two ombudsman offices, this data was sourced from their respective websites. While documentary evidence contains large amounts of information that is free and easy to access, (Merriam 1988, p.108), the researcher needs to remember that 'it was written for some specific purpose and some specific audience *other than* those of the case study being done' (author's emphasis) (Yin 2009, p.105). To minimise the risk of being misled by documentary evidence, Yin suggests that researchers identify the objective behind the production of documents to minimise the risk of documentary evidence misleading them.

This research also used personal interviews to establish 'what is in and on someone else's mind' (Merriam 1988, p.71). Yin states that 'well-informed participants can provide important insights' and 'facts as well as opinions' (Yin 2009, pp.107-108). Stake (1995, p.65) argues that the purpose of an interview is to obtain a 'description of an episode, a linkage, [or] an explanation' through a 'guided conversation' (Yin 2009, p. 106). Stake (1995, p.65) continues that in qualitative research the same questions are rarely asked of each participant as each participant will have their own stories to tell. Stake (1995, p.65) suggests that researchers prepare a list of 'issue-oriented questions'. Yin, similarly, talks of the interview being 'fluid rather than rigid' (2009, p.106) but also of the need for open questions (2009, p. 107).

Merriam (1988, pp.73-74) identifies three types of interview: structured interviews where the questions and the order they are asked are determined in advance of the interview and this routine is the same for all interviews; semi-structured interviews, where there is some information that is sought from all participants but the order and exact wording are not pre-determined thus allowing the researcher the freedom to adopt a more conversational approach; and unstructured interviews where there are no pre-determined

questions allowing a completely free-flowing conversation. For Merriam (1988), the use of unstructured interviews is useful when the researcher has insufficient knowledge of an issue to be able to set specific questions.

This research used a semi-structured interview approach. This approach allowed for a more conversational interview to take place while ensuring that all the subjects that it aimed to cover were in fact covered.

For two of the Scottish health boards which agreed to participate, the most recent five published upheld investigation reports were identified from the SPSO's website at the time of the interviews. The third Scottish health board did not want to participate in this analysis. During the interviews with the participants from the health boards that had agreed to this part of the research, enquiries of the participants' awareness of these reports and their recollection of what had happened as a result were made.

4.7.3.1 Triangulation

Patton (2002) describes four types of triangulation that can occur when conducting research where triangulation can, firstly, relate to the triangulation of data sources (data triangulation), secondly, triangulation among different researchers (investigator triangulation), thirdly, triangulation involving the use of differing perspectives on the same data (theory triangulation) and, fourthly, of methods (methodological triangulation). In case studies, triangulation is important as dependence upon a single source of evidence is not recommended (Yin 2009, p.114). It is argued that the use of multiple sources of evidence is more likely to lead to a more convincing and accurate analysis and conclusion (Yin 2009, p.116). In this research methodological triangulation will be used and occurs when different methods to collect evidence will be used: interviews, documentary analysis and case analysis.

Doing so also helps assure the construct validity of the research as the multiple datasets essentially allow for multiple analyses of the same phenomenon. The use of multiple sources of evidence allows for a more complete picture of the phenomenon being studied especially if one source of evidence has any particular weaknesses (Merriam 1988, p.69).

4.7.4 Interview participant selection

A critical realist approach to the selection of participants when studying organisations has been detailed by Smith and Elger who identify two classes of participants, those called either 'practitioners' or 'subjects' and who recommend that researchers try to interview participants from both groups (2014, pp.120-122). Practitioners, usually senior managers, will have expert knowledge on how and why policies were developed, implanted and whether successful or not. However, because their experience is held to be 'embedded in specific contexts', Smith and Elger (2014, pp.120-122) argue that practitioners will take much of what they do for granted, and therefore unacknowledged, and that their horizons may be narrow. Subjects, usually more junior operational staff, will have a narrower expertise but will be well placed to describe the impact of policies and have informal knowledge of policy development and implementation that can enrich analyses (Smith and Elger 2014, p.121). This view was used to inform the criterion-based sampling used in the identification of the participants.

For the ombudsman offices involved in the research it was intended to interview both practitioners and subjects. Practitioners were those individuals senior enough within the ombudsman office to have contributed to the development of strategies or business plans or have responsibility for delivery. Therefore, it was at Ombudsman/Deputy Ombudsman, Director of Strategy, Director of Communications and Director of Operations or equivalent roles that were targeted. Each Ombudsman's office is structured

differently dependent upon roles, responsibilities and available funding but these were the practitioner roles targeted. In addition, interviews were to be conducted with participants at the 'subject' level with a participant from both casework and external affairs interviewed.

In reality, those interviewed from ombudsman offices did not meet the original selection criteria. For the Scottish Public Services Ombudsman, seven participants were interviewed and did include a combination of practitioners and subjects. Five interviews took place. In one of these interviews there were three participants. This was at the request of the participants. However, for the Office of the Health Ombudsman Queensland, although eight persons were interviewed, they were all practitioners and the researcher was unable to interview subjects. This was unfortunate but reflected the reality that the researcher could only interview staff with the agreement of the ombudsman and, therefore, did not have completely free choice. Six interviews took place. In one of those interviews there were three participants. This was, again, at the request of the participants.

For bodies in jurisdiction, the researcher intended to adopt different criteria using the lifespan of an ombudsman investigation as the key determinant. Thus, as well as participants having to have knowledge of their local ombudsman service, they had to have had some involvement in an ombudsman investigation, thus interviewing both subjects and practitioners. In identifying these roles, the PHSO report '*The NHS hospital complaints system A case for urgent treatment?'* (2013) was used as it talks of complaint management from ward level to board level. Roles identified include complaint management, governance, service improvement, senior clinical leaders, managers and the non-executive with nominated responsibility for complaints.

The researcher contacted the Chief Executive of the potential health boards in Scotland submitting, with the request, a brief summary of the proposed research. Three health boards responded positively and each health board identified a liaison person as requested by the researcher. The researcher asked the liaison person to identify potential participants from within their organisation and to provide their details to the researcher. When the researcher had received that information, he then personally contacted each potential participant providing further information on the proposed research, namely, the brief summary of the proposed research, a participant information sheet and a copy of the consent form. When the potential participants then indicated agreement to proceed the researcher agreed a mutually agreeable time and location for the interviews.

Ultimately, in two of the three Scottish Health Boards, the researcher was able to interview both practitioners and subjects. In these two Health Boards, eleven and three participants respectively were interviewed. For the third Health Board, there were participants from two groups of staff that were interviewed: firstly, a group of practitioners, occupying senior positions within the Health Board and a second group of participants from the complaints function. In this Health Board a total of eight participants were interviewed. This means that a total of 22 participants were interviewed. Twenty interviews were held. In two of the interviews, there were two participants interviewed at the same time. This was at the request of the participants.

4.7.5 Data analysis

When conducting the interviews, the researcher sought agreement to digitally record them and the subsequent recordings were transcribed. The software package NVIVO was used to assist with the data analysis. Table 7, overleaf, below shows the average length of interview for each of the participating

organisations. Note that in health board 3, the analysis of five upheld investigation reports did not take place.

Organisation	Average duration of the interviews
SPSO	57mins 47 secs
OHOQ	48 mins 17 secs
Health Board 1	47 mins 29 secs
Health Board 2	47 mins 39 secs
Health Board 3	38 mins 40 secs

Table 7 Average length of interview by participating organisation

Braun and Clarke (2006, p.78) state that there are two broad types of qualitative analysis: those that are tied to a particular theoretical position and those that are effectively independent of an underlying theory and therefore can be used across a range of theoretical approaches. This research uses thematic analysis which falls into the latter category. Braun and Clarke (2006, p.79) define thematic analysis as ‘a method for identifying, analysing, and reporting patterns (themes) within data’ and state that thematic analysis ‘offers an accessible and theoretically-flexible approach to analysing qualitative data’ resulting in it being ‘widely-used’.

The researcher used thematic analysis to capture a ‘rich thematic description of the entire data set, so that the reader gets a sense of the predominant or important themes’. (Braun and Clarke 2006, p.83). This approach is particularly useful when ‘investigating an under-researched area’ (Braun and Clarke, 2006, p.83) such as health ombudsmanry.

When conducting the thematic analysis, the following approaches were adopted: a theoretical rather than inductive approach was used as the researcher wished to test out a conceptual model that the researcher developed from the literature. The identified themes were analysed at a semantic level attempting to link the identified patterns with previous literature and theory. When undertaking this analysis an essentialist approach was used which assumes that 'language reflects and enables us to articulate meaning and experience' (Braun and Clarke, 2006, p.85).

When conducting the coding an initial set of codes derived from the literature review was prepared. During the coding the limitations of this coding list to capture all the themes was identified and additional codes were created as required.

In the results sections, participants have been allocated a female name randomly generated by a computer. Using a human name creates a sense of person behind the responses. As only one male participated in the research from the three health boards and male participants amounted to only 11% of all participants, in order to maintain confidentiality, all participants were allocated female names.

4.8 Quality, Reliability and Validity

Merriam (1988) argues that 'all research is concerned with producing valid and reliable knowledge' and 'because of the nature of [qualitative case study] research these concerns may loom larger than in experimental designs' (Merriam 1988, p.163). Merriam then identifies techniques that should be used in qualitative case study research that would enhance its internal and external validity and reliability. Table 8 lists the case study actions, identified

by Merriam (1988, pp.163-177) that can be used to ensure good quality case study research.

This research used Merriam's recommended actions to maximise the quality of findings and conclusions with a small number of exceptions. Merriam suggests the use of long-term observation, peer examination and participatory modes of research to ensure internal validity but none of these methods were suitable for this research. The issues concerning observation and participatory research have already been discussed in the data collection section above while peer examination was not possible.

The assessment of the approach to securing quality, validity and reliability can also be considered via the different stages of the research approach. The research design has used existing theory to guide the approach to data collection and analysis including the interview frame. Meanwhile, the data collection process requires well-developed interview skills. The researcher undertook reading in this area, piloted the interview on an individual from a health ombudsman office not involved in the research (including recording the interview) and reflected upon these lessons to develop the appropriate interview skills.

Study actions	Phase of Research in which tactic occurs
triangulation	data collection
respondents check accuracy	composition
researcher's bias	clarifying researcher's philosophical and personal stances at outset of research; undertaking reflexivity
long term observation	data collection
peer examination	composition
participatory forms of research	research design
rich description	composition
explain typicality or otherwise of case	composition
cross-case analysis	data analysis
audit trail	all stages of the research process

Table 8 Case study actions for ensuring the case study validity and reliability (Merriam 1988)

4.9 Ethical considerations

Conducting this research raises a number of specific ethical issues. As discussed in the literature review, receiving a complaint can be psychologically traumatic for clinicians and interviews may risk resurrecting the trauma. In addition, for each complaint there will be a complainant to whom significant harm may have occurred either to them or to a family member. The contents of complaints can be very sensitive which is why health ombudsman are required to conduct their investigations in private. As the research was looking at the thoughts, attitudes and behaviours at a higher level than that of individual complaints, there was no need to look at individual complaints where such data may be revealed. (Note, in two health

boards, there was a review of five upheld cases but this part of the interview was based upon publicly available information previously published on the SPSO's website and did not involve the identity of the person(s) complained about or any other information relating to the complaints).

In order to minimise risk to individuals, participation in the interviews was entirely voluntary and participants were informed that they could withdraw at any time up to the submission of the thesis. Selection of health board participants was undertaken by the researcher's health board contact and, prior to the interviews, the researcher was unaware if any participant had been subject to a complaint or SPSO investigation. At the first contact with all participants the researcher sent to all potential participants a written explanation of the proposed research and the consent form, both of which had been approved by ethical committees at Queen Margaret University. The researcher was asked by one health board to obtain ethical approval from an NHS ethics committee and this secured prior to the research being undertaken. Prior to commencing the interview, the researcher orally explained the research, obtained written consent and reinforced both the voluntariness of participation and that participants could withdraw at any time including after the interview. Participants were reassured about confidentiality and anonymity.

Ethical approval for this research was gained from the Ethics Committee at Queen Margaret University and from a Scottish health board. Ethical approval was also obtained from Townsville HHS research ethics committee acting on behalf of all Queensland HHS. For both the Scottish health board and Queensland HHS the research ethics committees accepted that the submission could be light touch as there would not be the use of either patient/complaint identifiable information or personal information relating to the complained against. The result of these decisions was an ethics application similar to that required by Queen Margaret University.

4.10 Situating the research

Both the SPSO and the OHOQ operate within a healthcare and healthcare regulatory system that are outwith their design and control. In this section, information about the Scottish and Queensland ombudsman offices as well as information about their respective healthcare and healthcare regulatory systems is provided. This detail will assist the reader in contextualising the research results and discussion.

Before doing so it is helpful to note two points that relate to these systems and which will help contextualise the research findings and subsequent discussion. Firstly, as detailed below, there exists, within both Australia and Scotland, a polycentric model of healthcare regulation. This means that rather than there being a single authoritative regulator, health bodies are overseen by a range of regulators with differing regulatory responsibilities and regulatory strategies, leading to a more complex and challenging environment (Healy and Walton 2016). These health regulators, in turn, form ‘more or less connected governance networks’ (Burris et al. 2005, p.31). Such polycentric governance arrangements are associated with concerns about accountability and legitimacy as there is ‘the dispersion of regulatory decision-making across multiple entities’ (Healy and Walton 2016, p.502). Carney et al. (2017) note that these health complaint bodies have two distinguishing features: firstly, the multiplicity of statutory purposes, and, secondly, the statutory relationship that exists between health complaint bodies and formal health regulators.

Secondly, for Carney et al. (2017, pp. 70-71), health complaint bodies have to accommodate the following standpoints representing the expectations of different participant groups: firstly, for the public, the resolution of individual complaints; secondly, for managers, complaints are a mechanism by which

problems with services (or professionals) can be identified and action taken to remedy the problem; thirdly, for health practitioners, there is a dependence on public trust, which can be facilitated though transparent complaint and registration instruments which try to ensure the maintenance of professional standards; and, fourthly, for governments and the regulatory and accountability bodies, the maintenance of public safety is paramount. Carney et al. (2017, p.72) question whether any health complaint body in Australia can meet all these objectives, noting that it is both ‘unknown and untested’. It is suggested that this, equally, applies to the SPSO. Healy and Walton (2016, p. 501) consider the nature of the relationship between health complaint bodies and other members of the healthcare regulatory network suggesting that health ombudsman typically attempt to develop an ‘educative and reformative relationship using persuasion’.

4.10.1 Australian and Scottish healthcare systems

This section provides detail on the Australian and Scottish healthcare systems and their respective healthcare regulatory environments.

The federal Australian government retains responsibility for setting national health policy, the funding of most public services, and the regulation of much of the healthcare system. Individual states retain responsibility for health service organisation and delivery, and their local regulation (Dugdale and Healy 2014). There is a mixed provision of healthcare in Australia with a national public health insurance scheme, Medicare, which provides automatic coverage for all Australian citizens and permanent residents, although over 50% of Australians also hold private health insurance (Australian Prudential Regulatory Authority 2019). Within Australia there is a well-developed primary care service, which acts as a gatekeeper to specialist care. Hospital and specialist care are delivered through a mix of public, private and not for profit hospitals. It is claimed that this mix of public and private healthcare is

supported by the population (Dugdale and Healy 2014, p.14). This general picture of healthcare provision applies to Queensland.

Healy and Walton (2016) note that, in recent years, many countries have been revising the regulation of healthcare to ensure that healthcare providers have increased accountability for the quality and safety of the services that they provide, yet, further note, that these changes, which have resulted in an increased number and range of healthcare regulators, has also led to increased complexity in the healthcare regulatory system.

In Australia there exists the National Boards responsible for the registration of regulated healthcare practitioners such as doctors, nurses, dentists and pharmacists as well as setting the standards that such healthcare professionals must reach in order to be registered with their professional board and will investigate some complaints about registered health professionals. The National Boards are supported by the Australian Health Practitioners Regulation Agency (AHPRA) which is responsible for the registration and oversight of all health professionals. With the exception of the New South Wales Health Care Complaints Commission and the OHOQ, AHPRA will undertake an initial assessment of complaints on behalf of the National Boards. Both the New South Wales Health Care Complaints Commission and the OHOQ undertake this function for healthcare professionals within their jurisdiction. National Boards will normally manage complaints considered to be of a less serious nature, more serious complaints will be referred to their state- or territory- level civil and administrative tribunal for consideration (Healy and Walton 2016).

At the Australian level there also exists the National Health Performance Authority which reports on the performance of hospitals and primary care against a national performance framework the Australian Commission on

Safety and Quality in Healthcare which reports on patient safety and the quality of healthcare against national standards, but cannot enforce improvements, and, the Australian Council on Healthcare Standards (ACHS) which accredits hospitals and other healthcare facilities (Dugdale and Healy 2014).

Within the Australian healthcare regulatory system, each individual Australian state and territory is responsible for managing health complaints and the regulation of healthcare professionals within their state or territory. From the mid-1980s each Australian state and territory has established a complaints body, generically referred to as a Health Complaint Entity (HCE) (*Health Practitioner Regulation National Law Act 2009*). These HCEs represent a move away from considering solely the merits of an individual complaint as they also try to secure the prevention of errors and to contribute to system improvement (Carney et al. 2017).

Each HCE remains separate from one another with a range of goals and approaches adopted within the differing jurisdictions. The 'powers, structure and functions of the health complaints commissioners [HCEs] all vary somewhat depending on their jurisdictional context and legislation' (Carney et al. 2017, p.498). However, in common, all are statutorily based, funded through state or territory governments with commissioners appointed for a fixed-term, although this term can be renewed. The different HCEs may use differing definitions of complaints and utilise a range of approaches to resolve complaints, such as mediation, conciliation, assisted resolution, the provision of information as well as investigations (Carney et al. 2017).

Some of the smaller HCEs may be incorporated within a larger complaint organisation and which includes a number of commissioners, each responsible for different jurisdictional areas of responsibility, or they may be

standalone commissions but which include additional responsibilities such as disability, community services or human rights (Carney et al. 2017, Healy and Walton, 2016). The larger complaint bodies may have had modifications made to the model (Carney et al. 2017). In this regard, while the smaller HCEs are restricted to responding to individual complaints, have little in way of formal enforcement powers and be unable to undertake own-motion systemic investigations, the two largest bodies, the New South Wales Health Care Complaints Commission and the OHOQ, have additional, stronger, powers (Healey and Walton 2016). Both the New South Wales Health Care Complaints Commission and the OHOQ are able to prosecute healthcare professionals where it is believed that the healthcare professionals have committed serious professional misconduct. In these cases, both the New South Wales Health Care Complaints Commission and the OHOQ act as co-regulators in partnership with AHPRA and the National Boards in the disciplining and imposition of sanctions upon healthcare professionals. This is a significant and fundamental difference with the other HCEs. The additional powers and responsibilities held by the New South Wales Health Care Complaints Commission and the OHOQ may significantly impact upon their activities and priorities.

In this thesis the relevant health complaint entity under investigation is the Office of the Health Ombudsman, Queensland. Figure 2 demonstrates this polycentric regulatory environment in which the OHOQ operates.

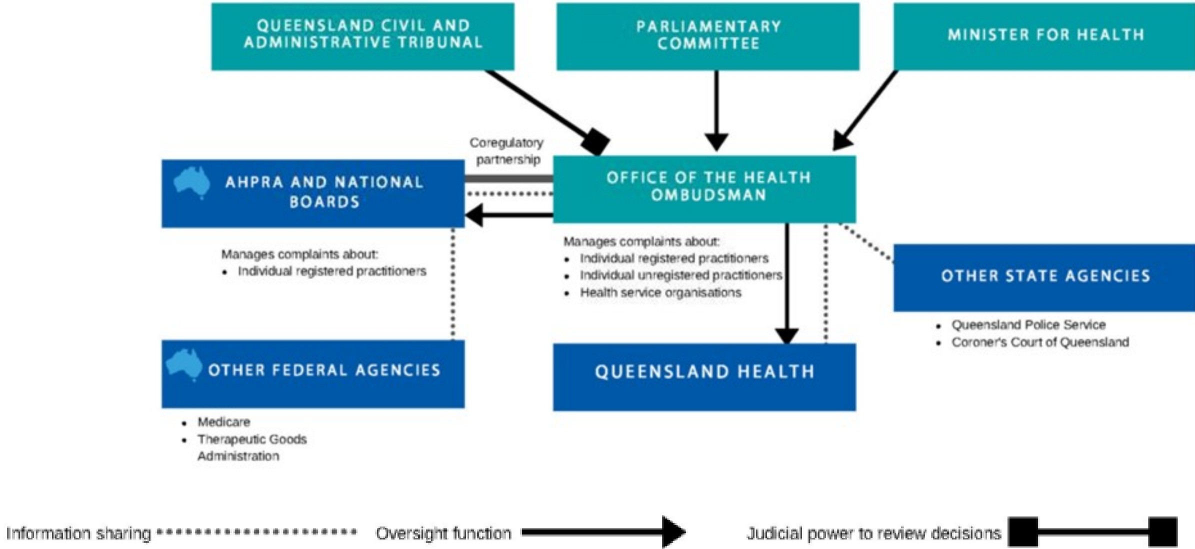

Figure 2 Queensland's coregulatory health system (OHOQ 2019, p.59)

Prior to the establishment of the OHOQ, there existed the Queensland Health Quality and Complaints Commission (QHQCC), which was responsible for considering health complaints, monitoring the compliance of health bodies with quality standards, and was able to commence own motion enquires into any concern it had about the quality of healthcare. Finally, the QHQCC had the power to require health bodies to report back to the commissioner any action they had taken in response to his recommendations. Of import, the QHQCC had powers to set standards for health services and monitor health bodies compliance with these standards (*Health Quality and Complaints Commission Act 2006,* Chapter 3) and had a specific obligation to use health complaints to improve the quality of health care (*Health Quality and Complaints Commission Act 2006* s50(1)).

This body was replaced by the OHOQ from 1 July 2014 and which was founded upon a statutory basis – the *Health Ombudsman Act 2013*. The key principle underpinning the Act is that the health and safety of the public are to be the ombudsman's key consideration (*Health Ombudsman Act 2013* s.4(1)). This Act provides the office with 'broad powers to deal with complaints and other matters relating to the health, conduct or performance of both registered and unregistered health practitioners and the services provided by health service organisations' (OHOQ 2019). The OHOQ is able to consider complaints about both public and private healthcare organisations. Section 3(1) of the Act details the main objects to be achieved:

> (a) to protect the health and safety of the public; and
>
> (b) to promote—
>
> (i) professional, safe and competent practice by health practitioners; and
>
> (ii) high standards of service delivery by health service organisations; and
>
> (c) to maintain public confidence in the management of complaints and other matters relating to the provision of health services. (*Health Ombudsman Act 2013* s 3(1))

The Health Ombudsman describes the purpose of the office as, to:

- Protect the health and safety of consumers
- Promote high standards in health service delivery
- Facilitate responsive complaint management (OHOQ 2020)

The OHOQ has the following powers: to require a provider to provide a response, undertake conciliation or an investigation, make recommendations or apply sanctions, require and monitor compliance and to prosecute health professionals (Healy and Walton 2016). In addition, the OHOQ is able to undertake both systemic investigations and inquiries, the aim of which is to contribute to system improvement (see page 125). In relation to systemic investigations and inquiries, the power to initiate such activities lies principally with the Health Ombudsman, although the Minister for Health, under the

legislation is able to instruct the Health Ombudsman to conduct such an investigation or inquiry (*Health Services Ombudsman Act 2013, Paragraph 28*). This makes the OHOQ both a co-regulator of health care, along with the National Boards and the AHPRA, as well as a health complaint entity, that is, a body able to consider health complaints. The OHOQ does not have the powers, held by the previous body, the QHQCC, to set and monitor health care standards or a specific obligation to use complaints to improve the quality of health care. The OHOQ is, however, now the sole entry point for all complaints about health care in Queensland, giving the OHOQ the responsibility for co-ordinating the handling of complaints (OHOQ 2019, p.33).

In the consideration of complaints concerning registered health professionals, OHOQ 'shares regulatory powers with AHPRA and the 15 national health practitioner boards' (OHOQ 2019, p.13) and may refer a complaint to one of these bodies unless it, the OHOQ, believes that the substance of the complaint may constitute professional misconduct or result in the suspension or cancellation of the health professional's registration, in which case the OHOQ is required to consider the complaint itself (OHOQ 2019). The OHOQ has responsibility for following up any complaint referred by it to another body to ensure that the complaint has been handled appropriately (OHOQ 2019, p.33). The ombudsman lacks powers to regulate unregistered health professionals (Healy and Walton 2016).

Within the United Kingdom, healthcare is a devolved responsibility with the Scottish government assuming responsibility for Scottish healthcare from 1 July 1999. The greater majority of healthcare provision in Scotland is funded through taxation and delivered by NHS Scotland through 14 geographically situated health boards. In addition, there are seven specialist NHS Boards and Healthcare Improvement Scotland. Health Boards are responsible to the Scottish government.

All Scottish health boards are unitary organisations. That is, they are responsible for the provision of acute services, maternity services, primary care services, community services, mental health services and health and social care partnerships, the last in partnership with local government. Population size, they vary from one of the smallest health organisations in Europe to the largest healthcare organisation in Europe. Many boards are a mix of rural and urban populations. This means that health boards are complex organisations and have complicated organisational structures to manage the different health sectors and/or geographical areas. In considering how bodies respond to SPSO this complexity must be remembered. Despite this complexity, there is broad similarity between the health boards that participated in this research on how they handle complaints and the problems that arise.

As with Australia, in Scotland, there also exists a polycentric model of regulation. Healthcare Improvement Scotland is the primary body responsible for the regulation and inspection of health services in Scotland and is supported by the Mental Welfare Commission for Scotland, which regulates mental health services (British Medical Association 2020). The regulation of healthcare professionals is undertaken by eight United Kingdom wide, profession-based regulators, including bodies such as the General Medical Council or the Nursing and Midwifery Council. In turn, these regulators are overseen by the Professional Standards Authority (Hirst 2018).

In Scotland, complaints about publicly provided healthcare are the responsibility of the Scottish Public Services Ombudsman (SPSO). The SPSO was founded on a statutory basis – the *Scottish Public Services Ombudsman Act 2002.* The Scottish Public Services Ombudsman is not only the ombudsman for health complaints, but as the name suggests, is the ombudsman for complaints about all public services in Scotland (Hirst 2018). Unlike OHOQ, the SPSO has oversight over public healthcare provision and

is not normally able to consider complaints concerning private healthcare providers.

The *Public Services Reform (Scotland) Act 2010* requires the SPSO both, to publish a set of complaint handling principles and model complaint handling procedures with which bodies in jurisdiction must comply and, also, to monitor compliance by bodies in jurisdiction with these principles and procedures and to promote best practice in this area. To meet this obligation the SPSO created within its organisation, the Complaints Standards Authority (CSA). The purpose of the CSA is

> to support continuous improvement in complaints handling by guiding all public service providers under our remit towards a simplified, standardised complaints procedure, which puts the service user at the heart of the process, focuses on early resolution, and values complaints as tools for feedback, learning and improvement (SPSO 2020).

The SPSO also acts as the Scottish Welfare Fund Independent Reviewer and, since 2020, also acts as the NHS Independent National Whistleblowing Officer. With regard to its healthcare complaint responsibilities, the SPSO has the following statutory obligations:

- To receive complaints about bodies in jurisdiction and investigate the complaint if the ombudsman believes that such an investigation is appropriate (*Scottish Public Services Ombudsman Act 2002*, s.2)
- Publish a set of complaint handling principles and model complaint handling procedures with which bodies in jurisdiction must comply (*Scottish Public Services Ombudsman Act 2002*, s.16A-B)
- Monitor compliance with these principles and procedures and promote best practice in this area (*Scottish Public Services Ombudsman Act 2002*, s.16D-G)

The *Scottish Public Services Ombudsman Act 2002* does not provide the SPSO with powers to conduct own-motion or systemic investigations.

The vision of the SPSO is to 'contribute actively and positively to Scotland's development and delivery of first-class public services: putting people and learning at the heart of what we do by being innovative and world-leading in our approach to complaints, reviews and standards (SPSO 2019d, p.2).

4.11 Use of the term 'investigation' by the SPSO and the OHOQ

Before considering the research findings, it is of value to consider the meaning of the term 'investigation' used by both the SPSO and the OHOQ. The use of the term 'investigation' is commonplace in the world of ombudsmanry but it can have different meanings dependent upon local context and statute. As the thesis has a strong focus on the potential systemic benefits to be accrued from complaint investigations it is useful to clarify the meanings used by both the SPSO and the OHOQ.

The SPSO complaints resolution process begins with as assessment of the complaint. The purpose of this assessment is to determine whether or not the SPSO has the legal powers to consider the complaint and to determine whether or not there is likely to be a 'significant benefit – or achievable outcome' to be obtained. If the complaint passes these tests it will be investigated which is where the SPSO gathers information from both parties in order to be able to reach a decision (SPSO 2021). The conduct of investigations is detailed in the SPSO's underpinning legislation, the *Scottish Public Services Act 2002.* Paragraph 2(4) of the Act empowers the Ombudsman to undertake actions that the ombudsman may think helpful in reaching a decision and when investigating a complaint, so long as the Ombudsman conducts the investigation in private and informs both parties that an investigation is being conducted is able to conduct the investigation in a manner considered most appropriate by the Ombudsman paragraph (*Scottish Public Services Act* 2002 para12(3)). Unsurprisingly, the SPSO

receives a much larger number of complaints than it investigates with approximately only one-third of complaints received by the SPSO closed after an investigation (see pages 150-1 for further details).

In the case of the OHOQ upon the receipt of a complaint, the OHOQ will also assess how it believes the complaint can best be handled. The Queensland's *Health Ombudsman Act 2013* provides the statutory basis for the actions available to the OHOQ to resolve a complaint. The OHOQ is able to consider a wider range of actions than is available to the SPSO, including the facilitation of local resolution, conciliation, mediation, referring the complaint to another body for action as well as investigating a complaint. When investigating a complaint, the OHOQ will collect pertinent information from both parties and will interview relevant individuals. In respect of investigations, the OHOQ states that it will only conduct complaints for the most serious complaints, where the OHOQ considers that there is material risk to the public or evidence suggestive of serious professional misconduct (OHOQ undated). This is unlike the SPSO which will investigate allowable complaints where the SPSO believes that there is public benefit to be accrued. Again, similar to the SPSO, the OHOQ conducts investigations in only a minority of complaints it receives. However, unlike the SPSO which investigates around one-third of complaints received, the OHOQ only investigates around 2% of complaints that it receives (see pages 129-131 for details). This reflects the wider range of actions available to the OHOQ and a focus by OHOQ on investigating only the most serious complaints.

4.12 The powers of the SPSO and the OHOQ for system improvement

This section sets out the actual powers available to both the SPSO and to the OHOQ to contribute to system improvement that are contained within their establishing legislation. The SPSO's underpinning legislation is the *Scottish*

Public Services Act 2002. This Act does not provide the SPSO with the powers to undertake own-motion investigations nor broad systemic investigations. In relation to upheld individual complaints the SPSO's ability to contribute to system improvement lies in its ability to make recommendations for improvements that remedy the failing to the body or person concerned. Should the body or individual refuse to comply with the recommendation, the SPSO can find that this complaint remains unremedied and using its powers under Paragraph 16 of the *Scottish Public Services Act 2002* is able to lay a Special Report before the Scottish Parliament. The Act is silent as to what the Scottish Parliament will do with the report but the inevitable resulting publicity that would arise from the laying of such a report will act as a form of powerful moral suasion upon the body or person involved to accept the recommendation(s). Thus, the SPSO has limited formal powers with respect to its ability to contribute to system improvement.

The situation is different for the OHOQ and its underpinning legislation, the *Health Services Ombudsman Act 2013*. Under this act the OHOQ has the power to conduct systemic investigations (Part 8 of the Act) or inquiries (Part 12 of the Act) into issues that arise from complaints or other matters about which the Health Ombudsman becomes aware. The OHOQ's legislation is, thus, significantly more permissive than the SPSO's legislation in allowing the Health Ombudsman to conduct systemic investigations and contribute to system improvement. In relation to making recommendations, the OHOQ has a duty to consult with the body or person affected but no requirement to gain the agreement of the body or person affected before finalising and publishing such recommendation(s). Overall, the OHOQ has significantly more powers than the SPSO to contribute to system improvement.

4.13 Conclusion

This chapter has provided detail on the methodology used to answer the research questions that had been identified. It also provided contextual information relating to the ombudsman offices central to the research along with information about their healthcare and healthcare regulatory systems.

Chapter 5 Research Findings – The Office of the Health Ombudsman, Queensland, and the Scottish Public Services Ombudsman

5.1 Introduction

This chapter presents the results of the research into both the Office of the Health Ombudsman, Queensland and the Scottish Public Services Ombudsman. The results for each ombudsman office are presented consecutively. Both sections begin by providing background information relating to the work of the individual ombudsman office which will help contextualise the results. The results for each office are then presented. When presenting the results in both chapters the section headings that are used reflect the themes that were identified and used in the analysis. For this Chapter the results start at Section 5.4 for the OHOQ and Section 5.8 for the SPSO.

5.2 Office of the Health Ombudsman, Queensland

'Because that's what we're here for. We're here to make sure that those rogues are dealt with' (Lydia).

The complaint handling process adopted by the OHOQ is detailed in Figure 3. The key stages of the complaints process are:

- Assessment: obtaining all relevant information and decide on the most appropriate course of action
- Take immediate action: where, in the opinion of the health ombudsman the health and safety of the public is at risk, the ombudsman may place immediate sanctions against a registered health professional's registration (including placing conditions or suspending the practitioner), or, with unregistered health

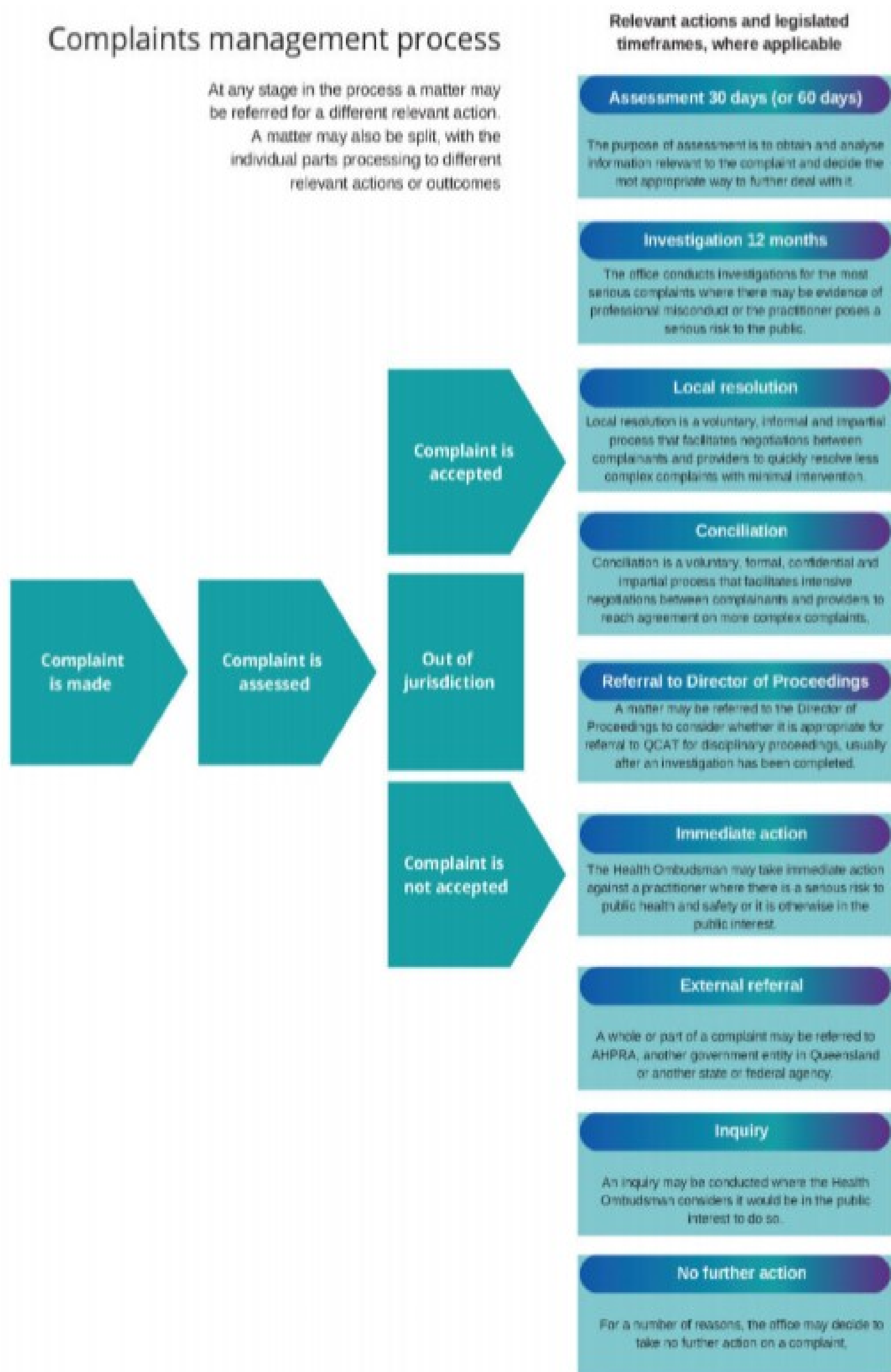

Figure 3 OHOQ complaints management process (OHOQ 2019, p.18)

professionals, issue an interim prohibition order which prohibits or restricts the practice of such a practitioner.

- Facilitate local resolution: the ombudsman facilitates communication between complainant and health service provider in an attempt to resolve the complaint short of ombudsman action.
- Attempt conciliation: the office may provide independent conciliation of a complaint if both parties agree to participate.
- Investigate the complaint: undertake a detailed examination of the complaint. The outcome of an investigation could include referral to the Director of Proceedings whose role is to consider referral to the Queensland Civil and Administrative Tribunal which conducts disciplinary matters against registered health professionals.
- Refer the complaint to AHPRA, the provider's registration board or other external organisation (OHOQ 2020).

While one may think that complaint handling within the OHOQ will follow a linear process, that is intake, assessment, investigation, referral where appropriate, a complaint can 'miss' steps in the process or, can be sent back to an earlier step for reconsideration. A complaint may be referred to AHPRA or other external government entity at any stage of the complaints process from intake through to investigation. The Annual Report for 2018/19 provides 37 pages of performance data but, while one can be confident of the outcomes at each stage of the complaints process, it is hard to be as confident about the outcomes of complaints as a whole. This is due in part to the fact that the consideration of complaints may well overlap reporting years, and, as mentioned, above, at each stage of the complaints process, case handlers are able to miss steps or refer the case back to a previous step for reconsideration. In addition, caseworkers will review each complaint and may break it down into separate components, each with a different action. For example, different elements of a single complaint it may be determined that one element is suitable for local resolution, a second element suitable for referral to AHPRA or other external body and a third element suitable for internal investigation.

Although the OHOQ is able to commence formal inquiries into:

(a) a matter to which a health service complaint relates:

(b) a systemic issue relating to the provision of a health service:
(c) another matter, the Health Ombudsman considers relevant to achieving the objectives of the Act'. (*Health Ombudsman Act 2013*, s.151),

as at the end of the reporting year 2-018/19, the OHOQ had yet to conduct any inquiry at all (OHOQ 2019, p.35).

5.3 Complaint numbers

In 2018/19, the OHOQ received a total of 8,575 complaints. Of these, 7,592 complaints were received from members of the public while an additional 881 complaints were the result of mandatory, voluntary or self-notification and a final 102 complaints were received from an external agency such as AHPRA or the Queensland Police. Of 8,241 complaints where a final decision was reached in 2018/19, 5,129 complaints were accepted for consideration and action, an increase of 16% from the previous year and 3,112 complaints were not accepted (OHOQ 2019, p.23). Key numbers from the OHOQ's Annual Report for 2018/19 include:

1. 1,196 attempts at local resolution were completed with a success rate of 81%;
2. 59 complaints were closed following conciliation between the parties;
3. 197 complaints were completed after investigation, after which 87 matters were referred to the Director of Proceedings, 80 cases referred to an external body for action and 66 cases where the case was closed with no further action;
4. 96 cases were referred by the Director of Proceedings to QCAT while 47 cases were referred back to the Health Ombudsman for reconsideration;
5. The Ombudsman made 31 immediate registration orders (taking immediate action against a registered health professional where it is felt essential to protect the safety of the public prior to the complaint being fully considered; the sanction is usually the placing of conditions on the professional's registration);
6. The ombudsman made a further 18 interim prohibition orders (taking immediate action against an unregistered health professional where it is felt essential to protect the safety of the public prior to the complaint

being fully considered; the sanction is usually prohibiting the unregistered health professional from working);
7. The Ombudsman consulted with AHPRA on 2,455 cases, leading to 2,381 cases being referred by OHOQ to AHPRA for action; and,
8. The Ombudsman referred 1,225 cases to other government entities.[12] (OHOQ 2019)

Table's 9-11 show the profile of complaint subject and those complained about.

Type of Health Organisation	**Number of complaints**
Public hospital	1780
Correctional facility	1257
Medical centre	508
Mental health service	384
Private hospital	236
Dental service	195
Specialist health services	128
Other (across 21 organisation types)	684
Total	**5172**

Table 9 Number of complaints by type of organisation (OHOQ 2019, pp.89-90)

Practitioner Type	**Number of practitioners**
Medical practitioner	2498
Nurse	590
Dental practitioner	329
Psychologist	197
Pharmacist	110
Unregistered practitioner	166
Other	176
Total	**4066**

Table 10 Number of complaints by practitioner type (OHOQ 2019, p.88)

[12] The Annual Report does not break down this figure or name the other government entities.

Issue	Number raised
Professional performance	4,822
Communication	1,541
Medication	1,530
Professional conduct	1,347
Access	912
Other (across ten areas)	2,098
Total	**12,250**

Table 11 Number of issues raised within complaints, by type (OHOQ 2019, p.97)

5.4 Results

The results of the research involving the OHOQ begins with the participants' views concerning the objectives of the OHOQ. Following this, the results follow the handling of a complaint received by the OHOQ and described above. It then provides the results of the OHOQ's approach to systemic investigations before ending with a review of the other activities undertaken by the OHOQ and which may contribute to improvement of the healthcare system

5.4.1 Objectives of the OHOQ

All eight participants from the OHOQ were asked about the objectives of the OHOQ. In each case, their first response was to say that the OHOQ's primary objective was to protect the health and safety of the public: for example, 'protect the health and safety of the Queensland community' (Aisha), 'protection of the health and safety of the public is paramount' (Rachel), 'it's about protecting the health and safety of the Queensland public' (Jasmine), 'the paramount guiding principle under the legislation is the health and safety of the public' (Lily), and 'the paramount guiding principle is

to protect the health and safety of the public' (Violet). On three occasions this answer was supplemented: 'by providing a service where people can make a complaint about their treatment or how they feel they've been treated by practitioners' (Aisha), the 'ongoing improvement in the delivery of health services and ongoing improvement and management of health service complaints' (Violet), and, 'maintaining professional standards' (Kara).

The participants were asked how they identified issues that arrived at the OHOQ to be health and safety issues. Kara clarified that the office utilised a risk assessment process that assessed potential risk within the complaint at every stage of the process. Examples of issues that would be viewed as a risk to public health and safety include 'professional sexual boundary violations' (Kara), 'anything to do with a criminal matter, any inappropriate touching of a patient' (Kara), 'it could even be verbally abusing a patient' (Kara), 'financial exploitation' (Violet), and, 'we look at vulnerability of patients, power imbalances' (Kara).

5.4.2 Complaint handling process

5.4.2.1 Intake and assessment

The first point of contact for any person with a complaint, enquiry or notification is with the OHOQ's intake and assessment team (OHOQ 2019, p.21). At this stage, the OHOQ will collect relevant information relating to the complaint and make a decision about how best a complaint should be handled (OHOQ 2020m). At the conclusion of the intake stage, 36% of accepted complaints were referred to AHPRA and the national boards, 31% were sent for further assessment, 21% referred for local resolution and 10% referred to another government entity (OHOQ 2019, p.23). Thus 67% of accepted complaints are referred to another body for action. Of the 31% of

complaints sent for further assessment, 9% of complaints were subsequently sent to AHPRA and the national boards, 34% referred to another government entity, 4% sent for conciliation, 4% sent for investigation and less than 1% sent for local resolution. 48% of complaints were closed with no further action being taken (OHOQ 2019, p.27). Thus, following the assessment stage, another 13.36% of the complaints originally accepted at intake are referred to an external body, meaning that slightly over 80% of complaints initially accepted by the OHOQ are referred to an external body for action by the time the complaint has been assessed.

5.4.2.2 Local resolution

'Local resolution is a voluntary, informal and impartial process for resolving matters between complainants and health service providers as quickly as possible and with minimal intervention' and '… matters identified for local resolution typically concern less complex clinical issues, breakdowns in basic systems or processes, or matters that result from a misunderstanding or failed communication between parties' (OHOQ 2019, p.29). The office states that local resolution is suitable for non-complex complaints, often involving communication issues and where the issue may be resolved quickly. It is not suitable for potentially serious complaints (OHOQ 2020j).

The office may play an active role in local resolution through analysing information and/or submissions provided by either party, facilitating meetings and/or communication between the parties concerned, and assist in the production of agreed actions that result (OHOQ 2019, p.29). The office plays an active role in local resolution starting with the facilitation of local resolution itself: 'one of the outcomes we negotiate commonly in the local resolution space is actually a direct meeting between the parties' (Betty), working with both parties 'on a sort of agenda that they can talk about' (Betty). Supporting

complainants appears to be a key objective for the office: ‘we try, if we can, to equip complainants to deal with a complaint themselves’ (Violet), ‘we’ve got some tips on the [OHOQ’s] website and links, I think, to other websites on the things to remember if you’re going to make a complaint direct to the health service’ (Violet). The office may even, on occasions, use its powers ‘to compel production of information’ (Betty). One of the reasons suggested for this involvement in local resolution is because ‘one of our important aspects in terms of improving the way that health service complaints are managed in the health system across the state is … equipping consumers and recipients of healthcare to have that kind of conversation’ (Violet).

The most likely outcomes that arise from local resolution are apology and an explanation of the treatment or service provided (OHOQ 2019, p.30) although the office does state that the local resolution process may result in improvements in the service provided by the health professional or organisation (OHOQ 2020j). If a complaint remains unresolved after local resolution, the complainant is able to return to OHOQ which may decide to accept if for assessment or refer it to an external body (OHOQ 2020j).

However, a positive outcome from local resolution depends upon an appropriate attitude from the complained about. As was discussed in Chapter 3, clinicians do not always respond positively when they are the subject of a complaint, with many doctors questioning the legitimacy of complaints received. The issue of attitude applies, in particular, to the attitudes of health professionals who receive a complaint:

> if they’ve got a lawyer and it depends on their lawyer. That will have an impact upon how the matter is dealt with. The ones that deal with it well, will generally engage in the process and try to genuinely learn from the process (Rachel).

Nonetheless, there is an optimism within the OHOQ that referring a complaint back to the original body for facilitated local resolution may lead to system improvement with improvements to clinical practice, policies or procedures all listed as potential methods of resolution on OHOQ's website (OHOQ 2020j), and also help improve complaint handling by health organisations,

> I think that's one of our important aspects in terms of our objectives in terms of improving the way that health service complaints are managed in the health system across the state is not only making sure that the providers know how to deal with a complaint but equipping consumers and recipients of healthcare in to have that kind of conversation (Violet).

Despite this optimism, eight per cent of complaints sent for local resolution by the OHOQ are withdrawn by the complainant (OHOQ 2019, p.30), which may be indicative of the complainant's unhappiness that the OHOQ is not taking on the complaint for independent consideration. Of complaints closed at local resolution, nearly 20% of complaints are unresolved. In addition, there is no routine follow up of the outcomes of local resolution to check that agreed improvements are implemented. Taken together, this optimism that substantive learning may be achieved from complaints resolved by local resolution may be unrealistic. The limitations of achieving system improvement through local resolution were noted by Betty who felt that conciliation was more likely to deliver improvement, 'you can probably pull and stretch system improvement in the conciliation space more that you could in the local resolution space'.

5.4.2.3 Conciliation

A small number of complaints are sent for conciliation. In 2018/19, 98 cases were sent for conciliation but, of these, 39 were closed as one party refused to participate (OHOQ 2019, p.31). Matters considered in conciliation are more likely to include complex issues which require greater assistance in

helping parties reach agreement (OHOQ 2019, p.31). ‘Conciliation is a voluntary process for resolving complex complaints that require detailed explanations or confidential complaint resolution’ (OHOQ 2019, p.31). Again, the OHOQ plays an active role in conciliation. Firstly, a complaint will have undergone internal assessment before referral to conciliation as ‘conciliation doesn’t have the power like local resolution does to ask for records, to ask for a submission, they really are at the mercy of the parties’ (Betty). Thus, the OHOQ will use its powers to obtain papers and, where appropriate, seek an independent expert opinion from a clinician (OHOQ 2020k). The OHOQ also facilitates conciliation through the use of specialist conciliators employed by the OHOQ.

The OHOQ states that potential outcomes from conciliation include apology, explanation, system changes and compensation (OHOQ 2020k) and, as with local resolution, if conciliation is unsuccessful, the office may accept the complaint for investigation or refer the complaint to an external body (OHOQ 2020k). While face-to-face conciliation is the preferred approach, if relationships are particularly poor, conciliation may commence with shuttle negotiations, with the intent of improving relationships to the extent that actual face-to-face conciliation can then take place (Betty). The approach to conciliation is evaluative rather than facilitative. This means that the OHOQ employed conciliators will ‘actually challenge people in terms of the level of information that they provide and we’ll challenge, we’ll reality test them on their views’ (Betty).

There is some suggestion that conciliation is a particularly effective way to secure system improvements. Discussions and negotiations that take place during conciliation,

> are legally privileged and that’s why systems improvement in the conciliation space are probably better able to be negotiated in that space, because you have providers who are the ones that control all

> the system changes and they don’t want to be admitting any liability or guilt in terms of what they’ve done Whereas they can do it probably a little bit more comfortably in the privileged area, because even if they agree to a process change, the complainant can't then go out and go into a court and seek legal proceedings, saying, well, clearly, it went wrong, they changed their processes and that's why it went wrong. So, you can possibly pull and stretch system improvements in the conciliation space more than you could in the local resolution space. And that's where they focus (Betty).

Despite this,

> the provider thinks why should I [participate], assessment doesn't think that we did anything wrong, necessarily, nothing critical, so why should I engage in another resourcing pack for me, to come along to this conciliation, it's voluntary, so they drop out. So, we don't actually get a large proportion of the matters into conciliation to a table because they drop out (Betty).

Nonetheless,

> during the course of conciliation, we could negotiate process changes. We'll try and steer parties to create a big picture outcome, which is more systems outcomes, rather than focus too much on what happened to them, and use that as a benefit to negotiate (Betty).

However, ‘we don't monitor this, you know, it's not a recommendation that they have to follow’ (Betty).

It was suggested by Betty, see above, that conciliation could result in significant system improvements. However, the commitments for system change made by health organisations are not routinely followed up and, as Betty said, providers may believe that if the assessment by the OHOQ did not indicate any significant issue of concern then why should they participate? Finally, only a small number of conciliations are undertaken each year. This, again, suggests that it would be optimistic to expect conciliation to bring about significant system improvement.

5.4.2.4 Investigations

'For more serious matters the office conducts formal investigations, which fall into one of two categories: individual health practitioner investigations or systemic investigations' (OHOQ, p.39). Compared to the number of complaints that it receives, the OHOQ undertakes a very low level of investigations with, approximately, only 1 in 40 complaints likely to lead to a completed investigation. 197 investigations were completed in 2018/19 (OHOQ 2019, p.40) of which 178 investigations concerned individual health practitioners (OHOQ 2019, p.43). This low number is, probably, because the OHOQ states that its objective is to 'Take proportionate and timely action in response to *serious* complaints and notifications about health practitioners' (author's emphasis) (OHOQ 2020i). The OHOQ (2019, p.39) states,

> In relation to individual registered health practitioners, we undertake investigations to determine whether the practitioner's conduct or performance constitutes professional misconduct, or whether another ground exists to suspend or cancel their registration. In relation to individual unregistered practitioners, we undertake investigations where it appears that the practitioner poses a serious risk to persons, due to the practitioner's health, conduct and/or performance.

Of the 197 investigations completed in 2018/19,

- 87 matters were recommended for referral to the Director of Proceedings
- 50 matters referred to AHPRA (see page 59)
- 30 matters referred to another external agency (see page 32)
- 2 matters referred for conciliation (see page 30)
- 66 matters on which the office took no further action (OHOQ 2019, p.42)

Roughly half of completed investigations resulted in a referral to the Director of Proceedings for consideration of prosecution at QCAT. Nearly 2 in 5 investigations result in a referral to an external agency, of which about two-thirds are referrals to AHPRA. Once a complaint is completed, the OHOQ may prepare a report of the investigation which may be shared with the complainant, the health provider concerned or external party and the report

may contain recommendations for action which may be followed up (OHOQ 2020l).

It appears to have been internalised within the OHOQ that it should only investigate 'serious matters' (all participants used this term in describing the cases that they accepted for investigation). The starting point for this view is the OHOQ's underpinning legislation which states,

> The health ombudsman may refer a health service complaint or other matter concerning a registered health practitioner to the National Agency, unless the matter indicates that—
>
> (a) the practitioner may have behaved in a way that constitutes professional misconduct; or
>
> (b) another ground may exist for the suspension or cancellation of the practitioner's registration. *(Health Ombudsman Act* S91(1))

and, while the OHOQ does have the power to investigate all complaints (*Health Ombudsman Act* 2013 s.14), it chooses not to do so.

In making this determination of seriousness 'you're looking at it in terms of where it should go, whether it's going to be unprofessional conduct or it might amount to professional misconduct. That will determine what the most appropriate action is' (Rachel). Or, 'for unregistered practitioners, that they pose a serious risk to the health and safety of the public' (Rachel). If it is not considered to meet the criteria in section 91(1) often, 'we will refer matters to AHPRA, if it's not in that serious category' (Lily). 'Anything that doesn't hit the threshold of professional misconduct or other conduct or performance, that would result in cancellation or suspension of registration. Then that usually gets sent to AHPRA to deal with' (Lydia). In some cases, the complaint may be split: 'you can hive off an impairment aspect and send that over to AHPRA … whereas we will deal with the serious conduct aspect of it' (Rachel). An interesting insight was also provided by Lydia when he said 'Because that's

really what we're here for. We're here to make sure that those rogues are dealt with'.

If a matter is investigated and it is felt that the concerns are founded 'then it goes up to the DOP, referred up to the DOP to make a decision as to whether or not to run it in a tribunal' (Rachel).However if it is not felt appropriate to refer the matter to the DOP then the case may be closed, but the OHOQ,

> still have all the other relevant actions available. So, say at the end of an investigation you get to it and go, oh this isn't serious, but there's still conduct that might amount to unprofessional conduct … we'll refer it up to AHPRA. (Rachel).

Although the OHOQ can look at both conduct or performance issues,

> while we [OHOQ] do investigate performance matters, probably the larger majority of what we do is conduct matters (Jasmine) where conduct matters are the sexual misconduct or the fraud, or whatever, so the performance goes to their performance as a practitioner (Jasmine).

One challenge that can be faced by the OHOQ during investigations is the attitudes with which they are faced from the complained about party,

> And I find that civil lawyers are anything but civil. They're nasty, they make it personal, it's always a fight, when there's no need to be a fight. And I think that part of that is that indemnity insurers fund the disciplinary proceedings and there's no incentive at the moment to settle, not that you can settle proceedings, but to co-operate in proceedings (Lydia).

The OHOQ recognises that,

> From a performance context there can often be a situation where the doctor's performance is influenced by a range of things, including hours of work and so forth; and the test that's applied as to whether something constitutes professional misconduct in part takes that into

> account, because the test is whether their performance has been substantially below the performance of someone of their qualifications and experience (Jasmine),

and,

> Having said that, there may also be in that sort of situation you may identify systemic issues which are contributing to that; and, if that was the case, we would separate that off and do a separate systemic investigation on that. (Jasmine).

5.4.2.5 Director of Proceedings

A key statutory post within the OHOQ is that of the Director of Proceedings. Where the ombudsman believes that a complaint is of sufficient seriousness then he may refer the issue within the complaint to the Director of Proceedings. The role of the Director of Proceedings is to assess whether the practitioner should be referred to the QCAT for formal disciplinary action. If the Director of Proceedings makes such a determination then he is required to prepare and present the case to the QCAT. Where the Director of Proceedings determines that referral to the QCAT is inappropriate then he must refer the complaint back the ombudsman for reconsideration and may make recommendations on proposed actions (OHOQ 2019, p.51). In 2018/19, the Director of Proceedings referred 96 matters to the QCAT and referred back to the ombudsman 47 matters. This number of 96 cases referred to the QCAT were a significant increase on matters referred in the previous two years (OHOQ 2019, p.53). During 2018/19, the QCAT delivered judgments on 18 cases referred to it by the OHOQ. In all cases, professional misconduct was found (OHOQ 2019, p.53).

5.4.2.6 Referring complaints to partners

The OHOQ may refer a complaint about a health professional to a national agency (in practice AHPRA) unless the complaint concerns professional

misconduct or other issue which may affect the professional's registration (*Health Ombudsman Act 2013* s.91(1)). Referrals will include complaints that indicate a need for health or performance assessment (QOH) 2019, p. 14) or conduct that does not meet the criteria of professional misconduct. The OHOQ states that it works closely with its regulatory partners, such as AHPRA and the national boards, to minimise the impact of the boundaries between them and works collectively on areas of system improvement (OHOQ 2019, p.58).

AHPRA is required to inform the OHOQ of all serious concerns that it receives relating to registered professionals (*Health Ombudsman Act 2013* s.193(1)). In 2018/19, the OHOQ was referred nine cases by AHPRA, of which it accepted three, while OHOQ discussed 2,455 complaints with AHPRA, ultimately referring 2,381 complaints to AHPRA (OHOQ 2019, p.60). OHOQ also has responsibility for monitoring the performance of AHPRA and the national boards, as well as compliance with recommendations contained within investigation reports (OHOQ 2020h). The OHOQ is also able to refer complaints to another state or federal government agency. In 2018/19, the OHOQ referred 1,242 matters to these external agencies which include organisations such as the Queensland Police or Fairtrade, although 'the range of government entities that we [OHOQ] refer matters to is extremely diverse (OHOQ 2019, p.33).

5.4.2.7 Systemic investigations

Section 80 of the *Health Ombudsman Act 2013* provides the ombudsman with powers to conduct both systemic investigations and own-motion investigations. An own-motion investigation is an investigation started by the ombudsman with the intent of pursuing a goal detailed within the Act but where the ombudsman has not received a formal complaint about the issue concerned (*Health Ombudsman Act 2013*, s.80)). A key objective of the

OHOQ is to ‘Identify and analyse systemic issues impacting on the delivery of health services, the regulation of health practitioners and management of health complaints’ (OHOQ 2020i).

Systemic investigations concern inquiries into issues ‘relating to the operation of a system, process or practice, including issues affecting the quality of health services rather than to the individual actions of a person or practitioner that occur within the system’ (OHOQ 2019, p.46). The ombudsman claims that conducting systemic investigations allows the office to adopt ‘a more strategic, proactive approach to protecting the health and safety of the public’ (OHOQ 2019, p.46). In 2018-19, a specific systemic investigation team within the OHOQ commenced ten systemic investigations and completed nineteen systemic investigations (OHOQ 2019). This team is looking to explore ‘innovative ways to increase public awareness regarding emerging issues and trends impacting on the delivery of health services and quality of health services, based on the office’s internal intelligence’ (OHOQ 2019, p.47).

Although it was noted by one interviewee that in the legislation which underpins the OHOQ, ‘there’s not really a huge focus in our legislation on that [systemic investigations], and, ‘there’s a lot of focus on individual health service complaints and your usual health providers’ (Lily), there was a lot of enthusiasm for the conduct of systemic investigations: ‘I think a greater service that we can provide is systemic issues that arise in the healthcare system’ (Aisha). One reason for this support is the assumed value for money ‘where is the best bang for the buck and I think systemics are a big area’ (Rachel) and ‘that’s where I think we can add great value’ (Aisha).

A second reason is the ability to make significant changes to the health care system,

> I think that's [systemic investigations] where you can really make some effective change. The problem with a lot of regulation is that it's reactive rather than proactive. And, I think that there has to be a balance, because if you can change the behaviour rather than constantly just react to it, then you're winning (Lily)., and,

> I think systemic investigations are potentially far more valuable because they have a much greater impact across a broader area and also have that prevention aspect to them, so not only are you addressing systemic issues but you're preventing poor outcomes moving forward (Jasmine).

A final reason for the positive attitude towards systemic activities were the positive results that had already been achieved:

> we have had some really good systemics that have happened. So, the medicines regulation in Queensland, there was a report that was done in relation to that. I think that was a really big systemic and it was a really positive outcome. So, it changed a lot the way that sort of system worked (Lydia).

One issue that arises in conducting systemic investigations is the method utilised,

> If you use traditional investigative methodologies it can take a very long time to progress the matter through, and by the time that you've progressed the matter through, any recommendations that may arise from it may well have been addressed to some extent anyway (Jasmine).

This concern led to the OHOQ attempting new approaches:

> we're going to try some very different approaches to systemic investigations where we meet with the agencies upfront and talk about what they are intending to do in response to particular incidents, and looking at implementing or getting an agreement around implementation a lot earlier (Jasmine).

One respondent cited an example where this new approach worked with maternity services:

> It let us go out to DG [Director General] Health and all the different HHS's [Hospital and Health Services] saying, we've identified this issue, you need to get it together. We bring the key stakeholders together, run a forum about that to drive a consistent approach (Rachel).

5.4.3 System improvement

There was a feeling among those interviewed from the OHOQ that complaints could be used to improve services provided the complaints are used in a way … a proper way (Rachel) but that it depends upon the culture of the organisation:

> if you're not in a continual improvement sort of mind-set, then you get the complaint come in, then you get adversarial you get your back up and you just say no. You don't learn from the complaint So, yes, I'm a believer that when the culture of an organisation is such that they look at complaints in that sort of way, then yes, complaints can drive improvement, like any complaint (Rachel).

A key element in securing system improvement is the recommendations arising from the systemic investigations that are undertaken and the subsequent monitoring of their compliance,

> And then we have recommendations coming out of the systemic issues; so when there's an investigation report we generally publish them, and they will have a series of recommendations; they will have a recommendations monitoring plan; we negotiate those with the hospital and health service or the facility up front, and then once that report comes out then we'll have time frames in the recommendations monitoring plan around the implementation and how we will measure the implementation. So, we're trying to move away from sort of documentary proof of implementation where you get flooded by a large number of documents every six months or so which may or may not give you a good sense of whether things have really improved on the ground or not. We're looking for recommendations monitoring things which we hope have more meaning, that we'll go and observe meetings, that we'll go and have discussions with people on the ground, that they will make staff available to us to talk to them about when they last had their training and what gaps they think they might have and… (Jasmine).

Of interest is the approach adopted to making recommendations,

> The position that we take on that [making recommendations] is that it is very much a negotiation. We've moved away very much from the position where you just go and impose a series of recommendations, because, really, that facility or that hospital and health service understands their business in a way that we don't; and sometimes there are things that they are doing in other areas that can have impacts on what's proposed (Jasmine), and,
>
> So, to have the best possible recommendations to make sure that they're as meaningful as possible, that they're going to contribute to a better hospital and health service in outcome, and that they will be meaningful on the ground, we find that having up front respectful discussions is the best way to achieve that (Jasmine).

There is a clear approach of working with bodies to identify meaningful recommendations that can lead to desired changes:

> So, I think it's about having the conversations with them up front about how we see our role, that we're the agency that stands between them and people who make complaints and that it's our job to investigate these matters and to look into them and to work out what recommendations are appropriate in the public interest; but we recognise that they don't come to work to do a bad job, that they come to work to do a good job; and that we have a mutual interest in achieving that, so by working together we can get that right in a more effective way (Jasmine)

As well as attempting to develop more meaningful recommendations, the OHOQ is also trying to ensure that the compliance process to ensure implementation of recommendations is also meaningful,

> So, we're trying to move away from sort of documentary proof of implementation where you get flooded by large number of documents every six months or so, which may or may not give you a good sense of whether things have really improved on the ground or not. We're looking for recommendations monitoring things which we hope have more meaning, that we'' go and observe meetings, that we'll go and have discussions with people on the ground (Lily).

An example was provided where a body had not appeared to deliver the intended change from previous recommendations:

> In this instance it's about a series of adverse outcomes which they've had previous recommendations but the recommendations haven't been implemented properly over time, so they're getting the same repeat mistakes. So what we're looking at is not so much a matter which is the subject of clinical views but rather how you manage performance monitoring and quality monitoring going forward, and what their committee framework has been to oversight that and what they do in practice to ensure that recommendations have in fact been implemented and how they do the assurance on that and checking on that over time. So, the subject of our discussions on that has been very much along those lines (Jasmine)

This move away by the OHOQ from documentary evidence of implementation of recommendations is seen as important in assuring itself that intended changes have been made:

> Yeah. But this is something that we've had a lot of discussions about lately, because in the past the position has been they have to come up with all this documentary proof that this has been done; we're saying we want a policy and procedure on this; and they're saying, we'd like to develop the process and fine tune it and when we're sure that we've got that process and right then we'll enshrine that in policy and procedure.
>
> So, the easy thing to do would be to sit back and say, well, we want all these documents produced and, until we see those documents, we're not saying that that's implemented. I think it's incumbent on us to work more constructively to work out what's going to be the most effective way; on the one hand you're carrying some risk there that they could be snowing you and that they're not in fact doing what is going to be necessary to achieve the outcome; but on the other hand you can mitigate that risk by putting in place monitoring processes which will pick that up if they don't. So, that's where we want to do the more on-the-ground monitoring as opposed to just receiving a whole lot of documents (Jasmine).

5.4.4 Other activities undertaken by the OHOQ

The OHOQ undertakes a number of other activities in discharging its statutory responsibilities. It provides brief advice on good complaint handling to people who, or organisations which, may be subject to a complaint (OHOQ 2020a) and advice to members of the public on how to make a complaint (OHOQ 2020b). It publishes a number of reports: monthly performance reports which detail the sources of complaint, the disposition of complaints' received, the age and sex profile of complainants, a summary of the issues contained within complaints and a profile of practitioners and bodies complained against (OHOQ 2020b); annual reports (OHOQ 2020c) and reports about the performance of AHPRA and the national boards. OHOQ also makes available on its website public information: educational videos (OHOQ 2020d), media releases (OHOQ 2020e), and, a range of fact sheets aimed at assisting in the submission of a complaint or notification (OHOQ 2020f) as well as a range of supporting forms (OHOQ 2020g).

The OHOQ undertakes a significant amount of stakeholder engagement, some of it of a general nature such as promoting the OHOQ to community groups and some which is more targeted such as to medical students at Queensland Universities (Lydia) or health bodies, law firms, medical insurers and staff unions (Lily). The OHOQ does attempt to encourage learning though outreach work. If the ombudsman becomes aware of issues then he may well 'look at topics and go and speak to various professions about those topics' (Lydia), including the unregistered area of jurisdiction:

> And I think the massage therapy one was one where the health ombudsman at the time, they brought in representatives from the different industry associations to talk to them about the kind of issues that were coming up, to try and influence their self-regulation to improve (Violet).

There was a general view that the OHOQ did not undertake sufficient media activity to promote itself as a body or the work that it undertakes, a view expressed by Aisha, 'we're not proactive in that, we're sort of reactive, so if the paper or media outlet contacts us then we might do something', Jasmine, 'I think that there's a lot more that could be done from a media perspective', and, 'I think it would be good to get into the modern age and get Twitter handles', and, Lydia, 'I don't think we promote ourselves well enough', and, 'I think that social media is another platform that we could use and we don't'. There was some concern about the balance that should be struck, with Lydia saying

> it's a double-edged sword because we are already getting well, well above the number of complaints that were ever projected when this office was set up. If you go out there and promote it even more, it [OHOQ} means, again, you're going to get more in the door.

5.5 The Scottish Public Services Ombudsman

'our dual objective is to put right what has gone wrong …[and]… the other side of our work has to be about public sector improvement' (Mia).

The complaint handling process adopted by the SPSO is as follows:

- Assessment: Ensuring that the SPSO has relevant information to determine if the matter is one which the SPSO is allowed to consider. If a complaint received by the SPSO is determined as not being suitable for action by the SPSO then it is closed as an enquiry.
- Early resolution: This is where the caseworker confirms that the matter is in jurisdiction and begins the evidence collecting exercise.
- Investigation: if it is considered appropriate, an investigation will be undertaken. Such investigations may be closed on proportionality grounds: 'some cases are closed if we are able to resolve them [without an investigation], we consider there would be no significant benefit to the complainant, or the outcome desired is unachievable' or by reaching a decision on the matter of complaint.

- Publication: the SPSO is required to lay its decisions before the Scottish Parliament and will publish decision summaries or full reports, dependent upon the importance of the complaint and the decision (SPSO 2019, p.13).

Unlike with the OHOQ, the complaint handling process within SPSO is more linear in nature. A complaint considered by the SPSO will follow the path of assessment, investigation and report with the principle action taken by the SPSO to investigate. The *Scottish Public Services Act* 2002 does not provide the SPSO with the same freedoms as exists with OHOQ to utilise a range of alternative dispute resolution methods such as conciliation or mediation, listing only investigation as the method to be used.

5.6 Complaint numbers

Key numbers (all complaints) from the SPSO's Annual Report for 2018/19 include:

- 1707 enquiries were closed
- The SPSO received 4,188 complaints of which 1,451 related to healthcare and reached decisions on 3,955 complaints of which 58% were 'upheld' in full or in part.
- The SPSO made 1,160 recommendations to improve public services (SPSO 2019, pp.4-5 and pp.10-12)

With respect to health complaints, in 2018/19, the SPSO

- Closed 5 complaints at the enquiry stage
- Closed 454 complaints for one of the following reasons: the SPSO provided advice to the complainant, on the grounds that the complaint had not been considered by the health body concerned or was not duly made or withdrawn.
- Closed 442 complaints at an early resolution stage of which about half were not able to be considered by the SPSO and about half on the grounds of proportionality.

- Closed 454 complaints following a full investigation of which 162 were fully upheld, 98 partially upheld and 182 were not upheld. The remainder were not duly made, withdrawn or resolved. (SPSO 2019a)

Tables 12 to 14 provide available detail on health complaints considered by the SPSO in 2018-19:

Health Sector	**Number**
Health Board	1076
General Practice	195
Dental Service	33
Ambulance Service	35
Community Pharmacy	3
Other (from five bodies)	19
Total	**1361**

Table 12 Number of complaints received by the SPSO by health sector (SPSO 2019f)

Subject of health complaint	**Number**
Treatment/diagnosis	924
Communication	118
Appointments/admissions	87
Policy/administration	56
Complaint handling	46
Nursing	32
Other (across 12 categories)	193
Total	**1,456**

Table 13 Subject of health complaint received by the SPSO (SPSO 2019b, p.4)

Closure Type (health complaints)	Number
Advice	435
Early resolution	442
Investigation	454
Total	**1,331**

Table 14 Number of closures at the different stages of the complaints process (SPSO 2019f)

5.7 The objectives of the SPSO

The strap line on the cover of the SPSO's 2018/19 Annual Report (SPSO 2019) is 'People Centred; Improvement Focused' and this same strap line is on the 2019-20 Business Plan (SPSO 2019e). The use of this phrase suggests that contributing to the improvement of services is a key aim for the SPSO. It claims to 'work with bodies under our jurisdiction to provide essential advice, guidance and training on complaints handling, share learning and best practice, and ultimately enable a more efficient delivery of Scottish public services' (SPSO 2020m). 'We have a very clear learning and improvement ethos' (Mia).

All participants were asked about the SPSO's objectives and the first stated objective from each participant was the handling of individual complaints but they were split on further objectives, with three participants stating that a second objective was to learn from complaints to improve services while two participants said it was to improve complaint handling. One participant stated all three objectives. Carney et al. (2017, p.82) note that ability for health complaint bodies to focus on both system improvement and the resolution of individual complaints has proven to be challenging 'both conceptually and in the overall governance system'.

An important objective for the SPSO, is, thus, to contribute to the improvement of the healthcare system. Partly because it is a good in itself, but also because 'the more improvement work you do the less pressure you have on the complaint, the individual complaint handling side of the business' (Chloe) and that while that may not result necessarily in less complaints 'you would hope that that the things that come to you are genuinely the things that are complex and intractable and genuinely need an independent view' (Chloe). While the number of complaints received has remained effectively static over the last three years at 4,188, 4,125 and 4,182 respectively, the proportion of premature complaints[13] has fallen over the last three years from 28% of complaints (2016-17) to 24% of complaints (2017-18) and then to 20% of complaints (2018-19) (SPSO 2019, pp.10-11). It is not clear whether this reduction is due to improved complaint handling or improvements to the overall healthcare system. If a complaint is upheld, then the SPSO will ask the body to 'apologise to you and explain why things went wrong. We may also ask them to take action to fix the problem if possible' (SPSO 2020j).

5.8 Results

The results of the research involving the SPSO begins with the participants' views concerning the objectives of the SPSO. Following this, the results follow the handling of a complaint received by the SPSO. It then provides the results of the SPSO's approach to system improvement before ending with a review of the other activities undertaken by the SPSO and which may contribute to improvement of the healthcare system

[13] A premature complaint is a complaint received by the SPSO before the organisation complained about has had an opportunity to try to resolve the issue(s) concerned.

5.8.1 Complaint handling process

In the investigation process, the SPSO is able to consider the professional judgment of health practitioners and as a lay office needs to obtain clinical advice to enable it to do so effectively:

> I think in that area [health], we rely more heavily on professional advice to help us assess whether or not people, whether the service has delivered, has been within the requirements of the professional guidance within that area (Chloe).

Asked how determinative was the clinical advice that was obtained there was a mix of views. 'I would suggest that, by and large, the advice would be accepted' (Mary) or 'Everyone in the system is very clear that it is the investigators that are making the decision and it is not the clinicians' (Chloe). In complaints that involve the use of clinical judgment, there is, inevitably, a tension between accepting advice that is received and suggesting that it is just one piece of evidence among others, of which investigators take account, before making an independent decision. Lay people may struggle to accurately assess the clinical evidence. If a health organisation 'felt that the advice was in any way flawed or erroneous or not up-to-date or not in line with sound guidance, then they may ask for the decision to be reviewed and that is something that we would do' (Mary). It is not clear how a lay complainant with no access to clinical opinion is able to challenge the opinion.

When a complaint is upheld the SPSO will publish the case, normally as a decision summary or, if it meets certain public interest requirements (SPSO 2020h), as an investigation report, although the SPSO's website does not detail the criteria used. A review of the last ten published investigation reports of health complaints, as at 9 April 2020, was undertaken. Summaries of

investigation reports were selected because they, supposedly, represent the most important cases published by the SPSO.

5.8.2 Investigation reports and decision summaries

Summary investigation reports are composed of a brief description of the complaint and investigation, the findings that arise and the recommendations proposed. Attitudinally, there appears to be a different approach between the section detailing the complaint, investigation and summary and the section detailing the recommendations that result. The findings are replete with the language of judgment. In each case complaints are either upheld or not upheld while the language within the investigation summaries is of failings, failure, significant failings, unreasonably failed, inadequate, and serious failure in care. Receipt by a clinician of a report which uses language such as the above is unlikely to be warmly received and may prompt negative emotions (see 2.4 about the responses by doctors to complaints). Similar language and recommendations are found in a review of the SPSO decision reports, which are summaries of complaint decisions held not to meet the public interest criteria for the publication of a full investigation report (SPSO 2020g).

5.8.3 Recommendations

Where a complaint is upheld, both an apology is required and recommendations for system improvement are made. Apologies are required to meet the standards within the SPSO's guidance on apology (SPSO undated). In 2018/19, the SPSO made a total of 130 recommendations relating to complaint handling, 386 'individual' apologies and 644

recommendations relating to learning and improvement (SPSO 2019, p.25)[14]. Only 48% of health recommendations were completed within the timescale set by the SPSO, although this figure rose to 84% completed within 3 months of the set target date (SPSO 2019, p.25).

As stated above, each recommendation will identify the outcome that the body is required to achieve. The outcomes required from recommendations tend to be that of established best practice – as identified within policies and guidance produced by the Board concerned or national standards and guidelines (see reports in SPSO 2020l). Thus, in using recommendations to improve healthcare services, the SPSO attempts to use normative standards to guide responses from Health Boards,

> If someone comes to you, us and says I think this should happen, what we look at is, what we look at is really what should have happened in line with national guidance or something. So if we are writing, making a recommendation, in a lot of cases what we are just telling the organisation is under the guidance you should be doing this, therefore take it away, look at it, see what the problem is, and make sure that in future you do act in line with the guidance (Susan).

The SPSO can take a strong line when ensuring that recommendations will be effectively implemented:

> Although they [health boards] have the opportunity to identify and evidence how they will achieve the desired outcome, the ombudsman, the SPSO, still retains the authority to say, well that's not quite good enough, or that's not fully delivering, or that's not you know, we don't, we have not abdicated responsibility in terms of recommendations (Mary).

The SPSO actively follows up recommendations to ensure that they have been implemented and will follow up if not satisfied – 'If they then supply

[14] Unfortunately, the SPSO does not provide a breakdown of these figures by sector

evidence to confirm that recommendations have been carried out and we are not convinced by that evidence then we will go back to them' (Ellie).

5.9 System improvement

While not able to undertake systemic or own-motion investigations, the SPSO has produced thematic reports which are reports that draw on common themes identified within the individual complaints. Their purpose is to highlight common issues and make more generalised findings and recommendations than can be made from individual complaints. The SPSO has published a total of two such reports, both in 2017; one report on the need for organisations to support staff through complaint processes, and a second on issues relating to informed consent (SPSO 2020a). The SPSO provides a relatively large amount of support and guidance to bodies in jurisdiction, the primary method by which it seeks to obtain system improvement arising from complaints is via the resultant recommendations,

> If you are upholding a complaint, it is because something went wrong, it is because you didn't do what you were meant to, something didn't go the way it should have, therefore you have upheld the complaint. There must be learning from that. There must be things you can improve at (Mary).

This commitment to learning from complaints begins with the complainant. Complainants,

> very often start with, I don't want this to happen to somebody else, and I think puts a responsibility on us [the SPSO] to ensure that we do pick up the service issues, we do pick up the standards issues, and we do pick up the communications and improvement and learning side of it (Mia).

At the time of the interviews with the SPSO, a new approach to making recommendations had recently been introduced with this drive for change coming from within the SPSO,

> I think it came out of a concern from CRs[15] a couple of years ago that we were making the same recommendation to the same body about the same thing and that, that didn't seem to be being particularly effective (Ellie).

'Before, we kind of sat there, at our desks, and tried to think what has gone wrong and what can fix it' (Ellie). It was suggested that this may be possible for simple individual errors, but when the complaint related to 'systems or a departmental issue, I think it was quite difficult to feel that we were making an effective recommendation because, while we had investigated one complaint, we had not investigated the entire process behind it' (Ellie). In the revised approach 'it is really up to the organisation to work out how they achieve that [the appropriate response to the upheld failing]' (Ellie),

> So, we are putting the onus back on the organisation and saying you, we have noticed some mistakes but it is still your system, so you take ownership of it and fix it, and tell us how you fixed it (Ellie).

The rationale behind this change in approach is quite clear as the following quotes indicate:

> I think the value from a perspective is that we may not always be best placed to make a recommendation that is appropriate because we might not know fully the extent of the organisation's structures and resources and so on. So, we might make a recommendation that we think is quite an appropriate and straightforward recommendation and, but it may have quite an impact on the organisation (Mary),
>
> But our recommendation system now is much more we set out what the vision should be and it is really is up to the organisation to work out how they achieve that. So, we are putting the onus back on the organisation and saying you, we have noticed some mistakes but it is still your system so you take ownership of it and fix it, and tell us how you fixed it (Ellie), and,

[15] CRs are caseworkers

> I think what we do now is much better where we are basically passing the problem back to them and saying have a look at this, you decide what is proportionate, find out if it is a widespread problem that needs something further done to it (Susan).

This changing of approach was described by one participant as a journey:

> The final point about all of this is the way that we make our recommendations. We are on the beginning of a journey that we started six months ago. And that is for individual [complaints], we divide recommendations into three types. For the complainant so that is personal redress, it is if we uphold there is inevitably an apology required. ... The second type of recommendation is learning and improvement, service improvement, good practice. And the third type is complaint handling. And what we do with both of those is we explicitly state our finding, we explain what we want the outcome to be of whatever needs to happen, and then we ask for evidence that that change, that improvement, that outcome has been or will be achieved (Mia).

In contrast with the OHOQ, the SPSO takes a different approach to making recommendations:

> I would never describe what we do as negotiation, ever. That is not appropriate to my mind. I think that everything you do has to be transparent, equally transparent, to the complainant. But I think that in a mature environment there has to be discussion and the reason I say that is because, erm, it will always be the case that a health board has more knowledge, or definitely should have more knowledge about how their systems operate, and we could be in a position where we make recommendations that have unintended consequences and that is not what we are trying to achieve (Chloe).

and, 'increasingly there is recognition that if what we really want is improvement then that has to be through dialogue, you know effective dialogue but without compromising our independence, our impartiality, and our transparency' (Chloe). This change in approach necessitated a change in relationship between the SPSO and bodies in jurisdiction which, while being open and collaborative, did not result in negotiated settlements:

> Now that sounds really easy in practice and it is absolutely the right thing to do but what I think it will lead us to do over time and it is already starting is that point between draft and final, there probably needs to be a better conversation with the public body in terms of how they demonstrate they have achieved the outcome. And I am beginning to see that creep in now. Rather than saying, here is my draft decision, have any comment? We are beginning to look at, in particular could you look at our recommendation for how the outcome will be achieved. The finding stands. This is not about, this is not a negotiation about the findings, it is about the deliverables. And it is not a negotiation, it is really a conversation to make sure that we do achieve that saving, that, that outcome, and that change (Mia).

An operational member of staff described the new approach as,

> … on some complaints, particularly the more significant ones, particularly the ones potentially where it goes to public report, and to start to say okay, this is what we have found, what do you think will make it less likely to happen in future, or can you explore what, what changes you think need to be made and then come back to us and tell you, and tell us what you want to do. That is much more labour intensive for us and it is much more labour intensive for the authority so you have to be very careful when you might apply that kind of approach. But that is, with some cases, where we are starting to move towards. And, that can be very effective, but it is certainly, the board is, or the authority is much more likely to identify more things to change and more things to, to improve their service that way than, than by just saying go make sure those staff get trained. But equally, you have to proportionate about it and you cannot, you cannot apply that approach to every complaint because it would just snow the system under (Poppy).

However, there appears to be some inconsistency in its use. On the one hand was a view that such conversations were taking place:

> We are beginning to look at, in particular could you [the body] look at our recommendation for how the outcome will be achieved. The finding stands. This is not about, this is not a negotiation about the findings, it is about the deliverables. And it is not a negotiation, it is really a conversation to make sure that we do achieve that saving, that, that outcome, and that change (Mia).

And if the SPSO is challenged,

> if a body disagrees with a recommendation or doesn't feel that it is based on, that the evidence from within the case doesn't, doesn't warrant the recommendation that has flowed from it, they can ask for a, request a review of the complaint and that is, you know, open to them to do and that would be something that they could pursue with us and we would have a think about whether that recommendation was appropriate and reasonable (Poppy),

and, 'it is rare but occasionally they will come back and say that is not something that practically we can do and so we are kind of open to discussing them at that point' (Ellie). On the other hand, there was a suggestion that this use of conversation was overstated: 'really, we, we don't generally speak to the organisation before we have made our decision and our decision includes the recommendations' (Ellie).

This change in approach was described as 'outcome-focused, so rather than being prescriptive in terms of what this is what you must do, the recommendation will identify what the ideal outcome should be for a particular complainant' (Mary). There is a suggestion that this new approach is welcomed by bodies, 'the feedback, anecdotally at least, but the verbal feedback that we get is that the new approach to recommendations is welcomed' (Mary). This is, perhaps, unsurprising, as bodies in jurisdiction will have some ownership of the proposed changes. As a safeguard, a caseworker may sense check the proposed response to the recommendation with a clinical adviser and ask 'do you think this is a reasonable response to this recommendation?' (Susan).

The intention is that this new approach delivers recommendations that, while meeting the requirements of the SPSO, are driven by the practical realities faced by bodies:

> … if I was a body, I would much prefer that ownership and empowerment rather than being prescribed to this is what I must to, this is how I must do it, this is when I must do it by, and this is the

> evidence you have got to give me to prove that you have done it. That is very tight and prescriptive and it not be not be the best approach (Mary).

While this may suggest that the approach is not intended to be prescriptive, one participant stated that the SPSO 'will set out what improvement we [the SPSO] will expect to take place, what evidence we want to confirm that that has taken place, and the implementation date' (Susan). The review of the ten investigation report summaries suggests that a more prescriptive approach is used in practice. Each summary contains the recommendations arising from that complaint and an example from a recently published investigation report is indicated in Figure 4 below (SPSO 2020l).

As can be seen from this figure, the boxes contain specific requirements that have to be delivered and in the key box detailing what the body is required to do there is use of the word 'should' (SPSO 2020l) and there is frequently a reference to guidelines and policies. The box detailing required evidence to indicate compliance is typically detailed about what is expected. Each recommendation on service improvement in recommendations uses the word 'should' (SPSO 2020l) and there is frequently a reference to guidelines and policies. This, together with the comment from Susan, suggests a more prescriptive approach is used than other participants suggested.

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
There was a failure to properly investigate Ms A for an underlying right hip infection over a period of five years in light of her presentation	Patients, who have symptoms suggestive of an underlying joint infection, should be fully and appropriately investigated, in line with recognised guidelines	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails. Evidence that the Board have prepared a local guidance policy, which is in line with recognised guidelines for investigating hip replacement infections By: 24 September 2019

Figure 4 Example recommendations from investigation report (SPSO 2020l)

5.10 The Complaints Standards Authority

As part of its CSA responsibilities, the SPSO has produced different model complaint handling procedures (model CHPs) for different sectors under its remit, such as higher education, local authority, social work and, importantly, the NHS in Scotland. The health model CHP was published in 2017 following

a collaborative development process involving the NHS in Scotland and patient representatives. To assist bodies to comply with the model CHPs, the SPSO 'produced a complaints' improvement framework which is a self-assessment tool' (Chloe) and a quality assurance tool 'looking at the journey of a complaint' (Mary). In addition, 'we do offer a, it's almost like a help desk, we offer, we provide, advice, guidance and support to bodies' (Mary). In 2028/19, the CSA provided advice on 259 occasions, of which, around one in four were from health bodies (SPSO 2019, p.22). While all participants spoke of the CSA working with bodies to improve complaint handling, Mia states that 'It's important in the sense of it gives, putting it on a statutory footing, gives us more leverage to improve complaint handling' suggesting that there may be an iron hand within a velvet glove.

The expectation is that NHS organisations review their complaint handling processes and ensure that they align with the model CHP (SPSO 2020c). NHS organisations must monitor their compliance with the model CHP and report this to the SPSO (SPSO 2020d). The model CHP includes information on required complaint performance indicators to be used by NHS bodies and which the NHS bodies should report (SPSO 2017). Bodies 'have to publish all of that data against set performance measures and that will include details of the learning that they have taken from those complaints' (Chloe). There is recognition that bodies struggle with this last requirement – 'It is difficult for them [bodies in jurisdiction] to demonstrate learning and improvement as a result of complaints' (Mary). Despite the requirement on bodies to publish data on complaints including performance measures, the SPSO is clear that 'we are not a regulatory body and so it really should be the role of the regulatory bodies that already exist to pick up that complaints data' (Chloe). One participant went so far as to state that the name, the Complaints Standard Authority could be a problem,

> because if you have the words Complaints Standards Authority then … the focus is on complaints standards and, I think, we need to look

> at … how do we make it work better and that is less about authority and more about collaboration (Mia).

The SPSO reports on compliance with the model CHP by bodies in jurisdiction in its Annual Report (see SPSO 2019, pp.22-23). The SPSO surveyed a sample of bodies in jurisdiction on the model CHP and reported high levels of satisfaction with the model CHP although there was less positive feedback on the performance indicators, the model CHP document structure and website (SPSO 2019, p.23). Since the introduction of the NHS model CHP, the SPSO reports that the number of complaints received by it concerning health organisations without the complaint having been first considered by the health organisation has fallen 4%, from 22% -17%[16], while there has been no difference in the number of upheld complaints considered by the SPSO (SPSO 2019, p.24).

5.11 Other activities undertaken by the SPSO

As well as complaint handling and the complaint standards roles, the SPSO undertakes other activities. In 2018/19, it provided 37 face-to-face training events to public service bodies; made four submissions to the Scottish Parliament (SPSO 2019, p.4-5) and six submissions to other organisations such as the Government of Jersey (SPSO 2020f). Training is also available online and the SPSO holds an annual conference (SPSO 2020i). The SPSO makes significant effort to support bodies through a range of activities including guidance and resource material covering complaint handling, communication with the public, learning and governance; insights for learning including thematic reports, investigation reports, decision summaries, case studies, complaint statistics, and a quality assurance tool; training on complaint handling; and, its newsletter (SPSO 2020i). It makes available a wide range of leaflets on complaints for both the public and bodies in

[16] Note the figures used are those in the Annual Report. This may be a rounding effect or a typographical error

jurisdiction (SPSO 2020e) and guidance to bodies in jurisdiction on apology and on redress (SPSOO 2020e). The SPSO publishes its findings on its website (SPSO 2020g) and publishes a monthly newsletter (SPSO 2020).

In 2019, the SPSO produced a ‘Support and Intervention Policy’ which details when and how the SPSO may undertake a support or intervention action. This Support and Intervention Policy appears to be a development of previous practice where the SPSO has,

> over the last four years met with organisations that are on, in that top ten to twenty to talk through with them where they think the issues are to try to leave them to improve practice. We, in the last year and a half, we have selected two bodies to work with in more detail and do much more targeted work. (Chloe)

The objective of these meetings is to discuss ‘the sort of complaints we are getting from them, what they can do to try and prevent the number of complaints coming through to us’ (Susan).

In implementing this new support and intervention policy, the SPSO commit to ‘supporting organisations to address issues proactively’ and, ‘engage[ing] openly and constructively with organisations’ (SPSO 2019c, p.5),

> A support or intervention action is action taken by SPSO to encourage good practice or address poor performance by an organisation under our jurisdiction in relation to … the organisation’s complaint handling … or … the organisation’s engagement with SPSO investigations/reviews (SPSO 2019c).

Examples where the SPSO may intervene include ‘non-compliance with the Model Complaints Handling Procedure … evidence of poor local complaint handling … evidence of a lack of learning from complaints … failure to adequately respond to an enquiry or recommendation’ (SPSO 2019c, p.6). Interventions may range from discussions at casework office level for minor

issues to the laying of special reports before the Scottish Parliament for the most serious issue or where there is persistent non-compliance (SPSO 2019c, p.7). Thus, a document which uses the language of support, engagement and working openly and constructively, also uses the language of failure and non-compliance with, what some may construe as, a threatening list of sanctions for bodies which fail to do what the SPSO requires.

Each year the SPSO sends to the Chief Executives of some of the bodies in jurisdiction, such as health bodies, local authorities, water companies and the Scottish Prison Service, an annual letter detailing key data about the complaints that it, the SPSO, had received about the body. In addition, the letter provides a brief overview of the year from the perspective of the SPSO along with details of developments that had occurred within the SPSO (SPSO 2019d).

5.12 Working with partners

The SPSO works with a range of external regulators and, because of this, has a memorandum of understanding with 13 such regulators (SPSO 2020j). The SPSO will share its data with other relevant regulatory bodies as 'I think it is right and appropriate that the data is used by the regulatory bodies that already exist to analyse the information that is there' (Chloe). In pursuit of this, the SPSO is a member of the Healthcare Intelligence Sharing Group which 'consists of all the regulators within the health field' (Mary) which meet to share their data about specific health boards 'to build up a national regulatory picture of that health board and that is fed back to the health board by HealthCare Improvement Scotland' (Mary).

5.13 Conclusion

This chapter has presented the results of the research involving the OHOQ and the SPSO. Although both are health complaint entities, it is clear that their objectives and activities are very different, due, in large part, to their underpinning legislation, but also arising from decisions made by the ombudsman post-holders.

Chapter 6 Results – Scottish health boards

'You know. It's like Big Brother watching you a wee bit' (Trish).

6.1 Introduction

This chapter details the results of the research involving bodies in jurisdiction in Scotland. The chapter, firstly, considers awareness by health board participants of the SPSO and their perceptions of the SPSO's roles within the healthcare system, before considering how health boards respond to an SPSO investigation. The chapter continues by considering how bodies handle the resultant investigation reports and associated recommendations. The chapter concludes with a consideration of the awareness by participants of a small sample of published reports concerning their health organisation. The description that follows is drawn from the responses made by all participants. Although each of the three health boards will have slightly different arrangements the commonality exceeds the differences. As was the case with the results from the two health ombudsman offices, the themes used in this analysis are identified by the section headings, in this Chapter starting at Section 6.3.

A total of 21 staff from three Scottish health boards agreed to participate. The demographics of the study sample are shown in Table 15 overleaf.

Staff category	Number of participants
Director level	7
Nursing staff[17]	8
Patient affairs/complaints staff	6
Non-clinical operations manager	1

Table 15 Demographics of participants from Scottish health boards

6.2 Awareness and perceptions of the roles of the SPSO

As would be expected, all participants were aware of the SPSO although this general awareness related to the SPSO's complaint handling function. There was less, and mixed, awareness of the other activities undertaken by the SPSO. Excluding complaint handling, Table 16 provides details on nine other activities cited by participants together with the number of participants citing that activity.

Activity	Number of participants mentioning this activity
Education and training programmes	12
Publication of decisions	11
Visits from the SPSO	10
Improving complaint handling	7
Publication of reports (not individual case)	6
Colleague was a clinical advisor	3
SPSO Newsletter	1
Guidance on the SPSO website	1
Professional relationship with SPSO staff	1

Table 16 Awareness by participants of SPSO's non complaint activities

Those participants who identified education and training were representative of the broader cohort of participants. Ironically, participants from complaint

[17] Note that all of the eight nurses had operational management responsibilities

offices were less likely to raise the SPSO's activities in the improvement of complaint handling. Nurses were much more likely to be aware of the published investigation reports and decision summaries than other staff, while senior staff were more likely to be aware of the other reports produced by the SPSO and to know of visits by the SPSO to their organisation.

A second way of viewing the awareness of different SPSO activities by participants is to consider how many activities were identified by individual participants and this is shown in Table 17.

Number of SPSO non-complaint activities identified by participants	Number of participants
Six activities	1
Four activities	5
Three activities	5
Two activities	6
One activity	1
No activity	3

Table 17 Number of participants identifying different SPSO non complaint activities

All 21 participants were aware of the role of the SPSO in complaint handling with 12 participants stressing the importance of the SPSO's independence when investigating complaints. Twelve participants identified the SPSO's role in contributing to system improvement, of whom, five participants stated that the recommendations made by the SPSO when upholding complaints were a driver of learning and improvement. Five participants suggested that the SPSO had a role in 'scrutiny' and holding bodies to account, while three participants suggested that the SPSO had a role in promoting learning from other complaints while another two participants suggested that the SPSO had a role in educating health boards on complaint handling and. Table 18 provides detail on the breakdown of participants and their views on the role of the SPSO, excluding complaint investigations, by organisational grouping.

Organisational grouping	Independence	System improvement	Learning from recommendations	Scrutiny	Learning from complaints	Complaint handling
Director	5	5	1	2	3	1
Nursing	3	2	1	1		
Complaint teams	4	4	2	1		1
Operational management	0	1	1	1		

Table 18 Number of participants who identified differing SPSO roles

6.3 Participants' views on SPSO investigations

All the health boards had clear processes in place to respond to investigations commenced by the SPSO. These would involve the collation of information from the clinical service about which the investigation was targeted, the complaints department and the health records department. In addition to this information, health boards may, at that time, offer additional comment on the case that they believe relevant. During the interviews three themes arose from participants relating to the way that the SPSO conducted its investigations: firstly, the interactions between the SPSO and health boards during the investigation, secondly, the ability to challenge the ombudsman, and, thirdly, the use of clinical advice by the SPSO.

6.3.1 Interactions

As stated above, the health boards have in place clear procedures to handle complaints being investigated by the SPSO. Participants from all three health boards stated that when handling SPSO investigations, health boards would ordinarily have a single point of contact, which may be an individual or a specific team, and which would liaise with the SPSO during the investigation. Accordingly, for clinical staff, although informed that an investigation is taking

place, they were not likely to be made aware of, or have any interaction with the SPSO, until the outcome of the investigation is complete. For clinicians, ‘it feels like it goes into the ether’ (Eleanor).

Such interactions, as do take place, tend to be in writing, with little in way of spoken communication, with many participants bemoaning this lack of personal interaction between health boards and the SPSO: Rhoda described the relationship between health boards and the SPSO as ‘it feels like an administrative process. … I think it’s bureaucratic’. For Darcie, ‘it seems to be just black and white. You take everything from what’s written’, Deirdre, ‘There’s quite a lot of electronic chatter rather than face to face. … I just wonder if there could be some improvement around face to face discussion about the case’, Donna ‘but that’s what I see as missing because they’re there and we’re here and only the twain shall meet in writing’, Jessica, ‘They’re not coming out to us and talking to us and interacting with us’, and, for Vicky ‘So it tends to be by email, and so I would say the majority of it is by email, but when there’s a phone call, it’s usually because they need something relatively quickly, or it’s a bit more complex’. This lack of communication can make it difficult for health board staff to respond appropriately to the SPSO:

> It’s as if there’s this barrier, and it’s like, why can’t we pick up the phone and say, “Can I just clarify, what is it you’re looking for? Can I just …? We were thinking of doing X, Y and Z, would that be sufficient? Is that what you’re looking for?” … These people are just doing a job the same as us, so why can’t we phone up and question them?’ (Emma).

Some of the participants expressed concern about the lack of oral communication: Darcie, ‘I think for me it’s sometimes frustrating, because it’s a one-way process’,

> I think you can get so much more information from talking to somebody, so I could write anything to you and you could interpret it in

> any way you liked, … but if you speak to me, you can ask me questions (Darcie), and,

> I think the more communication probably the better for both ways. For the ombudsman to understand more, but also for the teams here to actually be able to recollect some things in a different way and view things differently (Phoebe).

6.3.2 Challenging the ombudsman

It was noted earlier that, where the SPSO viewed that it was in the public interest to publish an investigation report, it would afford health boards the opportunity to comment on the draft report, but where a decision summary was to be published no such opportunity was afforded: Jackie 'No. if it's a decision letter we don't get a draft, we just get a final decision letter. If it's an investigation report we get a draft to check for factual accuracy', and,

> Again, that's where there's a slight variance in terms of what happens. I think in terms of the decision letters, one of the frustrations for me certainly was that, unlike the published report, you didn't get to see the draft decision letter. … [I] never really understood that to be honest (Tess).

While health boards can appeal a decision letter this presents problems for both health boards and the complainant,

> And the difficulty with that is that you can appeal it, there's an appeal period, but the decision letter has already gone to the patient. So, if we appeal it and win our appeal, they [the SPSO] then have to write to the patient and say, "Actually we're withdrawing that decision letter based on this information" (Jackie).

This can lead to pressure for health boards to accept the decision letter:

> Because when we get the recommendations in, almost always one of the recommendations is that we write a letter of apology. So, there's no way I would allow a letter of apology go to a patient, then we appeal it, and we withdraw that letter of apology (Jackie).

However, one problem of doing this is, as Phoebe stated,

> Sometimes you get a very upset, angry, frustrated clinician who think that it's been unfair and if that's the case, we will contact the ombudsman and we will say X, Y, Z or whatever. They listen, but very often the letter's been issued by then and we just need to work with our own teams and support them, moving forward.

This difference, between decision letters and investigation reports, was of concern to participants, as, while many participants recognised that they could challenge the factual accuracy of reports, issues arose when there were concerns within the report, 'actually you're only asked to comment on factual inaccuracies not necessarily clinical opinion' (Vicky) or 'We can challenge the factual accuracy of it [the draft report] with evidence, but we can't challenge their recommendations' (Rhoda).

There was a feeling among many participants that it was inappropriate to challenge the ombudsman: 'I was always made to feel as if you shouldn't question anything they ask you' (Emma), 'I think it's almost a given that your starting point is that you don't challenge the ombudsman (Tess), 'I don't think they like being challenged (Vicky), and, 'I get the sense they're [the SPSO are] quite directive and not really open to a challenge'. One participant described a particularly difficult case where

> 'actually, the process to go through in terms of challenging it [the report], and sometimes the response you get from the Ombudsman's office isn't really worth it. We challenged once and the Ombudsman came back and chastised us for challenging it. … It felt quite punitive' (Rhoda).

Many participants questioned the utility of challenging the ombudsman: 'Generally speaking, in my experience, the ombudsman very, very, very, very rarely amends the report unless it's factual accuracy' (Phoebe).

> I don’t know that there’s been anything that they’ve ever challenged … that actually the Ombudsman’s said “Okay I agree with you. That actually we’ll change that”. Any that I’ve been involved in where we’ve challenged them, the Ombudsman has basically come back and said, “No, that’s our decision, and we’re not going to …” (Emma),

> The way that I seem to see it is, it’s almost a done deal and they’ll only change something if it’s factually incorrect … but if I think there are things that people are disagreeing with, and it’s not factually incorrect, it’s just that they disagree that’s not how we do it here or whatever, there seems to be – you seem to come up against a stone wall’ (Jessica), and,

> … my perception from thinking about it, just as a gut reaction, is that where we will go back and perhaps offer some further information or try and illustrate why we feel like that’s not the case, I’m not sure that many will change. I don’t have a feel that that has much influence. I don’t ever have the sense that actually there’s a significant change in their findings (Millie).

An interesting story was provided from one participant who described a meeting with the ombudsman office. The health board felt strongly that the SPSO had made an error in their investigation and decision as the health board disagreed with what the SPSO’s external clinical advisor had opined, believing that the external clinical adviser was unaware of the context and pathway of care for the condition concerned. The health board felt especially aggrieved as its clinician was a recognised clinical leader in this area. As a result, a meeting was held between board representatives and the ombudsman. The meeting, and its outcome, was described thus:

> While the ombudsman is always very willing to come and talk to us about things, they talk at us. And it’s not a genuine dialogue. I felt that a little bit when X and I went across to talk to the ombudsman and the team. I did feel it was … it was a very interesting initial conversation about the needs to have dialogue and then the dialogue, but I didn’t feel there was any real intention to take our points of view on board (Donna).

Donna concluded, the health board is left asking, ‘Why exactly did the reviewer take that view when, actually, our clinician’s one of the speciality

advisors to the Chief Medical officer [of Scotland] and he's one of the lead clinician's in the field?'

One participant did report some success in challenging the ombudsman, it 'Sometimes depends on who the reviewer is. You get ones that are a lot more reasonable than others. Some that get it and some that don't' (Jackie).

6.3.3 Clinical Advice

The SPSO is able to consider complaints of a clinical nature and in 2018/19, complaints about clinical treatment or diagnosis amounted to approximately two-thirds of all health complaints (SPSO 2019b). Medicine is renowned for the fact that there can be differences in clinical judgment as to the diagnosis and management of patients. This difference in clinical judgment was picked up by participants. 'There's always the potential that they may be an expert in their field but there are lots of experts in the field [that] may have a different view' (Fiona), 'Sometimes there's no right and wrong answer. It's about clinical opinion at that point in time' (Emma), and, 'I think the experts they have engaged have given us their professional opinion. But they're one person, they're not sense testing with others' (Meg).

When health boards receive the draft investigation report or decision letters, they may disagree with the clinical advice provided to the SPSO and upon which the SPSO relies to reach its judgment. At that point health boards may try to challenge the clinical opinion, normally with little success: 'But you've not got much grounds if you've got "I disagree with your clinical advisors". They'll [the SPSO] go "Tough"' (Jackie), 'The bits we have queried have all been around clinical opinion and their expert's view. And even when we've gone back with guidelines … we didn't get anywhere' (Isobel), and, 'We have gone back. We have challenged it [clinical advice] and we've been told, this

is the clinical advisor for the panel, and this is the outcome, so, therefore, there you go' (Rhoda). For Rhoda there can be particular concerns as 'some of their [the clinical advisors] assumptions are wildly wrong'. Isobel provided an example where a complaint was received about a consultant physician and her health board commissioned an independent review of the physician's actions. This, second, physician supported the actions of the original physician. To be confident, the health board then obtained a third clinical opinion from a totally independent physician. This person also agreed that,

> the care that we had given was absolutely entirely appropriate and correct. So, we fed it into the system to say that we didn't think it [the SPSO's clinical opinion] was correct but we didn't really get anywhere because the specialist that they [the SPSO] had brought in agreed with the person complaining. And that left, probably, a consultant who was a very, very good, very cautious, good clinician, feeling undervalued (Isobel).

The SPSO does not name the clinical advisors that they have used. 'They don't tell you. They don't even tell you who they are' (Donna), and,

> I guess it would come back to what the parameters are of their recruitment of their external advisors. How current are they in their speciality? How senior are they in their speciality and, how, if you like, well respected are they in the patch?' (Donna).

This lack of transparency and the inability to discuss the case with the clinical advisor, leads to concerns about the quality of advice either due to concerns about the expertise of the advisor in a particular clinical area, 'I think the two [health board] clinicians that were involved are having conversations with the CMO[18] about it because they are particularly concerned that the individual [clinical advisor] takes a very specific view on things' (Donna), 'the fact that the advisor said one thing from one particular perspective, whereas, actually, the majority of the clinicians in the field would not have done that and we checked that out' (Donna), or because the health boards doubted that the

[18] Chief Medical Officer for Scotland

expert advisors had sufficient understanding of the context in which they operated,

> we've had some where medical staff have been really quite exercised about some of the things that have been said, because at the end of the day, we're a district hospital and maybe the advisor – I don't know where they came from (Jessica),
>
> So, their expert, their advisor has almost said is … it just doesn't fit with the footprint of our hospital. I think because, it seems to me, and I might be wrong about this … you think, "You're just not getting that. We don't have whatever it is you say is on tap as you say because we're not a tertiary hospital full of lots of different specialities" (Trish), and,
>
> because there's an issue as well about the cohort of advisors that they use. You know? So, for particular cases, we might have a clinician that's saying that's not the right person to advise on that because although they're a specialist in this, they might not know about X, Y and Z (Vicky).

There was some sympathy expressed from participants for the challenges involved in providing clinical advice. 'The expert practitioners have been given this [the casefile], and I could make a judgment on that, but reading notes and that doesn't tell me much' (Fiona), and, 'they're looking at the written documentation, which doesn't always tell the whole story' (Eleanor). As a result, there were comments that there could be better communication between the health board and clinical advisor: 'And sometimes you think it would be nice to sit down with their expert and say "Can you talk me through how you came to this decision"' (Eleanor),

> I think sometimes it's a shame that you can't have a little bit more of a discussion or they couldn't speak to the person challenging that to get an understanding of why Doctor X is so keen that that's not the way it should be (Jessica), and,
>
> The Ombudsman won't allow us to speak to any of their advisors because they say that they have to keep it anonymous and things. But, actually, sometimes it would be helpful if there could be a clinician to clinician discussion. But that's never facilitated (Jackie),

Negative clinical reactions can be caused by disagreements between health board clinicians and the SPSO's clinical advisors, 'So, there are occasions where they proceed to print things that our clinicians don't agree with. Which gives us a challenge back from the board then, how do we deliver the action plan for improvement?' (Meg).

> There'll be differences of opinion. And, I suppose, maybe more so for your nursing and medical staff. That's where it's maybe difficult. Because they [the SPSO] bring in advisors to the Ombudsman a lot of the time and, sometimes they don't necessarily agree with their [the SPSO's advisors] opinion' (Emma),
>
> And, I think, relationships, they can become quite tense. In particular, I think, for medical staff and [the SPSO's] independent reviewers. So, there may well be a question of that person's [the independent reviewer's] ability, or do they know better than sort of thing' (Deirdre), and,
>
> We have made challenges and they just haven't been taken forward and staff get really quite, we've had some where medical staff have been really quite exercised about some of the things that have been said, because at the end of the day, we're a district hospital and maybe the advisor – I don't know where they came from (Jessica).

6.3.4 How bodies handle SPSO investigation reports and decision letters

The report or letter (hereinafter the report) issued by the SPSO will be sent to the chief executive of the health board. From here, the report will be sent to a lead director, the choice of which will be determined by the nature of the complaint. For example, if the complaint is about the care provided by a hospital it will be sent to the management team of that hospital, or, if the complaint is about a community service it may go to the clinical lead or geographical sector lead. It is the responsibility of that individual to determine how best the health board should respond and who should be involved in that response. This person will also decide who should see the report and arrange for it to be cascaded through the management chain: 'it's then getting it [ombudsman reports] cascaded down. And, I think sometimes, that's where there's occasions where it works brilliantly and there's other

occasions where, maybe, it hasn't worked so well' (Emma), and, 'I think … we've got mechanisms to perhaps share in a way that's quite quick, consistent, one-pagers' (Deirdre). In all boards this cascade would stop at the level of senior charge nurse or equivalent. 'We keep it at a certain senior level, and then it's up to the service to disseminate that: 'That's why when it comes in, it only goes to a finite group of people' (Sally), 'the lead nurses take my agenda and then replicate it with their senior charge nurses, so it's cascaded down that way' (Rhoda) and, 'if we get a report, a published report, that's cascaded across all of them [the organisation]' (Meg). Those who have been involved in the complaint will also receive a copy of the report.

It is the responsibility of the senior charge nurse to then cascade the report to other members of staff. It is that this point that the cascade becomes more difficult. A senior charge nurse may be responsible for a staff of 60-70 persons, who work shifts and rotas. This means that the cascade to those members of staff tends to be by email. However, whether the emails are read was seen by some to be unlikely, 'If you've received a complaint about X hospital, you might sit here in Y hospital going, "Nothing to do with me"' (Millie), 'You know what it's like. If you send it on email, people will open a document and they'll read the first couple of lines and think "I can't be …"' (Darcie), due in significant part by 'because, increasingly our clinical staff have not got a lot of free time and, therefore, we rely on our managers and others prodding to get things from clinicians' (Donna). As a result,

> for so many people it will depend on the communication of individuals. So, there'll be some that are really slick at it, and there'll be some where I bet a nurse on a ward wouldn't even know who the ombudsman was (Jackie).

In addition to emails, and again dependent on the senior charge nurse and the report, there may be debriefs where

> we'll go back and we'll talk through the issues that the complainant or that were raised in the complaint to see what learning we can take out

> of that …so that's what will do if there have been significant issues, we don't do it with every complaint (Jessica).

The lead manager will identify who needs to be involved in drawing up the action plan, its implementation and the subsequent reporting on delivery. The membership of these ad hoc groups will tend to be determined by the subject of the complaint and the findings in the report. There will be communication up and down the management chain as the group produces a draft action plan, it is approved or amended and then implemented.

Reports will be sent to the relevant managerial meetings and to board committees with responsibility for clinical governance which will have oversight in ensuring that learning from the reports is secured. The formal board of management in each of the three participating health boards will not receive the actual report but will receive high level detail on its contents and updates on implementation of the associated action plan.

The approach adopted by health boards is configured to try and ensure an appropriate response to the report but it does not necessarily ensure that the reports and the issues contained within them is passed between clinical or geographical areas. Even within a hospital the information may not be shared: '[It] depends on what it's about. … So that's where I think the organisation, probably, we need to get better at' (Emma), and, 'so, my background is in acute medicine, … so I can absolutely tell you what I would expect to happen here but surgery, orthopaedics and urology, I couldn't. I don't have that assurance' (Eleanor).

Generally speaking, health boards took ombudsman reports very seriously: 'If the ombudsman is involved we need, obviously we take them seriously anyway but we need to reflect on what the ombudsman has said' (Trish),

‘What we’ve got here is an independent looking at facts as they see it, from complainants and from the service and forming a view’ (Fiona), ‘we understand it’s [the complaint is] thoroughly investigated. … Something along the line has failed there but at the end of the day we always want to improve and we always want to make it better for somebody else’ (Justine), ‘I think we try to be on the positive side’ (Eleanor), and, ‘we’re missing the most important thing, which is actually to make the patient, the complainant, whoever it may be, feel better and feel that we’ve properly listened to the recommendations and are acting upon them’ (Jackie). When a complaint was upheld by the SPSO, it ‘was a big shock, but probably a good shock. It was something that you need to have – it was sad for the people involved in it, but for us as an organisation, that’s how we keep learning’ (Jessica), ‘I look at it as a gift. You sometimes can’t see the wood for the trees in your own environment, so getting feedback from them on what they think we could have done differently is always helpful’ (Meg), ‘We take the ombudsman very, very seriously. We do see the ombudsman as an external reviewer if you like’ (Phoebe), ‘I think, generally, we saw the ombudsman as having a role in terms of driving improvement’ (Tess), ‘So, actually you can really learn a lot, although they are really sore to get’ (Trish), and, ‘I think we do take them [the SPSO] seriously and do look to them to learn from them’ (Trish).

However, some participants took a different view, where they felt that health boards were obligated to comply for fear of sanction: ‘We don’t see it as an opportunity, we see it as a threat’ (Vicky), ‘And there’s other people who, if you say, “I need it for this or this”, they literally jump because they’ve got this fear factor’ (Vicky), ‘From our point … we’re saying “I don’t think that recommendation is right” but we have been told by our bosses you just have to accept it’ (Darcie), ‘from what I’m told from my seniors, if the ombudsman makes a recommendation, it’s sort of suck it and go with it’ (Darcie), ‘everyone says, “the Ombudsman”, it’s like the grim reaper’ (Darcie), ‘I think there’s still a fear factor. There’s definitely a sort of fear, that, as an organisation we’re going to be seen in a bad light, and, that at all costs, try

and stop the ombudsman from upholding something' (Darcie), 'I think it was always seen as they [the SPSO] were there to put a sanction so the minute you hear the ombudsman you think, "Ugh"' (Isobel), and, 'generally, I think we're sitting in the camp of defensiveness, we're doing it because we think we're going to get into trouble, and, therefore, the commitment is lacking' (Yvonne).

Several participants talked of negative behaviours from the SPSO. 'I think their view would be [that] it [the SPSO] is collaborative, but from a services point of view I would say it's pretty remote' (Fiona), 'We challenged once and the Ombudsman came back and chastised us for challenging it. … So, you wouldn't want to challenge if you're going to get something publicly like that' (Rhoda), 'so, there's not an engagement and dialogue with us around that in any shape or form' (Meg), 'I'm not sure the relationship between the SPSO and the health board is collaborative enough. They are very separate …' (Yvonne), 'it's very much a kind of stick approach as opposed to engagement, working collaboratively, coming up with solutions' (Fiona), 'They tell us. And it's not a communication, it's not collaborative. It's a shame actually' (Jackie), and, 'Collaboration involves discussion and explanation and negotiation. I don't get a sense that happens a lot with the ombudsman' (Yvonne).

A sense of disengagement was also voiced, 'And, then other things we think, "Really?". It's almost making recommendations for the sake of it rather than genuinely understanding what happens in the system' (Donna), and, 'There are some who are probably, like, "the SPSO, who? I don't really care what they [say] you know?' (Vicky).

Finally, there were those participants who took, what may be described as, a pragmatic view: 'I suppose it depends what the recommendation or what it is

they’ve upheld as to what we need to change or potentially change’ (Jessica), ‘It will vary, I suppose, on what the recommendations are’ (Emma), and, ‘I think respect and doing everything that say are two different things though’ (Jackie).

This problem in the relationship between the SPSO and health boards led to some interesting characterisations of the SPSO. ‘I think they’re quite directive and not really open to a challenge’ and ‘I think they’re more dictatorial’ (both Jackie), ‘I suppose they almost seem to be in a place where they’re untouchable’ (Jessica), ‘They’re seen as scrutiny’ (Meg),’It actually feels really aggressive, but you have to think from their perception was that … it’s a two way thing isn’t it? But it feels really persecutory at times’ (Rhoda) and, ‘I suppose they almost seem to be in a place where they’re untouchable. That’s the way it feels. They’re not very approachable really, they’re sort of in their little ivory tour almost. That’s the sense that you get’ (Jessica).

6.3.5 Recommendations

The key approach from the SPSO towards contributing to the improvement of the healthcare system, is through the recommendations made by the SPSO in each of its upheld complaints. Stuhmcke (2006) suggested that ombudsman can make recommendations for two types of changes – large policy changes or smaller process type changes. Several participants indicated that the type of recommendations made by the SPSO varied in scope: ‘I would say it varies to be honest’ (Emma), and,

> so, we’ve had a couple that have said that the board should look at its policy carefully … but some of it, where it says, you know, “This should be fed back in a meaningful and supportive way”, it’s dead easy just to bash out a memo (Rhoda)

Participants recognised that it was easier to make simpler process changes rather than bigger policy changes, ‘for us to change a policy, … there is a process that we need to go through, one that involves partnership and engagement and all of that’ (Fiona), ‘To some extent, policy changes can be reasonably easy, providing it’s not, you know, a complete rewrite. It sometimes just requires a tweak’ (Millie). There are ‘recommendations that have a system-wide, organisation-wide, maybe national policy impact’ (Phoebe), and, ‘I can think of one or two big changes’ (Beatrice) but, mainly, participants were of the view that the changes were principally small-scale in nature: ‘I haven’t seen the big, wider organisational changes, I must say’ (Fiona), ‘Generally speaking, … it’s the more local conditions specific or client specific things’ (Phoebe), ‘I would say most of them are manageable. None of them … have been reflective of organisational change across the whole of the board’ (Sally), ‘For our system, most of it has been small-scale things’ (Donna), ‘our recommendations are fairly small’ (Jackie), and, ‘I think maybe from my experience, I think maybe more on the procedures rather than the policy’ (Jessica). Although many changes are viewed as small, some participants suggested that they may have a big impact: ‘The ones that I’ve seen are very manageable. … it’s just smarter thinking, how we do things and very small things, but actually would make a huge impact’ (Yvonne), and,

> we know sometimes we have to start small. We don’t set our goals too far because we want to achieve small changes to make the big changes … but the small changes can have a big effect on somebody and a big effect on what we do (Justine)

During the interviews three broad themes emerged relating to recommendations: the clarity of the recommendations and the evidence required to demonstrate compliance with the recommendation, the achievability of the recommendations, and, securing learning.

6.3.5.1 Clarity of the recommendations

While some described the recommendations positively, such as ‘generally sensible’ (Fiona), ‘most of them in the circumstances seem reasonable’ (Donna), ‘I would say on the whole they’re probably quite measured and realistic’ (Vicky), many participants were critical of the clarity of the recommendations. Indeed, six different participants used the term ‘woolly’ to describe the recommendations that had been made by the SPSO. Typical comments include: ‘I don’t even understand that. I don’t know what … it is not clear what they’re looking for’ (Emma), ‘Some of the ones that come back and you kind of think, “That’s a bit woolly. What does that mean?”’ (Isobel), ‘sometimes you have to read it a few times to figure out what it is that they’re getting at’ (Trish), ‘some of them will be very, very generic. And the generic ones are the ones that are harder for us’ (Isobel),

> Some of these things you think, “Well we’ve sent them the policy, so what’s wrong with the policy? … If we’ve to review, what is it in the policy that you think needs reviewed? That’s not clear. It just maybe says, “Policy should be reviewed?” (Jill), and,
>
> You’d love to see them in the boardroom to say “What do you mean by that? Explain what you actually want us to do, because again in black and white, I can read that and think “I don’t know how I can deliver that …? (Darcie),

This lack of clarity in the reports and recommendations can be a challenge for participants, ‘I think sometimes, even the way it’s written from the commentary, it would be, and this is probably, I don’t mean to be lazy, but you have to read the whole thing to sort of get sometimes to the point’ (Darcie), ‘they pass it to us on site and I’m going, I don’t even understand that, I don’t know, it is not clear what they’re looking for (Emma), ‘sometimes they’re a little bit difficult to interpret sometimes, what they’re actually asking us to do’ (Jessica), and, ‘It’s very difficult to know, sometimes, what she’s expecting of us. It would be good to have a clearer picture of what he or she feels we should be doing differently’ (Jill).

In addition to a lack of clarity about the proposed recommendation, there was also concern from a small number of participants about the lack of clarity about the evidence required from health boards to demonstrate compliance with the recommendation: ‘And sometimes what’ll happen is, you’ll go back to the Ombudsman with what you’ve done. And sometimes they’ll [the SPSO] come back and say, “Well, that’s not what I’m looking for. I’m looking for this’ (Emma), ‘Staff at different levels within the organisation get themselves worked up because what do they mean by evidence’ (Tess), and, ‘That’s the question I’ve been asked I don’t know how many times, “What do they mean by evidence?”’ (Vicky).

However, where there was a lack of clarity about the meaning of a recommendation, a number of participants felt comfortable about seeking clarity from the Ombudsman’s office: ‘I can think of one recommendation that went back to them and they did listen and agreed that they should get a different opinion’ (Fiona), ‘very occasionally the recommendation may not be clear and that’s where we tend to have the dialogue with them’ (Donna), ‘I would pick up the phone and have a conversation’ (Jackie), and, ‘we would go back if we thought a recommendation was inappropriate and we’d give them the rationale for why we thought it would work better if it was different, or worded differently’ (Meg).

6.3.5.2 Achievability of recommendations

Participants raised the issue of the achievability of some of the recommendations: ‘You can write one sentence [in an action plan], but that sentence actually could be months and months and months of work’ (Darcie), ‘part of the challenge we’ve got is, … they’ll give us local recommendations and we’ll go away and work things up, but sometimes there are bits that they come back with, that you think, “This is completely unrealistic.”’ (Isobel).

Concerns about the achievability of some of the recommendations was increased by anxieties that the SPSO did not have a full understanding of the implications arising from their recommendations:

> It wasn't clear how we would actually make the change because we already have our regional multidisciplinary team for cancer patients and, therefore, that was already happening. And that's the bit where I think that lack of general understanding about how the system works these days. (Donna),
>
> But sometimes they do come back and they come out with wild stuff about "See everybody within 12 weeks and make sure that somebody doesn't have to travel from A down to B for a scan. And you think "Okay. Right. Move on." (Isobel), and,
>
> We're having discussions around, "well how do we do that?" Because one has gone back to [X] and if they implement it, then we need to do it across the board, and it doesn't quite fit. So, I think that some of the complexities of what we have to deal with is quite difficult. (Isobel)

There was a common second criticism about the recommendations that they were exercises in box-ticking: 'You can sometimes feel a lot of their recommendations are about ticking boxes' (Eleanor), 'It's about what you need to discuss at a meeting. Tick the box' (Isobel), 'But some of it where it says, you know, "This should be fed back in a meaningful and supportive way". It's dead easy just to bash out a memo and send it and not follow it up' (Rhoda), 'We'll submit minutes or an agenda or an email from the clinical director saying I've discussed it with the person. Is that evidence or is that just ticking the big box to say "Oh, we said we've done it' (Vicky), and, 'I think from an operational perspective, it's a bit of a tick box exercise' (Vicky).

6.3.6 Learning

The importance of a receptive organisational culture which promotes learning from ombudsman reports and other sources was seen as important. 'I think the culture now is a lot better to make changes. We're very encouraged to do improvement all the time and always learn from the many issues that we've

had, any errors that have occurred' (Beatrice), 'You look for more learning, actually you look for … because we're all in a quality improvement environment' (Eleanor),

> I think it's the philosophy of the way that you work. … But actually, we start our day with a huddle but we start with a safety focus. So, if you're listening about safety, and the ombudsman's telling you that your systems are not safe, it is negligent for me not to do something about it. So, it's about how you embed safety and improvement in your culture (Isobel), and,

> So, we get a huge amount of feedback from various sources, but it's how we actually create a learning system that can take some of those recommendations and ensure that we've got widespread change across the system. So, that's the hard bit (Deirdre)

Identifying learning and improvements would be the task of those involved in the complaint: 'this would go to the general manager, and the lead nurse for medicine, who would then be charged with agreeing an action plan in relation to specific objectives' (Fiona),and, 'so we would say, "Ward 27, this has come back. You need to go away and you need to address it"' (Isobel).

However, these messages were not felt to be accepted by all staff, 'I also don't think that the staff within the NHS organisation … I think they still believe that improvement is very separate to the day job and, in actual fact, it should be their daily language' (Yvonne), 'So, they'll see the quality piece as an extra, rather than the urgency of the day to day work' (Deirdre), 'And, I think you can pay lip service too, then if you do a wee bit here and a wee bit there because there are competing demands' (Laura).

Although all health boards will produce and implement an action plan in response to the SPSO recommendations, there are issues about the depth, breadth and sustainability of the resulting learning.

Reports received from the ombudsman are shared across the organisation: ‘There’s a couple of forums that we include critical incidents or complaints … so there’s an inter-speciality event which is open to all professions’ (Millie), ‘We do a lot of shared learning, absolutely’ (Beatrice), ‘acute colleagues organise something called an inter-speciality clinical governance meeting … this is our learning, this is what we did, this is what we changed and this is how we’ve tried to ensure it won’t happen again’ (Donna),’we will do a debrief with the ward staff’ (Jessica), and,

> part of it would be sharing that [ombudsman reports] with the staff on the wards … everything that comes in from the Ombudsman, if it’s about a ward, we’ll share it with the senior nurse on the ward, and it would be their responsibility to share it with their staff (Emma),

Health boards do try to share learning across their organisation, especially where it is seen to be of particular importance:

> I think that’s the kind of thing we talk about at our Q and P[19], so all the service managers are there and they will be told, “Actually, everybody needs to do this”, and that’s how we try to get it through (Isobel),

> So, every year, if we get a formal [investigation] report, a published report, that’s cascaded across all of them [the organisation]. If it’s a standard review letter, with recommendations and the action plan, that goes to the site, and unless it’s a speciality them, they would share it across the speciality (Meg),

> But I think, if we don’t share it, we’ve not learned enough. I would say that more than anything, if you’ve only had local sharing and it’s only that one team, then the learning is only here and now, for the most part (Meg),

> So yes, although this one would be a good example of a local solution to ensuring staff were informed about their practice, I could probably show you another two or three complaints that have happened on this site, and other sites since, with the same kind of themes. So that’s the organisational learning bit (Meg),

> It’s hugely challenging. There’s a couple of forums that we could include critical incidents or complaints, and actually, oftentimes, it’s a number of these things and all part of the same thing, so there’s an inter-speciality event, which is open to all professions. … In actual

[19] Q and P = Quality and Performance Group

> fact, it’s a crucial point in terms of how we more systematically share, because the themes are very similar although the context may be different (Millie), and,
>
> Okay, if it’s something that’s got significant learning, quite often we’ll work with our clinical governance team and [produce] a learning summary. There’s not an awful lot of those, but sometimes significant learning will go out in that format, for sure (Rhoda).

Sharing learning across individual health boards was seen as a challenge by many: Confirming that if a ward involved in an SPSO report would be aware of the learning arising from an SPSO report, Fiona acknowledged that ‘how the [wards] in another hospital find out about it, that’s where we fall short’ as ‘I suppose if it directly relates to your area you’re much more responsible. The wider learning, it’s just in the context of, “Well, there’s hundreds of learning out there for us”’,

> But that ultimate bit, about organisational learning, I think we’ve still got the most to do. Because I think it’s clear that we don’t know. The site might know, the patch might know, but we’ve not got a systematic process for sharing that’s robust enough yet (Meg), and,
>
> I think the delivering of them [action plans] locally, I could categorically say, that there is an action plan and they work it to the end. Whether it’s shared where it should be, or to the extent that it should be, is the bit we’ve still not got right (Meg).

The limitation of these approaches were recognised: ‘Just telling someone to just do something, it doesn’t make a difference’ (Rhoda), ‘I would say that more than anything, if you’ve only had local sharing, and, it’s only that one team, then the learning you have is only here and now’ (Meg), ‘It depends which meetings you go to as to whether you’ve seen them [ombudsman reports]’ (Jessica), ‘I don’t know that we’re as robust as we could be in making sure everyone’s absolutely aware’ (Millie), ‘I think we’re mindful about how we share learning’ (Deirdre), ‘In a busy environment that can sometimes be difficult’ (Deirdre), and, ‘I think the learning side is where you can always make improvement’ (Emma).

A second approach to try to secure learning from ombudsman reports were the clinical governance and other quality improvement mechanisms instituted by health boards: 'it also goes immediately through local clinical governance groups' (Phoebe), 'if it's something that's got significant learning, quite often we'll work with our clinical governance team and [produce] a learning summary' (Rhoda),

> So, I think what the plan is, is to use our quality department. … So, I think it would be their remit to go out to assist the acute sites, primary care sites, and contractor groups and drive up quality' (Vicky), and,
>
> We will talk about ombudsman cases. I have a monthly quality and performance meeting and the first half of that is looking at complaints, ombudsmans and action plans … so all the service managers will be there and there they will be told "Actually, everybody needs to do this"'(Isobel)

This approach was not always seen to be successful: 'So, we don't, I would have to say, I don't know, we probably don't learn, … we don't use the information, from a QI[20] perspective, to the level that we should' (Fiona), 'You just do a wee bit of everything not particularly well' (Deirdre), 'And that's as you know, just telling someone to just do something, it doesn't make a difference. A policy doesn't make a difference because the words don't change anything' (Rhoda),

> I would say, that in my experience over the last 18 months of being in the complaints department, and looking at those SPSO letters that do come through and action plans, from the improvement side, I see no improvement (Yvonne),
>
> You may find that, because so few people are involved in the ombudsman, when they are involved and they've got a specific recommendation, they, as an individual, may say, "Well that's happened to me and it's not going to happen to me again", (Fiona), and,
>
> I don't know what your email box is like, but if you think about the enormous amount of emails and things that come through. So, one email about, "This decision letter came in, it was highlighted that blah, please can you make sure that your staff are aware of it", then that's

[20] QI = Quality Improvement

> filtered on. And people say, “Yeah that’s really good”, They remember it for about five minutes, they file it away, and … I’m not saying that does happen, but it wouldn’t surprise me if it did (Jackie).

There was a plea that the SPSO could do more to make learning from its work more accessible:

> I think if the Ombudsman’s picking up something that boards are constantly doing, … I think there maybe should be some sort of annual report, where, on so many occasions we fail to follow policies, or we fail to do this or adhere to that, or whatever, … If they [the SPSO] are coming across trends that we are not doing through our process, then they should be letting us know that we need to change our process (Jill), and,
>
> The information coming in, you can deal with information coming in, but it takes quite a lot to remember to go seek the information to bring it in. … Maybe that’s something that would make a difference, actually. If there something meaningful that just got posted out to us. (Rhoda).

Wariness over external scrutiny on high profile issues was also a driver for action. ‘It’s keeping the wolf away from the door sometimes as well’ (Eleanor), ‘We have to deliver on the recommendations. And, if we don’t, they [the SPSO] don’t close the case, and they write to our Chief Executive, and that comes back to the reputational issues’ (Jackie), ‘We probably risk assess it [the SPSO report]. What’s going to have the biggest impact for us, because you don’t want to end up on the front page of the Daily Record, and things like that’ (Jill), and, ‘I guess the thing is, there’s a pretty clear message around these kind of … there’s that whole bit around reputational risk’ (Tess).

There was concern raised about the sustainability of the changes arising from the recommendations. Rhoda said, ‘Just telling someone to just do something. It doesn’t make a difference. A policy doesn’t make a change because the words don’t change anything’. Asked about the sustainability of the changes that arise, Fiona replied ‘No. Unless we are constantly following up to see …But how do we continue to monitor performance against the

policy', while Jackie said, 'No, probably not. It depends on the circumstances and, again, on the individuals involved. You would like to think so but probably not as much as it should', 'The bit, I say, that we've not got good at is the organisational learning' (Meg), 'Possibly not in isolation, if I'm being very honest …If I'm being really, really honest, you can respond to the Ombudsman with a piece of paper in an isolated case' (Rhoda)

> Do you know, I suppose for me the challenge is more about sustaining, or making sure it's an embedded action. I think in the main you can actually get out there and, if you put a bit of drive behind it, you can complete an action plan. Does that lead to improvement? Does that lead to change? Not necessarily, because without the work that has to go in the back of it, then it'll be a moment in time (Millie), and,

> So, I, perhaps cynically, think that it's a paper exercise that health boards get given. We will provide assurance in terms of policy or whatever's required to say we've done that, but, in actual fact, the sustainability of those changes are [sic] not evident … I suppose, the thing is, if those recommendations were put in place and we saw them being sustained, why do we keep getting the same type of complaints, and with the same themes? And, why are they not working? (Yvonne).

One of the issues raised by several participants was a feeling that staff at the SPSO did not fully understand the realities involved in making changes to the delivery of healthcare. 'So, we've tried to make it straightforward and, the problem is, all these things generate an industry and, therefore, you've got industries around the SPSO, you've got industries around the complaints process' (Darcie), 'because it can be an industry, complaints, and I think it's trying to get the learning across the sites' (Laura), 'Because, in an ideal world, you want to fix everything as soon as it happened, but, sometimes, with the pressure on the business, we can't do everything at the timescale, pace and scale that we need to' and, the other thing, as well, is you get so busy, don't you? Caught up in delivering what's happening today' (both Rhoda),

> So, I suppose the things that make it challenging … the number of staff, the movement of staff, the high level of activity that's ongoing every minute of the day. We were talking yesterday about just trying to

> find five minutes head space to stop and think about something, and I think that's for everybody in the organisation, no matter what your role is. So, in that moment in time, you think, "oh God, that is awful, and we must do something about that and we must change", and it's there in that minute and committed to doing it. Then within five minutes there's all these emerging priorities that continue and continue and continue (Millie), and,

> Resources to get something done is very rare. For me, one of the actions I've got is sharing learning of sepsis on a ward that I don't cover, … and I've no resource to do this, so this just has to be done within my day job, into another ward that I don't work with, which is not an issue. That is quite hard. (Darcie)

This issue of the SPSO failing to understand the complexity of healthcare was raised by several other participants.

> For me, there's been a couple of complaints that have been upheld by the ombudsman, or issues in a complaint, that, for us as an organisation, I don't feel as if they've looked at the actual big picture. … I sometimes feel as if it's very much they're only looking at a small factor of the issue, not looking at the bigger issue (Darcie).

> I suppose, and this is again, goes back to maybe the ombudsman not appreciating the mechanics of how it works, but, for us to change a policy, it's not just a question, because there is that process what we need to go through, one that involves partnership and engagement and all of that (Fiona).

> I suppose it's like saying, "A health service is a health service is a health service". It is to a certain degree, but local context is really important. How things happen and why they happen, and [their] level of understanding (Meg).

> I think that there's that aspect of, we try to understand what the ombudsman's all about and probably don't get it completely yet. But I'm not sure how much the ombudsman really tries to understand the context within which we are working and trying to deliver care these days (Donna).

> We're not really convinced that they really listen to the service perspective on issues. Because we have a very complex system now, we've got an aging population and patients very rarely come in with a single thing. Therefore, the understanding of that complexity and how it manifests itself then in terms of what we're meant to be trying to deal with, I'm not sure that's understood (Donna)

6.3.7 Prioritising recommendations

Despite the pressures being experienced within the health service there was a feeling from participants that they just had to deliver on the recommendations: ‘You’ve just got to pick yourself up and go on and do it. And you do your work, whatever hours it takes to do what you need to do’ (Eleanor), and, ’Well, it’s just part of the systems and structures … That’s just part and parcel of what we would see in part of our improvement, our feedback and improvement approach’ (Phoebe). Recognising the pressure, there was recognition of the need to prioritise, ‘So we get hit by competing priorities, locally, nationally …’ (Deirdre), ‘there’s just not enough hours in the day or resources in an organisation to deal with every single item that you’re asked to do, so you have to prioritise’ (Rhoda), and ‘I think we often try to do too many things and we do them all badly. Whereas if we took on a few things, we could do them well and make that bigger impact on safety and care’ (Isobel). However, there can be times when there are so many priorities ‘we end up prioritising our priorities because it’s constantly on the go’ (Eleanor), and, ‘I think we need to get better at that. I think we tend to knee-jerk respond and react and I’m not sure that we do that correctly’ (Millie).

Approaches to prioritising include, ‘it just gets set against the deadlines’ (Fiona), ‘I know that my senior manager would expect that we were meeting the deadlines for them all’ (Tess) ‘I think it depends very much on the nature and scale of the reports’ (Phoebe), ‘patient safety is at the core of everything we do. We generally, the outcome, the complaints, feedback, ombudsman reports are all linked to patient safety and quality of care. So, that’s our bread and butter’ (Phoebe). Where a formal approach is adopted, it is often on the basis of clinical importance, ‘Clinical importance, as in harm to patients, and then thematic stuff, probably. It goes back to that matrix, that high-risk, low-risk importance, impact’ (Rhoda). However, there was a recognition that people took risks,

> There’s a real risk that people are, because of the amount in the system, I think there is a risk that people are, I think probably that is happening all the time, people are taking risks. I’m mot singling myself out as somebody who’s not, I guess that the thing is that I might be taking a shortcut with something that I hope is not as high profile or priority. So, I think, I can afford to miss that, and then get my fingers slapped or whatever. I’ll live with that. And there will be something about that high-profile stuff that you’re less likely to take a risk on (Tess).

6.3.8 Obstacles to change

Participants noted some obstacles to implementing changes recommended by the SPSO. Two common themes were identified by participants, those of time and resources, particularly time availability: ‘I suppose time will be there … When I say time, I mean in the round, I mean capacity’ (Fiona), ‘Time and resource capacity’ (Donna), ‘I suppose if it was to involve money, staff, and money again’ (Jessica), ‘I sometimes feel that the pressures are not taken into account’ (Vicky), ‘I don’t know where you would get the resources from, because it’s usually time’ (Darcie), and,

> Just time. We’re so squeezed all the time now. I mean, if I had a pound for every time I had to chase somebody, hunt them down, and, you know, contact a service …I mean I get that these people are trying to see patients, they’re trying to do research or trying to do admin, they’ve only got a certain amount of time. … You’re putting that extra additional stress and pressure on them, and, it’s on top of their job and I’m not quite sure that they’re given enough time to do that. (Vicky)

A particular problem was around staffing: ‘I mean staffing can be an issue’ (Jill), ‘I don’t know what other battles clinicians are dealing with. They could be having all sorts of operational issues that I’m unaware of’ (Vicky), and,

> We’ve got people that will be on shift rotas, there are people that are on annual leave. So very often it can take us a bit of time to track somebody down. Plus, you’ll have doctors in training that maybe pop in, and they’re in, and then away over at X Health Board for the next three months (Fiona)

Despite the challenges, there was one view that

> Because you could mitigate anything by saying, “We’re busy, we’re underfunded, we’ve got increasing people. It’s awfully tricky because there’s lots of new things happening”. But the fundamental principle is, that it’s why you come into work today, every day, isn’t it? It’s your belief that people should be getting the best from the service, and we should always be striving to do better and learn more (Rhoda).

Defensive behaviours from clinicians and other staff was seen to be a potential problem, ‘we can all be quite defensive when we’re responding to complaints’ (Eleanor), ‘I have witnessed other folk, so other members I’ve seen, perhaps, getting quite defensive and feeling that some of the recommendations or commentary is personal’ (Deirdre), ‘I think there’s a culture within some organisations like this one, whereby, people, there’s defensiveness’ (Vicky), ‘nobody wants their care criticised at all, which is very difficult’ (Isobel), ‘I’m quite saddened sometimes to get the reaction from, particularly, clinical staff who feel very aggrieved’ (Vicky), and,

> I suppose it depends how that person, who is going to be responsible for that change, feels about the report themselves, … if it was one where they weren’t happy … then they’re probably not too keen on a recommendation that comes out’ (Jessica)

6.3.9 Analysis of reported cases

As part of the research, it was proposed that for each of the three Scottish health boards, the five most recently upheld investigation reports issued by the SPSO at the time of the interviews would be used to ask participants about their recall of the reports and actions subsequently taken to improve the healthcare system. In the end, only two health boards (sixteen participants) agreed to participate in this aspect of the research. Investigation reports are issued relatively infrequently but relate to the more significant complaints as viewed by the SPSO.

It should be recalled that health boards are complex organisations, usually with multiple acute hospital sites along with primary, community and mental health services. The health boards are typically comprised of 'units' which may consist of an acute hospital or a speciality based such as community or mental health services. Each unit will have its own unit management team.

In relation to the response by participants to the five published investigation reports it was found that: if the investigation report was issued prior to the participant joining the health board then they would be unaware of the report and could not explain what happened as a consequence of the report. Where a report related to another unit within their health board but not their own, then, in the majority of cases, partcipants were likely to have an awareness of the report but could not speak informedly to the report and had only vague recollections of what had happened as a result of the report. Where a report was issued when a participant was employed by the health board and working in the unit at the centre of the report, then they had greater recollection of the issue and could speak more informedly of the actions taken. However, even then, in the majority of cases memories were vague. There was one report which had widespread recollection from the unit involved and this report was atypical. Not only was it a recently published report there had been widespread coverage of the report in the media. It will be recalled that a significant fear for participants was adverse publicity to the health board relating to the publication of reports and this combination appears to have created a set of circumstances which made the report have greater resonance to participants.

This aspect of the research was disappointing due principally to two factors affecting the method used. Selecting investigation reports and not decision letters meant that many reports were several years old by the time the interviews took place. The inability to recall cases was likely to increase due to the time lag. Secondly, the researcher is unaware if any of the participants

had been involved in incident central to the complaint or the subsequent attempt at complaint resolution but for the majority, if not all, of the investigation reports the researcher believes that this would not have been the case. As many respondents indicated that due to the pressures of work and the lack of available time, keeping oneself informed of SPSO reports was always found to be challenging. As a result of the weaknesses in this method, in Section 8.4 a recommendation for further research which addresses these weaknesses is made.

From this the following was established: if a report predated the participant joining the health board then the participant would not be familiar with the report; if a participant worked in a particular hospital, care sector or setting then they were likely to be familiar with the report. However, they were unlikely to remember detail and any specific actions and changes that resulted; if a report was not applicable to their position it was unlikely that they remembered anything more than the vaguest of details about the complaint; and, even those participants with health board wide responsibilities did not recall all cases.

6.4 Conclusion

In this chapter the results of the research into the three Scottish health boards are presented. Participants highlighted concerns about the nature and degree of interaction and communication that takes place between health boards and the SPSO when the SPSO was investigating complaints. These concerns were heightened when they related to issues concerning the clinical advice received by the SPSO. Participants also had concerns about the clarity and achievability of the recommendations made by the SPSO following an upheld complaint. The difficulties, noted by participants, in learning from SPSO investigations and recommendations was also detailed.

Chapter 7 Discussion on research findings

7.1 Introduction

This chapter discusses the research findings in the context of the wider literature. The purpose of the chapter is to consider the three research questions that were set at the beginning of the research. For each of these questions, the conclusion reached by the researcher is presented first and is followed by the arguments to justify that conclusion. The research questions are:

1. What approaches do the OHOQ and the SPSO take to administrative justice?
2. What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement?
3. How do those in the healthcare system receive and respond to these approaches?

This chapter begins, however, by considering a prior-order issue that arises as a result of the research findings, and which is important to this work, and relates to the status of both the OHOQ and the SPSO as ombudsman. It is the view of the researcher that, while the SPSO is an ombudsman, the OHOQ is not an ombudsman but, to use a term used by Carney et al. (2017), is, in fact, a health complaint entity. This is an important conclusion that has not been reached previously by researchers.

Internationally, there is little consensus concerning what is an ombudsman. As Gulland (2010, pp.470-471) states ‘defining an ombudsman is difficult, as the name means different things in different countries and, even within the

United Kingdom, there is a variety of different definitions', with Buck et al. (2011, p.13) stating that it would be a mistake to think of ombudsman 'as neatly fitting into any standard and fixed model'. The IOI excludes private sector ombudsman schemes, while other ombudsman umbrella bodies such as the Ombudsman Association and the Australia and New Zealand Ombudsman Association (ANZOA) include both public sector and private sector ombudsman schemes as members, but, even then, do not include all local schemes with ombudsman in their title, and do not include organisational ombudsman. There is also an International Ombudsman Association, comprised principally of North American organisational ombudsman, bodies which would not the meet the membership requirements of any other international ombudsman umbrella organisation. The International Ombudsman Association is, thus, the ombudsman equivalent of the World Series. Academics have also contributed to the debate, with, for example, Buck et al. (2011) indicating their agreement with the inclusion of private sector ombudsman within the ombudsman family. Overall, however, there is little consensus about what is an ombudsman.

This discussion on what is an ombudsman appears to depend upon one's standpoint. Shakespeare (1594, 2000) wrote that 'a rose by any other name would smell as sweet' suggesting that the name of an object is unimportant while, Nietzsche (1882, cited in Kaufman 1974, p.58) wrote, conversely, 'what things are called is incomparably more important than what they are'. Nonetheless, it does appear that, with the expansion and changes in the nature of the ombudsman institution, the meaning of the word 'ombudsman' is in danger of becoming whatever anyone wishes it to be: 'When I use a word', said Humpty Dumpty in rather a scornful voice, 'it means just what I choose it to mean'. 'The question is' said Alice, 'whether you can make words mean so many different things' (Carroll 1872, 1988, p.205).

7.1.1 The OHOQ

The OHOQ refers almost all of the complaints that it receives back to the body concerned or to an external body. The OHOQ casework figures (section 5.3), not only suggest a focus on the conduct of individual practitioners, but also suggest that complaints about health organisations are unlikely to be considered, unless there is evidence of criminal or other inappropriate behaviour which would justify referral to the police or other regulatory body.

While the OHOQ receives, confidentially, complaints about the activities of bodies and people in jurisdiction, which meets the first requirement of the American Bar Association (ABA)'s definition of an ombudsman (see section 2.8), it is harder to argue that the OHOQ fully meets the second part of the definition which is to 'address, investigate, or otherwise examine these issues independently and impartially' (American Bar Association 2001), as this would necessitate accepting that, by referring the vast majority of complaints back to bodies in jurisdiction or to external organisations, the OHOQ is, by doing so, actually addressing, investigating or examining the issues independently and impartially.

The primary focus of the OHOQ is, instead, to investigate and prosecute serious complaints about health professionals which means that it is neither a reactive ombudsman, with a primary focus on complaint resolution, nor a proactive ombudsman[21], with a primary focus on system improvement. It is of note that the OHOQ is not a member of the Australian and New Zealand Ombudsman Association. ANZOA is concerned about the misuse of the term ombudsman, stating, 'Using the term Ombudsman to describe an office with regulatory, disciplinary and/or prosecutorial functions confuses the role of Ombudsman with that of a regulatory body' (ANZOA undated). Adopting this

[21] For a reminder on the models of ombudsmanry see section 2.8

stance, together with its disposition of complaints received, indicates that the OHOQ is not an ombudsman as it holds both regulatory and prosecutorial functions.

Does it matter that the OHOQ is called an ombudsman but is not an ombudsman? In New Zealand the term ’ombudsman’ is protected by legislation. Restricting the use of the term ombudsman is viewed to be of benefit to the New Zealand public as it will reduce public confusion about the role of the ombudsman, which should, in turn, promote public confidence in the government (New Zealand Ministry of Justice 2018). Use of the term ‘ombudsman’ is seen to confer legitimacy to the organisation using the term, and explains why international ombudsman associations, such as the Ombudsman Association and ANZOA, place conditions on potential members which those potential members must meet. The argument is that complainants who use an ombudsman should have clear expectations about the independence of the body, it’s roles, the approaches it uses when handling a complaint, and the public accountability of the ombudsman office (Ombudsman Association undated). There are fears that unfettered use of the term ‘ombudsman’ by organisations which do not meet these expected criteria could cause a public loss of confidence in the whole ombudsman institution.

Instead of being a health ombudsman, the OHOQ appears to be a curious amalgam of, firstly, a complaint triager and referral agent for undifferentiated health complaints, secondly, a complainant advisor, providing advice to complainants who may undertake local resolution, thirdly, a regulator, prosecuting complaints concerning serious issues, and, fourthly, an auditor, through its systemic investigations. Carney et al.’s (2017) ‘health complaint entity’ is a more appropriate term to describe the OHOQ. Despite not being a health ombudsman, the OHOQ plays an important role in the management of

health complaints in Queensland and deserves consideration as argued by Healy and Walton (2016, p.493).

7.1.2 SPSO

The SPSO focuses its activities mainly upon the investigation and adjudication of individual complaints, although it also delivers a significant number of activities aimed at system improvement in both complaint handling by bodies in jurisdiction through the CSA as well as through its use of recommendations. The activities of the CSA are within the remit of classical reactive ombudsman, as they focus on standard setting, and the provision of advice and guidance on good complaint handling, particularly through its model CHPs. The SPSO also acts as the Scottish Welfare Fund Independent Review Service, which carries ‘out independent reviews of decisions the councils make on community care and crisis grant applications’ (SPSO 2020o), and, as the Independent National Whistleblowing Officer for the NHS in Scotland, where it is able to investigate concerns raised by whistleblowers concerning the NHS in Scotland (SPSO 2020p). While these roles, provide the ombudsman with additional activities, the functions, themselves, are, nonetheless, very similar to those undertaken by classical reactive ombudsman. However, the SPSO additionally provides significant educational activities to bodies in jurisdiction on good complaint handling and how bodies in jurisdiction can learn from complaints. For Stuhmcke (2012), this would be enough to categorise the SPSO as a variegated ombudsman. The researcher views the SPSO as a variegated ombudsman.

7.2 Research Question One: What approaches do health ombudsman take to administrative justice?

The research found that the dominant administrative justice model within the OHOQ is the legal model demonstrated by the OHOQ's emphasis on collecting the correct evidence indicative of professional misconduct in order to be able to mount successfully a prosecution at the QCAT. In contrast, the dominant model of administrative justice exhibited by the SPSO is that of bureaucratic rationality. The approach of the SPSO is one based upon complaint resolution and feedback, with complaints either upheld or not upheld, and decisions based upon normative standards.

Mashaw (1974) identified three models of administrative justice: bureaucratic rationality, professional treatment and moral judgment. The bureaucratic rationality model is concerned with the efficient and accurate implementation of decisions which reflect the legislature's will; the professional model is dominated by a professional culture which takes account of the incompleteness of information, the fact that no two cases are alike, and therefore professional judgment is required to make decisions; and, a moral judgment model which is concerned with determining which side is to be supported when the interests and values of two sides are in conflict (Mashaw 1983, pp.26-30). Later work by Adler (2003) developed thinking around these three models and, Adler, firstly, recast Mashaw's moral judgment model as a legal model, as he suggested that Mashaw's moral judgment model, which was legitimated by 'fairness' was unhelpful as he said it implied that the other models were 'unfair' (Adler 2003, p.329). Instead, Adler felt that the legitimating value was the assertion of legal rights. Secondly, Adler identified three additional models: a managerial model, a consumerist model, and, a market model. Both Mashaw (1983) and Adler (2003) argued that the models were in competition with each other for dominance and, as one gained strength, the other models diminished in power.

7.2.1 OHOQ and administrative justice

Carney et al. (2017) applied Mashaw's and Adler's models to health complaint entities in Australia and suggest that most Australian health complaint entities, with their emphasis on complaint resolution and feedback, are most associated with the bureaucratic rationality model although they do recognise that there also exists elements of both the professional judgment and legal models. However, Carney et al. (2017, p.76) continue that when linked with health regulation, the professional model becomes more dominant, before noting that the New South Wales Health Care Complaints Commission (NSW HCCC), with its prosecutorial responsibilities, has 'strengthened the legalist elements'. As with the NSW HCCC, the OHOQ has prosecutorial responsibility for professional misconduct.

In the results section it was identified that all participants from the OHOQ stated that the OHOQ's primary objective was to protect the health and safety of the Queensland public, and, that the risks to health and safety were described in terms such as 'professional sexual boundary violations', criminal matters, the financial exploitation of patients and the verbal abuse of patients, all of which are potentially criminal acts. Lydia's comment that, 'We're here to make sure that those rogues are dealt with' is very much the principal logic of the OHOQ.

The great majority of the OHOQ complaint investigations only take place where the issue is thought to be of a serious nature and which may result in the suspension or cancellation of a health professional's registration. While the OHOQ is able to, and does, conduct investigations into health services they are relatively small in number, amounting to only 19 out of 197 investigations concluded in 2018/19 (OHOQ 2019, p.43). Such investigations are conducted with a view to enabling the Director of Proceedings to be able

to prosecute the health professional at the QCAT. There is very much a legal focus to these activities as there is a need to present a legal defensible case at the QCAT. Inevitably in these investigations, there are elements of the professional judgment model as the OHOQ does obtain clinical opinions as part of its evidence gathering activities to help inform any prosecution. However, the professional judgment model is clearly second to the legal model.

The very limited amount of systemic investigation work that the OHOQ undertakes demonstrates an alternative approach. Here, the OHOQ works with bodies, facilitating improvements in services and, in adopting this approach through which bodies have a dominant role in identifying solutions, the OHOQ adopts an approach in keeping with professional judgment. However, as the OHOQ's systemic work is minor compared to its work on prosecuting health professionals, the dominant model of administrative justice remains the legal model.

There may be two reasons which account for the legal model being the dominant administrative justice model within the OHOQ. Firstly, there is the OHOQ's underpinning legislation. Although generally permissive in nature, in that it empowers the OHOQ to undertake a variety of actions in relation to the complaints that it receives, the OHOQ is subject to two obligatory responsibilities. The first relates to the main objective of the OHOQ, which is the obligation to promote the health and safety of the public (*Health Ombudsman Act 2013 S3(1))*. Secondly, there is the requirement for the OHOQ to undertake investigations where the issue may result in the suspension or cancellation of a health professional's registration (*Health Ombudsman Act 2013 S91(1))*. A need to focus on serious issues was emphasised by the example made of the first Ombudsman, Leon Atkinson-McEwan, who was suspended by the Queensland Minister for Health for not taking immediate action against a health worker accused of stealing drugs

(Crockford 2017). Lily confirmed to the researcher that the OHOQ's underpinning legislation focused principally upon individual complaints with less focus on systemic investigations.

A second reason that may influence the adoption of the legal model by the OHOQ is the membership of the its Executive Leadership Forum. Composed of six members, four of the team are lawyers all of whom have experience in professional regulation and/or discipline. Of the two non-lawyer members of the Executive Leadership Forum one also has a background in the professional regulation of doctors (OHOQ 2019, pp.70-71). While the team may have been appointed because the orientation of the office was already focused on disciplinary matters, given that the OHOQ is a young office, it is also possible that the team, collectively, determined the approach of the office.

Taking together an executive team dominated by persons with experience in professional regulation and the OHOQ's underpinning legislation with its focus on public safety and professional misconduct creates an environment where a legal model of administrative justice dominates.

7.2.2 SPSO and administrative justice

The SPSO is in a different place regarding administrative justice models. It does not have any regulatory responsibility. The primary purpose of the SPSO is complaint resolution with feedback and guidance to support service improvement. Recommendations that arise from individual complaints are the key mechanism by which the SPSO attempts to secure improvements within the healthcare system. Such recommendations are generally normative in nature, with a focus on securing 'the ideal outcome for a particular complainant' (Mary). The approach of the SPSO is one based upon the investigation of individual complaints which conclude with adjudicative

decisions based upon normative standards such as national or local guidelines. With the need for clinical opinions, there is also a strong, but secondary, professional judgment element.

The historical contingency of the SPSO helps explain its approach. The SPSO's origins lay in the United Kingdom's PHSO which previously had responsibility for the actions of government agencies in Scotland. The PHSO was established in 1967 as the Parliamentary Commissioner for Administration, to consider complaints against the actions of United Kingdom government agencies but this did not include the National Health Service (NHS). The NHS did not become subject to ombudsman oversight until 1973 with the establishment of the Health Service Commissioner, a post held jointly with the Parliamentary Commissioner for Administration, thus creating the PHSO (Gregory and Giddings 2002). However, even then clinical issues were excluded from consideration by the PHSO, a situation unremedied until 1997 (Gregory and Giddings 2002). For the first 30 years of its existence the PHSO was unable to consider clinical issues but was restricted to considering the correctness of bureaucratic decisions made, firstly by government agencies, and then also by the NHS. Given this history it is unsurprising that a bureaucratic model of administrative justice was adopted by the PHSO. However, this history and culture persisted into the approach to considering all health service complaints.

The SPSO was created in 2002 as a consequence of the establishment of the Scottish parliament and government. The underpinning legislation of the SPSO is the *Scottish Public Services Ombudsman Act 2002*. This legislation allows, but does not require the ombudsman to investigate appropriate complaints involving service failure or failure to provide a service where the complainant claims to have suffered an adverse consequence, but does require the ombudsman to produce a report should the ombudsman conduct an investigation. The history and legislation of the SPSO manifest

themselves in a bureaucratic rationality approach to administrative justice. Overall, there is broad alignment between the SPSO's dominant bureaucratic rationality model of administrative justice and that identified in most Australian health complaint entities (Carney et al. 2017) and in other UK ombudsman (see PHSO 2009).

7.3 Research Question Two: What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement?

The research found that the OHOQ uses two main approaches to contribute to system improvement, those of prosecuting health professionals and conducting systemic investigations. However, the researcher found the ability of these approaches to make a significant contribution to system improvement was limited. Of the nearly nine thousand complaints received by the OHOQ in 2018-19, in only around 60 cases were health professionals prosecuted by the OHOQ. In addition, the OHOQ conducts only a small number of systemic investigations each year. In the case of the SPSO, the researcher found that the principle approach to system improvement was its use of recommendations in upheld individual complaints. Although the SPSO conducts a sizeable number of health complaint investigations each year, using recommendations to contribute to system improvement was found to have significant limitations in practice and contributes to an informational learning approach.

It was noted earlier that Stuhmcke (2012) and Buck et al. (2011) had identified a range of activities undertaken by ombudsman aimed to contributing to the improvement of the system over which they have oversight (see section 2.9). During this research, the activities undertaken by both the OHOQ and the SPSO which could be used to contribute towards system

improvement were identified and are compared in Table 19 overleaf. In addition to the range of activities identified by Stuhmcke and Buck et al., Table 19 lists two additional activities that were identified by the researcher, one from the OHOQ and one from the SPSO. The OHOQ prosecutes health professionals where it believes that professional misconduct has occurred, while the SPSO has responsibility for setting the standards for complaint handling by bodies in jurisdiction. An important point to note is that although Table 19 provides details on the breadth of activities undertaken by the OHOQ and the SPSO, it is silent as to the depth of undertaking of these activities. It is here where the researcher identified that there were very significant differences between the two ombudsman.

Ombudsman activities identified by scholars	**Activities undertaken by OHOQ**	**Activities undertaken by the SPSO**
Complaint handling	✓	✓
Systemic investigations	✓	
Own-motion investigations	✓	
Production of reports	✓	✓
Production of guidance	✓	✓
Submissions		✓
Training		✓
Audit, inspection, monitoring	✓	
Meetings with agencies	✓	✓
Prosecuting health professionals	✓	
Setting complaint standards		✓

Table 19 Comparison of activities undertaken by the OHOQ and the SPSO

7.4 Approaches used by the OHOQ to improve the healthcare system

The researcher found that the OHOQ uses two main approaches in its contribution to system improvement, one of which can be considered a negative approach to system improvement, namely the ability to prosecute health professionals, while the second would be considered a positive approach towards system improvement, namely the use of systemic investigations. There is, however, greater focus on prosecuting individual health professionals and less on systemic investigations, a balance, attributed by Lily, to the OHOQ's underpinning legislation, which she stated placed a large degree of emphasis on individual complaints and less on systemic activity. The researcher found that the OHOQ also uses two indirect approaches to system improvement, namely those of local resolution and conciliation.

7.4.1 Prosecuting health professionals

It was found by the researcher that there is an internalised view within the senior management of the OHOQ as occupying a regulatory position and role. Four of the eight OHOQ participants described the OHOQ as being a regulator or as part of the co-regulatory landscape for healthcare in Queensland, using expressions such as: 'we don't have, like a lot of other regulators …, and, we're coregulators with the Boards and AHPRA' (Lydia). All the OHOQ participants discussed the OHOQ's role as focusing upon serious matters relating to professional misconduct. This emphasis on complaints about professional misconduct, the term used by all participants, was best exemplified by Lydia,

> But this agency deals with the more serious matters. Anything that doesn't hit the threshold of professional misconduct or other conduct or performance, that would result in cancellation or suspension of registration. Then that usually gets sent to AHPRA to deal with …

In addition, every participant from the OHOQ stated that the overarching objective of the OHOQ was, ‘to protect the health and safety of the public’ or some variant thereof. This focus by all participants on the health and safety of the public and on investigating only serious complaints about individual health professionals suggests that the office is focused upon the safety of the public *from* health professionals. This view is supported by participants’ explanation of how complaints are identified for potential investigation by the OHOQ with the focus on criminal, and, in particular, sexually criminal, offences or cases where a health professional may exploit their relationship with the patient (see section 5.4.1). The assessment made by the OHOQ is based on conduct issues rather than performance issues and this approach will focus, necessarily, upon individuals rather than organisations as conduct issues are related to the behaviours of individuals. While the OHOQ has the powers to attempt to resolve the majority of complaints that it receives, it chooses not to do so, and this decision will be influenced by the fact that the senior management of the OHOQ views the OHOQ as a regulator and not as a body with a primary focus on complaint resolution.

The argument for using disciplinary action against health professionals as a system improvement measure, is that by sanctioning incompetent doctors, or doctors who endanger patients through professional misconduct, then the overall quality of care will be raised. If a health professional is replaced by someone who is more competent or less dangerous then this argument has validity. The risk of facing regulatory action may also act as a disincentive for professional misconduct. In this situation, disciplinary action acts *pour encourager les autres*.

However, this approach is not without its downside. There was a discussion earlier about the effects on doctors of being complained about (see section 2.4). It is quite clear that being the subject of a complaint is not something easily shrugged off by the majority of doctors, particularly where the

complaint is being considered by the professional regulator. There is a significant and long-lasting negative impact upon the quality of their work post-complaint, including significant psychological morbidity leading to idea of the health professional as a second-victim. This translates into negative consequences for professional practice, including defensive behaviours such as the over-treatment of patients or the avoidance of patients or clinical situations perceived to be difficult. This response by health professionals to complaints and professional regulation will have a significant, but unknown and unknowable, adverse impact on the quality of care. This is not an argument to decrease the accountability of health professionals but rather an argument that such activity, while necessary, has a significant downside that needs to be taken into account.

This is particularly the case when it is recalled that in 2018-19, the OHOQ conducted 178 investigations concerning health professions of which only 87 resulted in a referral to the Director of Proceedings. The Director of Proceedings then reviews the case and, in 2018-19, prosecuted only two in three cases referred to him by the ombudsman. In broad terms this means that only one in three investigations commenced by the OHOQ into professional misconduct will result in a prosecution, while research suggests that it is likely that many of the 178 health professionals involved in the investigations will have suffered significant psychological harm and possibly conducted defensive medicine thereafter.

One potential reason why only one in three cases investigated by the OHOQ results in a prosecution at the QCAT, may lie in the behaviours of the health professionals named in the complaint and their legal representatives. Lydia found that ‘civil lawyers are anything but civil’ and indemnity organisations had no incentive to co-operate. Even when the OHOQ has clear ‘overt’ evidence of misconduct, the health professional’s legal representative will ‘still want to have a fight about it’. This behaviour may seem unreasonable to

the OHOQ, but it is important to remember that successful prosecutions are likely to have significant negative consequences for a health professional's professional standing and livelihood as well as the potential negative psychological responses discussed previously. From the health professional's perspective this behaviour may seem entirely rational.

7.4.2 Systemic investigations

Systemic investigations are a recognised method by which ombudsman can contribute to system improvement and are seen by academics as an important function for ombudsman (see Kirkham 2005, 2012, Stuhmcke 2010), and were memorably described as fire-watching by Harlow and Rawlings (2009). The support for ombudsman to have own-initiative and systemic investigation powers is due to the track record of success arising from systemic investigations conducted by the public service ombudsman such as the Ontario Ombudsman, Commonwealth Ombudsman and the New South Wales Ombudsman. However, although the OHOQ has established a systemic investigations team, it conducts a relatively small number of systemic investigations each year which reduces its ability to contribute towards system improvement.

In 2018-19, the OHOQ commenced only ten systemic investigations (OHOQ 2019), and in its four years of existence is yet to conduct a single inquiry. This is despite the fact that systemic investigations were viewed positively by participants from OHOQ, partly for their alleged value for money (Rachel, Aisha), but also because of their perceived ability to bring about changes to the healthcare system. Systemic investigations are believed by the OHOQ to be able to bring about a greater impact to a broader area while also having the ability to prevent errors and complaints in the future (Jasmine).

There was recognition from the OHOQ participants that successful systemic investigations necessitated new ways of investigating and working with bodies in jurisdiction. This new approach was to work more collaboratively with bodies, where the OHOQ highlighted the concerns that it held, and facilitated bodies to work together to create solutions. This was particularly the case when it came to the making of recommendations. Here, participants from the OHOQ were open about negotiating with bodies on the final recommendations that would be made. The reason for this change was due to the recognition that bodies were better placed to understand the complexities of delivering healthcare, including the potential unforeseen consequences of recommendation implementation. The aim was to make recommendations as meaningful as possible (Jasmine). This finding is in keeping with Hertogh's (2001) and Smith-Merry et al.'s (2014) view that working with bodies to identify the best solution to recognised problems was most likely to bring about successful change.

The other two, more minor, methods used by the OHOQ to contribute to system improvement are local resolution and conciliation. This research indicates that the view, held by the OHOQ, that they contribute to system improvement may be over-optimistic in practice.

7.4.3 Local resolution

Participants from the OHOQ were hopeful that local resolution may bring about system improvement (see also OHOQ 2020j). The OHOQ may play an active role in local resolution by supporting complainants through analysing information provided by both parties, facilitating meetings between the parties and assist in the production of agreed actions (OHOQ 2019, p.29).

It is hard to assess how successful local resolution is at securing improvements in the Queensland healthcare system. Outcomes are not published by the health organisation involved or by the OHOQ and it is noted that 8% of complaints sent for local resolution by the OHOQ are subsequently withdrawn by the complainant (OHOQ 2309, p.30). This high rate of withdrawal of a complaint may be indicative of the complainants' unhappiness with the OHOQ for not accepting the complaint for independent consideration. In addition, 20% of complaints closed at local resolution are closed as unresolved. As 1,196 complaints were closed at local resolution stage in 2018-19 (OHOQ 2019), and assuming that this is a typical proportion of unresolved complaints, this is likely to leave a large number of complainants dissatisfied. The limitations of what can be achieved at local resolution was noted by Betty who felt that conciliation offered greater opportunity as 'you can probably pull and stretch system improvement in the conciliation space more than you could in the local resolution space'.

7.4.4 Conciliation

The second indirect approach used by the OHOQ is that of conciliation. The role adopted by the OHOQ in conciliation is active. Before conciliation is offered, the OHOQ will undertake an initial assessment of the case where they can obtain relevant documents from the health organisation and, if considered appropriate, also obtain an independent clinical opinion (OHOQ 2020k). OHOQ will also employ specialist conciliators to facilitate the conciliation. The approach to conciliation used by the OHOQ is evaluative rather than facilitative. This allows the conciliators to challenge both parties and 'reality test them on their views' (Betty).

Participants from the OHOQ expressed confidence in the ability of conciliation to deliver results as discussions are legally privileged which can allow for more honest discussions and potential solutions explored without risk that what is said can be interpreted as an admission of liability (Betty).

One problem faced by the OHOQ is that there is no obligation upon health organisations to participate, and a large proportion of complaints suitable for potential conciliation are not advanced due to the unwillingness of health organisations to participate (Betty). This may be due, in part, to the fact that, as the initial assessment of the complaint undertaken by the OHOQ did not reveal any significant issue of concern, then the health organisation may think that there is no reason for them to participate (Betty).

In 2018-19, only 59 complaints were closed after conciliation indicating that the successful use of conciliation is very limited. The other problem relating to conciliation is that, due to the confidential nature of the conciliation process, the recommendations agreed at conciliation are not able to be followed up by the OHOQ. In summary, very few cases are closed at conciliation, the OHOQ is unaware of the outcome and agreements, and there is no ability to follow up the complaint to ensure that any agreed change has taken place.

Taking these four approaches to system improvement together, it was found that the effects of the OHOQ on system improvement are likely to be limited in scope.

7.5 SPSO and system improvement

Unlike the OHOQ which has a statutory duty to identify and report on systemic issues (see above), the responsibilities of the SPSO in this regard are much more limited: to investigate appropriate complaints received about bodies or persons in jurisdiction (*Scottish Public Services Ombudsman Act 2002*). With the exception of section 16G of the *Scottish Public Services Ombudsman Act 2002* which requires the SPSO to promote best practice in complaint handling, there is no requirement within the Act to the ombudsman

to contribute towards system improvement. In practice the legislation has been internalised to mean that,

> So, in respect of our complaints function, we have three remits effectively. First is by taking individual complaints, to consider, investigate those and to provide individual redress and to remedy the injustice that has happened. Secondly, to identify learning and improvement and increasingly … our role is focusing on that learning and improvement element. And thirdly, in Scotland, we have a duty to establish and monitor complaints handling procedures across the public sector (Chloe).

All SPSO participants replied in similar terms, although there was less emphasis from some on the SPSO's role in improving complaint handling. While all participants expressed a desire for own motion powers that would allow the SPSO to undertake systemic investigations similar to those undertaken by the OHOQ, in the absence of such powers, the focus is on using the outcomes of individual complaints to try to secure system improvement.

The SPSO attempts to combine both the investigation of complaints and system improvement through the use of recommendations. However, combining complaint investigations with system improvement is seen as problematic by Carney et al. (2017, p.82) 'both conceptually and in the overall governance system'. In support of this view, this research found that a strong accountability logic and coercive approach to administrative control adopted in the investigation phase by the SPSO adversely influenced the health boards' perception of the SPSO's investigations and recommendations. Often feeling bruised by the SPSO's reports, implementation by health board staff was often due to a sense of capitulation rather than commitment and this is likely to be less effective in making sustained change.

7.5.1 Using recommendations from upheld complaints to improve the system

The key approach to contributing towards system improvement from the SPSO is through the use of recommendations arising from its upheld investigations. However, as shall be seen, the SPSO's approach to its recommendations is problematic in its construct and is likely to lead to an informational mode of organisational learning.

Mary claimed that an upheld complaint indicated that something had gone wrong and there was an onus upon the health organisation to learn from the complaint. The use of recommendations is intended to ensure that future practice meets established best practice as defined by delivering care in line with recognised standards and guidelines. At the time of the interviews, a new approach to making recommendations had recently been introduced by the SPSO due to an awareness from caseworkers that they were seeing the same issues from the same bodies. This new approach is similar in some ways to that used by the OHOQ in its systemic investigations and the reason for adopting this approach is also similar to the reasons put forward by the OHOQ: an awareness that an SPSO caseworker may not appreciate the impact of a recommendation on the health organisation (Mary). The intention is to put the 'onus' back on the health board to 'take ownership' of errors identified in an SPSO investigation and for the health organisation to tell the SPSO how it would resolve the problem (Ellie). The approach requires the health board to determine if the problem is widespread and to decide what would be an appropriate response (Susan). Again, as with the OHOQ's approach to systemic investigations, this is similar to the finding from Smith-Merry et al (2014) and the 'all roads lead to Rome approach' used by the Netherlands ombudsman and described by Hertogh (2001).

Three particular issues arise from using recommendations as the driver for improvement. The first, and biggest, issue is that, in making recommendations to improve healthcare services, the SPSO attempts to use normative standards to guide both their adjudication on complaints and the recommendations and responses from Health Boards. The outcomes required from recommendations tend to be that of meeting established best practice – as identified within policies and guidance produced by the Board concerned or national standards and guidelines. However, it is not clear that asking bodies to review their practices does result in significant normative improvement. Adler (2003, p.328) notes that as complaints received by bodies, let alone those considered by ombudsman, are only a fraction of the issues about which complaints could be raised, then the normative power is likely to be variable and of low magnitude.

More significantly, this normative approach, which is also used by other UK health ombudsman, was strongly criticised by the United Kingdom's Appeal Court in the case of *Miller and Howarth v the Health Service Commissioner*[22], where Sir Ernest Ryder (Senior President of the Tribunals) described it as an,

> approach that permits of no nuances in clinical practice or opinion' and 'if the ombudsman's clinical advisors take one line of professional good practice as they did in this case, it matters not that there is another entirely valid good practice, it can be ignored (*Miller and Howarth v the Health Service Commissioner*, para.79).

Ryder goes on to note that the General Medical Council's standard is whether the actions of the doctor have 'fallen seriously below the standard of a reasonably competent doctor in his or her specialist field (*Miller and Howarth v the Health Service Commissioner*, para. 81). Damningly, Ryder concludes,

> The [normative] standard chosen by the ombudsman is beguilingly simple but incoherent. It cannot provide clarity or consistency of

[22] The Health Service Commissioner is the health ombudsman in England

> application to the facts of different cases. There is no yardstick of reasonable or responsible practice but rather a counsel of perfection that can be arbitrary. It runs the risk of being a lottery dependent upon the professional opinion of the advisor that is chosen. It is unreasonable and irrational and accordingly unlawful. (*Miller and Howarth v the Health Service Commissioner*, para.82).

This normative approach is the approach utilised by the SPSO but, as was seen in the results section, many health board staff expressed concerns about the clinical advice upon which the SPSO relies to make decisions. Many Scottish health board participants argued that, firstly, there can be legitimate differences in clinical judgment as to the diagnosis and management of patients, and, secondly, the clinical advice did not take into account the local context for the delivery of healthcare. As the SPSO was not willing to discuss the clinical advice with health board staff, the staff affected were often left frustrated, especially when they felt that the clinical advice was ‘wildly wrong’ (Rhoda).

Secondly, there also exists a more fundamental problem for SPSO in its use of a normative approach, created by the huge number of clinical guidelines that now exists and has been described as ‘both unmanageable and unfathomable’ (Greenhalgh et al. 2014, p.2). As an example, Greenhalgh et al. (2014, p.2) cite, ‘one 2005 audit of a 24 hour medical take in an acute hospital, for example, included 18 patients with 44 diagnoses and identified 3679 pages of national guidelines (an estimated 122 hours of reading) relevant to their immediate care’.

Such an example suggests two problems for the SPSO. Firstly, due to the volume of guidelines, it is not always reasonable for the SPSO to use clinical guidelines as the norm by which to judge clinical practice, a problem which is compounded by the reality of healthcare, where patients may present with multiple morbidities or medications, and which will impact upon the

usefulness of guidelines. Given the scale of guideline production, it is not possible for any clinician to be aware of them all and their use as an appropriate normative standard, therefore, becomes extremely problematic. Secondly, it is arguable that the solution to a single instance of a clinical failing in healthcare is an instruction to do more work on guideline implementation. There has been significant research on why clinicians fail to comply with guidelines with reasons including lack of applicability or evidence, environmental factors, unclear guideline recommendations and lack of awareness of the guideline (Lugtenberg et al. 2009, Cranney et al. 2001). In addition, the use of clinical guidelines is not seen to be without risks. Woolf et al. (1999) pointed out the limitations of guidelines: the science upon which the guideline is based may be limited, the recommendations within guidelines are influenced by the membership of the guideline group and may reflect personal biases, and guidelines may consider factors other than solely patient benefit, such as resource constraints or the protection of special interests. As a result, Woolf et al. (1999) claim that there is the risk of harm arising: the limitations may result in suboptimal treatment for patients and that a standardised approach, which takes reduced account of individual patient need, becomes the dominant practice.

The use of normative standards in recommendations is attractive yet problematic. Stating that a normative standard such as a guideline applies may not convince those who are faced with the nuances involved in the delivery of care, the context of which may not match the assumptions upon which the guideline is based. As health boards may be sceptical about the clinical advice upon which the decision relies, and, thus, the SPSO's decision, it becomes a problem for the health board to implement change: 'So, there are occasions where they proceed to print things that our clinicians don't agree with. Which gives us a challenge back from the board then, how do we deliver the action plan for improvement?' (Meg).

The SPSO needs to put itself in the position of understanding the decisions that were made by the health professionals involved in the complaint yet, as a result of the sparse communication and refusal to discuss with health boards the clinical advice upon which it relies, the SPSO chooses not to do so. The result is minimal unsustained change which appears to comply with the SPSO's requirements but which does not truly solve the problem leading to the recurrence of similar complaints.

The issues identified above in using recommendations as the driver for system improvement make it likely that the ability of recommendations to deliver this desired system improvement will be limited. This is, however, not a given. The approach adopted by the SPSO is at the discretion of the ombudsman in post. The SPSO could, theoretically, adopt an approach more attuned to professional judgment, such as investigating complaints in a manner similar to that used to investigate significant adverse clinical events[23]. Such an approach may be appreciated by complainants. As Carney et al. (2017) stated, complainants are often interested in the quality of services, and that making simple binary decisions, such as upheld or not upheld, can be less than satisfactory to complainants, and may also oversimplify complex, multi-faceted issues. In addition, as both Bismark et al. (2011) and Friele et al. (2013) found, an important outcome sought by health complainants is for lessons to be learned. An approach similar to that used in investigating significant adverse clinical events is more likely to be able to secure these outcomes and also take into account the complex nature of health complaints.

To do this, however, would require the SPSO to alter significantly its approach towards investigating health complaints and to move away from a bureaucratic approach to administrative justice towards a more dominant

[23] For details of this approach, see, for example, M Woloshynowych, S Rogers, S Taylor-Adams and C Vincent (2005)

professional judgment model. Making this switch would not be simple. One of the strengths of ombudsman is that they are a form of alternative dispute resolution, which focus on correcting errors made by the state. Part of their legitimacy lies in their lay status and their independence from the sectors over which they have oversight. Adopting a professional judgment model, with greater emphasis on professional judgment and approaches risks undermining their perceived independence. Complainants already criticise United Kingdom health ombudsman as being biased towards the NHS.[24]

There is also the time lag inherent in the complaints process. For the SPSO to investigate a complaint, the body must have had an opportunity to attempt to resolve it. Thus, there is a delay before the complainant lodges the complaint to the body concerned. There is a second delay while the body attempts resolution and there is a third delay before the complainant then approaches the SPSO. There are no available statistics which measure how old complaints are before they reach the SPSO but it is likely to be several months. In addition, a complaint may take several months to be completed by the SPSO. The SPSO is silent about the average duration of the length of time it takes to investigate and report on a complaint but the 2018/19 Annual Report (SPSO 2019, p.13) does state that it completed 97% of complaints within 260 working days. Significant time lags run the risk that the recommendation is no longer relevant due to changes in the service or personnel or that it may have already been implemented. Such a finding was found by Smith-Merry et al. (2016) in their research on the responses of complaint managers to the outputs of their health complaint entity, where the complaint managers claimed that, on many occasions, the hospital had already implemented the changes prior to the outcome of the investigation.

[24] For an example, see PHSOTHETRUESTORY at https://phsothetruestory.com/

7.6 Research Question 3: How do those in the healthcare system receive and respond to these approaches?

The ability to understand how bodies in jurisdiction respond to the activities of their ombudsman is important for ombudsman, complainants, bodies in jurisdiction, and, the wider public. This section begins by discussing the awareness of the participants from Scottish health boards of the outputs from the SPSO before outlining a new conceptual model to aid the understanding of how Scottish health boards respond to these outputs.[25] This new model builds upon, and seeks to integrate, previous academic research into ombudsman and supplements this foundation with ideas drawn from organisational learning and institutional logics.

7.6.1 Participants awareness of the SPSO

With the exception of the SPSO's complaint handling activity, there was limited awareness by participants from the Scottish health boards of the other activities undertaken by the SPSO aimed at contributing to system improvement (Table 19). The SPSO will be disappointed that much of its work bypasses the attention of health board staff, with the greater majority of participants only able to recall between two to four of the seven areas of activity undertaken by the SPSO. Indeed, approximately three-quarters (15 out of 21) of participants recalled less than half of the activities.

There were some interesting results in the area of awareness. Only 11 out of the 21 participants mentioned that the SPSO published its investigation reports and decision summaries, which is lower than may be expected as many participants mentioned concerns about reputational risk from upheld

[25] It will be recalled that Queensland HHS did not agree to participate in this research

reports and of the fear of details of upheld complaints being published in newspapers. Nursing staff were more likely to mention the publication of reports with some stating that they actively looked at published reports to identify potential learning. Only one in three participants mentioned the SPSO's role in improving complaint handling, with, ironically, staff involved in complaint teams less likely to mention that activity.

Half of the health board participants recognised the SPSO's role in contributing towards system improvement, although only half of those who did make this recognition identified recommendations as being the driver. Directors of health boards and complaints teams were more likely to identify the SPSO as contributing toward system improvement. Nursing staff, although having relatively higher awareness of published investigation reports and, of whom, some stated that they looked at these publicised reports as a source of learning, were noticeably less likely to mention the SPSO's role in contributing towards system improvement.

These results demonstrate the difficulties facing the SPSO as they attempt to 'cut through' to the attention of health board staff. All health board staff talked of the pressure under which they worked which resulted in them focusing on activities of immediate relevance and importance. While this remains the situation, the SPSO is likely to continue to struggle with its system improvement work. The focus of health board staff will remain on the SPSO's complaint handling and, as shall be discussed below, this is not always viewed positively by them.

7.6.2 The conceptual model

The outcome of this research, built, as it is, upon previous academic research in this area and the theoretical constructs of organisational learning

and institutional logics has allowed the researcher to develop a novel conceptual model to explain earlier research findings that there is limited and equivocal evidence that ombudsman contribute to system improvement. As shall be argued, the dominant institutional logic within an ombudsman office provides the mechanism that shapes the model of administrative control exerted by the ombudsman office upon bodies in jurisdiction. In turn, this model of administrative control sculpts the nature of the relationship between ombudsman and body in jurisdiction, and which will, again in turn, influence how bodies respond to their ombudsman. The model also explains earlier research findings through the recognition of the complexity of both healthcare organisations and the delivery of healthcare and the social structures in which the SPSO and health boards operate. The construction of this novel model is now explained by way of explaining its individual components.

Health ombudsman will have, either as a strategic objective or as a statutory requirement, responsibility to contribute to the improvement of the system. In practice, an ombudsman will provide some output which is intended to prompt a response from a body in its jurisdiction, causing this body in jurisdiction to change some aspect of its activities leading to system improvements. This is shown diagrammatically in Figure 5 below:

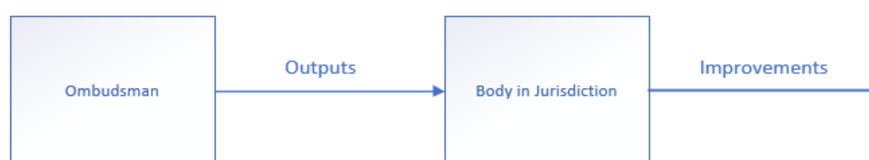

Figure 5 Basic diagram demonstrating how ombudsman contribute to system improvement

Stuhmcke (2006), identified two types of output from ombudsman, those which are direct and are measurable, and those which are indirect and are immeasurable. In addition, Stuhmcke (2006), also identified thick and thin

changes resulting from ombudsman outputs. Thick changes are policy changes while thin changes are procedural type changes. These can be incorporated into the model as illustrated below, Figure 6:

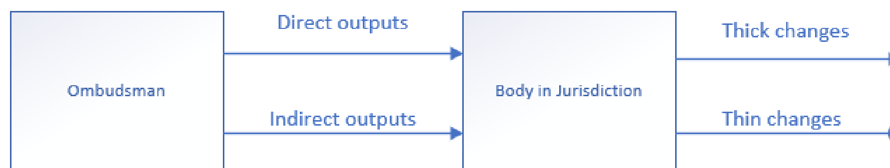

Figure 6 Revised diagram incorporating the work of Stuhmcke (2006)

This basic model can then be developed further though the addition of Hertogh's (2001) work on cooperative control or cooperative control. In this work Hertogh argued that the impact of an ombudsman relates to the clarity of the decisions provided to bodies in jurisdiction, the degree of tension that exists between that message and extant organisational values and policies, before the body considers whether or not to implement the decision. For each of these stages there was a potential obstacle to change, a lack of clarity, a significant gap between the decision and current values and policies, and defensive behaviours. The relationship between the phases and barriers is shown diagrammatically in Figure 7 below.

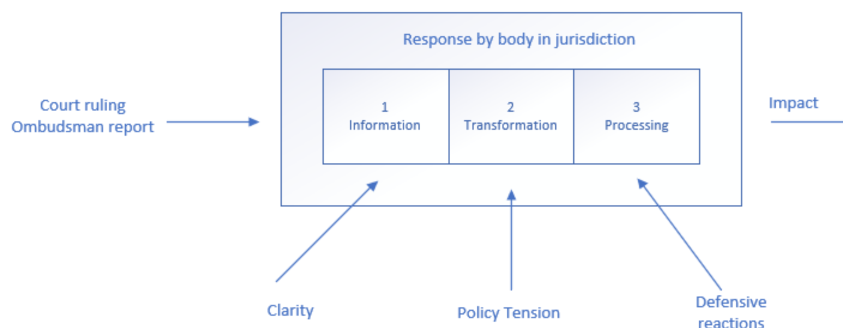

Figure 7 Relationship between phases and barriers (Hertogh 2001)

Hertogh's model can be integrated into the proposed new model as indicated in Figure 8 below:

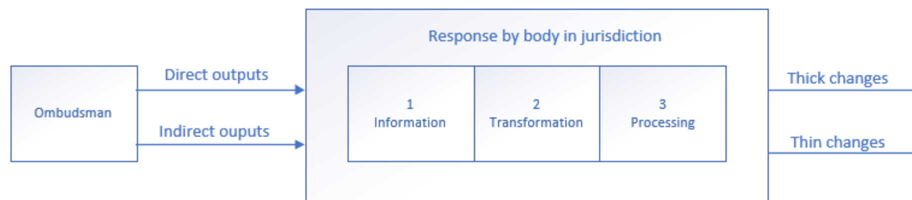

Figure 8 Revised model incorporating the work of Hertogh (2001)

As Hertogh (2001) suggested in his discussion on cooperative control and the barriers to implementation of ombudsman recommendations, organisations must decide how to respond when subject to recommendations from an external controller. Work by Braithwaite (2014) and Smith-Merry et al. (2016) indicates that the responses by organisations will be strongly influenced by the motivational postures adopted by individuals within these organisations. Accordingly, it is suggested that the motivational postures adopted by individuals and organisations will impact upon the transformation and processing stages in Hertogh's model. That is, the postures will affect how individuals and organisations interpret what the decision will means for them, how the recommendations relate to the goals and operations of the body, and how best should the body respond to the decision. The ideas of motivational postures are added to the model as indicated in Figure 9 below.

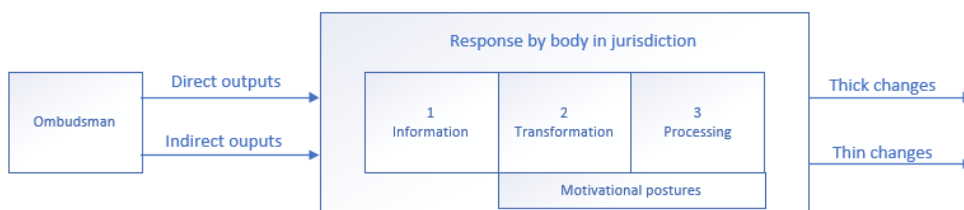

Figure 9 Revised diagram incorporating the work of Braithwaite (2014)

This model is now developed further by incorporating the work of Gnyawali and Stewart (2003).

Gnyawali and Stewart (2003) suggested that there are two types of learning, informational and interactional learning, which result in cognitive and behavioural change respectively (see 3.2.3). Informational learning 'focuses on the acquisition, storage and distribution of information' the intention of which is to provide detailed information to individuals within the organisation responsible for action while interactional learning is concerned with the sharing of knowledge between individuals in order to develop new processes or routines (Vos et al. 2008, p.11). The addition from and Gnyawali and Stewart (2003) are now included within the model as shown in Figure 10 below.

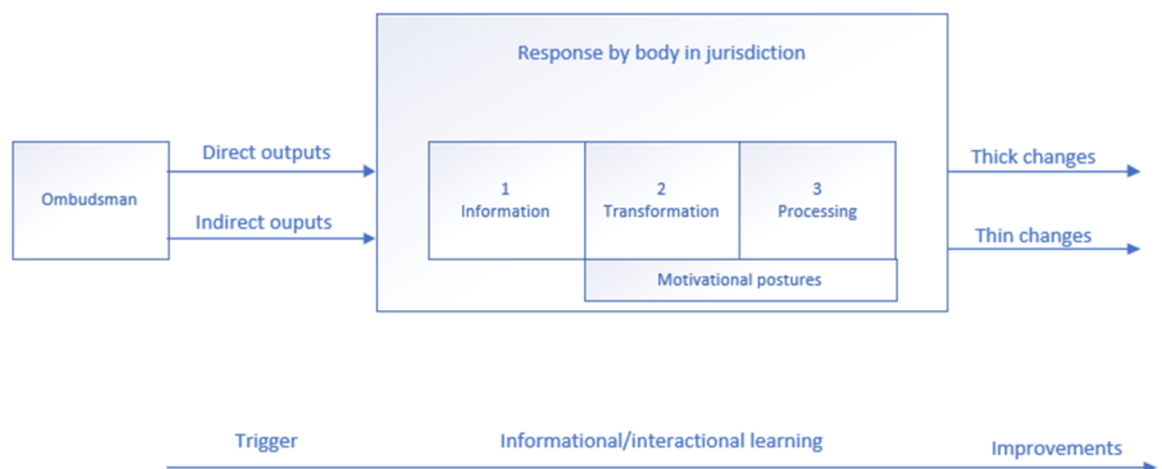

Figure 10 Revised model of how ombudsman outputs can lead to service improvements

Finally, earlier in the thesis there was consideration of the metatheory of institutional logics, in which it was noted that there were two conflicting institutional logics in the field of improving patient care: the logics of accountability and of learning. This conflict may have implications for health

ombudsman as they attempt to reconcile their twin roles of adjudicating on individual complaints, which is likely to involve the accountability logic, and contributing to the improvement of the system, which implies a learning logic. The dominant logic within an ombudsman office will affect the nature of the relationship between ombudsman and body in jurisdiction and this is indicated in Figure 11 below.

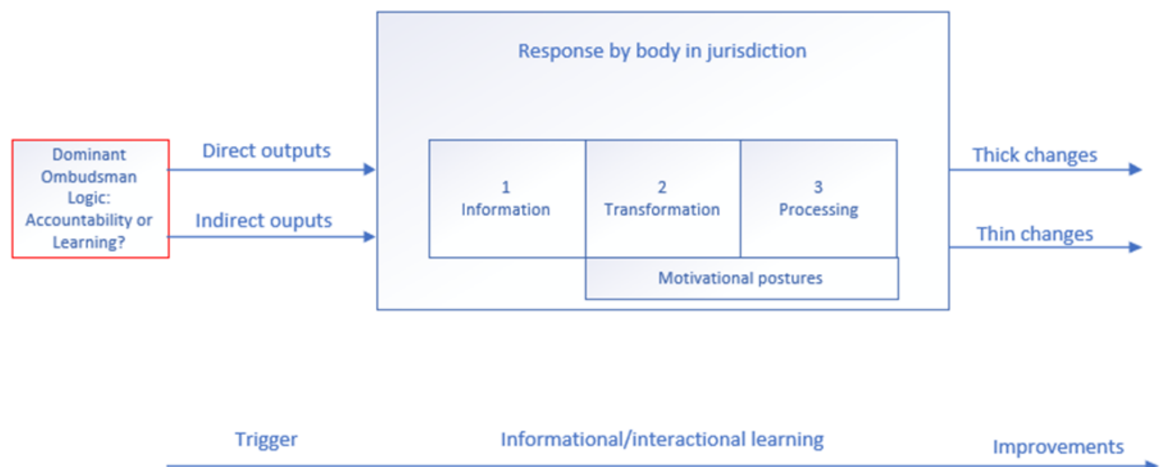

Figure 11 Revised model highlighting the possible institutional logics dominant within health ombudsmanry

Synthesising the academic research with theories of organisational learning and institutional logics has enabled the researcher to create a new conceptual model to explain how health boards respond to the outputs of their health ombudsman. This model suggests that the ability of health ombudsman to contribute towards system improvement is determined by the motivational postures adopted by persons within bodies in jurisdiction. These motivational postures then mediate the transformation and processing phases of the body’s response to the ombudsman, as well as the barriers to implementation integral to Hertogh’s model of administrative control. The result of this will be a number of changes which can be categorised as thick or thin dependent upon whether they are policy or procedural changes. Whether the body in jurisdiction uses on an interactive or informational model

of organisational learning will determine its approach to implementing changes and their sustainability.

The motivational posture adopted by staff within a body in jurisdiction will be influenced by the nature of the relationship that exists between the ombudsman and that body. The nature of this relationship will be based upon the model of administrative control adopted by the ombudsman, being either the coercive or cooperative model of control and which will, in turn, be strongly influenced by the dominant institutional logic that exists within the ombudsman office. An accountability logic will result in a different model of control and relationship between ombudsman and body in jurisdiction and, thus, the motivational posture that is likely to be adopted by the body, compared to that which may be adopted where the dominant logic within the ombudsman is a learning logic. This relationship is shown diagrammatically in Figure 12 below.

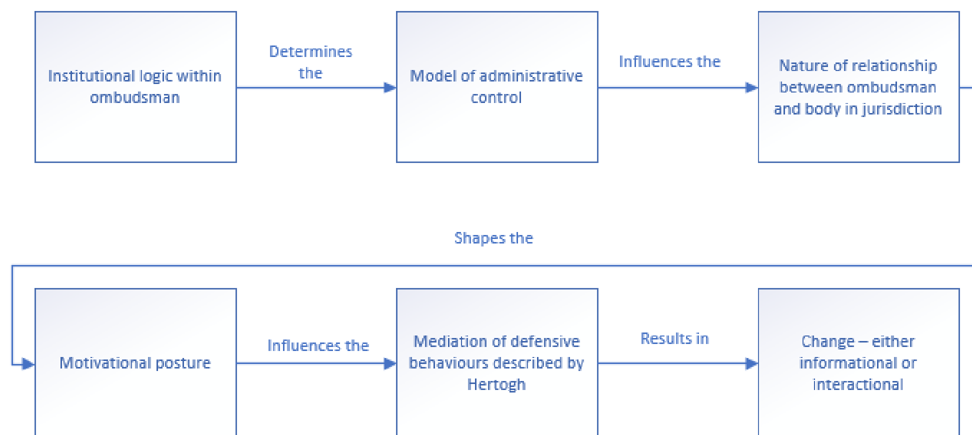

Figure 12 Relationship between the differing elements in the conceptual model

7.6.3 Using the conceptual model

The model provides a framework that explains how health ombudsman are able to work most effectively with health organisations and professionals

within their jurisdiction to secure meaningful improvements in the healthcare system. In using this model as a basis for the discussion, the discussion follows the model detailed in Figure 12. It begins with a consideration of the institutional logics that influence how the SPSO operates and is followed by the consideration of Hertogh's models of administrative control and its effect on the nature of the relationship between the SPSO and health boards. The discussion continues with consideration of the dominant motivational postures adopted by health board participants before concluding with the types of changes that arise from SPSO investigations and examines the health boards' dominant mode of organisational learning.

7.6.4 Determining the dominant institutional logic within the SPSO

Identifying the dominant institutional logic within the SPSO is challenging as the SPSO attempts to utilise both the accountability and learning logics. These two institutional logics make for uneasy bedfellows and, inevitably, one of these logics will become the dominant logic. This dominant logic will affect the nature of the relationship between SPSO and health boards. The research found that the dominant institutional logic within the SPSO is that of accountability with its focus on adjudication, error and prescriptive recommendations.

The underpinning premise of the metatheory of institutional logics is that 'the interests, identities, values and assumptions of individuals and organisations are embedded in dominant institutional logics' (Thornton et al. 2011, p.6). Institutional logics act as a framework that influences the decisions and actions of individuals and organisations. In the field of healthcare quality there exists two dominant institutional logics – firstly, the accountability logic, predicated upon the allocation of responsibility where things go wrong. Healthcare professionals are accountable for their actions and ought to be

able to justify their actions by comparing their practice with that of their peers or normative standards. The second institutional logic, the learning logic, is predicated upon the importance of learning where things have gone wrong through 'no-blame' investigations aimed at maximising learning through interactional learning.

In the investigation and adjudication of complaints the accountability logic is used by the SPSO. The language of the published investigation reports and decision summaries is full of words indicative of a dominant accountability logic: there is a focus on error, complaints are upheld or not upheld; health professionals and organisations 'should' have done something they did not do and many investigation reports contain examples where the actions of health professionals have been unreasonable. From these reports it appears that health professionals do not make errors but act unreasonably. In addition, the SPSO has a support and intervention policy which aims to reduce poor practice in complaint handling. While there is language indicative of a supportive orientation, the policy is backed up by a list of possible sanctions should bodies in jurisdiction fail to respond as the SPSO wishes.

At the same time, the SPSO undertakes activities to support bodies in jurisdiction and, in its revised approach to recommendations, the SPSO is attempting to use a learning logic. The intention of this revised approach to recommendations is to provide organisations with the ability to identify their own 'road to Rome', which, again, could be indicative of a learning logic. However, this approach is more prescriptive than suggested. Organisations are instructed in broad terms what they should do to achieve a specified outcome by when and are told what evidence will be required by the SPSO to demonstrate compliance with the recommendations. In practice, this suggests a more dominant accountability type logic than a learning logic.

This dominant institutional logic within the SPSO will be determined by a number of reasons (see Kagan 2010). Three reasons contribute to the mechanism which creates the dominant accountability institutional logic within the SPSO, and, these are the corporate sole nature of the ombudsman post-holder, the SPSO's underpinning legislation, and the organisation's historical contingency.

It was stated earlier that the post-holder of the SPSO has corporation sole status. As a result, the ombudsman office will reflect the attitudes, beliefs and decisions of the ombudsman. Many participants noted that there had been a recent change in the Ombudsman post-holder and stated that, following this change in personnel, they had noticed the beginning of changes in the approach from the SPSO with the SPSO becoming less aggressive. The change in approach to recommendations was seen by some health board participants as a sign of this more positive approach. This does confirm that the ombudsman does strongly influence how an ombudsman office operates but, while it would be easy to think that the attitudes, beliefs and decisions of the Ombudsman is the determinant of the approach adopted by the SPSO to its relationship with health boards, they are not the only influence.

The SPSO's underpinning legislation, the *Scottish Public Services Ombudsman Act 2002*, while permissive in allowing how the ombudsman conducts their role, is prescriptive about the ombudsman's role. The legislation requires the ombudsman to investigate appropriate complaints and to publish reports of such investigations. There is no requirement to contribute to system improvement except in relation to its recent new powers to improve complaint handling. This legislation shapes the actions of the SPSO. As one of the duties of the SPSO is to hold bodies in jurisdiction to account for any maladministration, it is important for the SPSO's reputation that it is not seen as maladministrative. Complying with its legislation will help protect the SPSO from such criticism and will contribute to a bureaucratic approach focused on holding bodies to account.

One of the underpinning principles intrinsic to institutional logics is that organisations are historically contingent, that is, the historical environment and situation of organisations will influence what will be the dominant logic. Earlier in this chapter, when considering which model of administrative justice was adopted by the SPSO, the historical contingency of the SPSO was noted, from its roots as the Parliamentary Commissioner for Administration, through its transformation into the PHSO, but with a focus on bureaucratic decisions of the NHS, before the PHSO was given powers to consider clinical issues. It was identified that this historical contingency was one influence on adoption by the SPSO bureaucratic rationality model of administrative justice. The bureaucratic rationality model focuses on accuracy and efficiency and compliance with established norms. Similarly, this historical contingency will influence the dominant institutional logic. Just as the bureaucratic rationality model of administrative justice focuses on efficiency and compliance with accepted norms, the focus of the accountability logic lies in holding the performance of health professionals to account by means of comparing their performance with normative standards.

7.6.5 Hertogh's models of control and the relationship between the SPSO and health boards

Hertogh (2001) suggests that the model of administrative control used by ombudsman is the cooperative model. In contrast, this research found that the model of administrative control utilised by the SPSO was actually the coercive model of control. This demonstrates that the model of administrative control used by ombudsman is not restricted solely to the cooperative model. Rather, the model of administrative control will vary between ombudsman, and will be shaped by prior order mechanisms such as the ombudsman's dominant institutional logic.

The SPSO would like to think it is developing an increasingly cooperative relationship with health boards but this was not the lived experience of most health board participants who cited a lack of communication between them and the SPSO, the inability to discuss the case and the clinical advice obtained by the SPSO which was often determinative of the decision, and issues surrounding the clarity of recommendations. Many participants commented on the lack of a cooperative approach adopted by the SPSO. 'I think their view would be [that] it [the SPSO] is collaborative but from a services point of view I would say it's pretty remote' (Fiona), 'collaboration involves discussion and explanation and negotiation. I don't get a sense that happens a lot with the ombudsman' (Yvonne), 'there's not an engagement and dialogue with us around that in any shape or form' (Meg), 'they tell us. And it's not a communication, it's not collaborative' (Jackie), 'I'm not sure the relationship between the SPSO and the health board is collaborative enough. They are very separate' (Yvonne), and, 'they're not very approachable really, they're sort of in their ivory tour almost' (Jessica).

This feeling that the SPSO is not cooperative and distant is due largely to the lack of interaction between SPSO and health boards during an investigation. Participants reported that communication between the SPSO and health boards was sparse and mainly conducted through email: 'it feels like an administrative process … I think it's bureaucratic' (Rhoda), 'it seems to be just black and white. You take everything from what's written' (Darcie), and, 'but that's what I see as missing because they're there and we're here and only the twain shall meet in writing' (Donna).

Similar to the findings in Australia and the Netherlands, participants from health boards were keen to have conversations around the issues contained within the complaint but felt frustrated that these could not occur. Even when health boards were invited to comment, at the draft stage of the investigation report, or after the issuance of a decision letter, participants felt that they

could not challenge the SPSO or that doing so was of little value as it was unlikely to lead to change. There was a feeling among many participants that it was inappropriate to challenge the ombudsman: ‘I was always made to feel as if you shouldn’t question anything they ask you’ (Emma), ‘I think it’s almost a given that your starting point is that you don’t challenge the ombudsman (Tess), ‘I don’t think they like being challenged (Vicky), and, ‘I get the sense they’re [the SPSO are] quite directive and not really open to a challenge’. This last view was supported by Rhoda who stated that ‘we challenged once and the Ombudsman came back and chastised us for challenging it. … It felt quite punitive’. Many participants questioned the utility of challenging the ombudsman: ‘Generally speaking, in my experience, the ombudsman very, very, very, very rarely amends the report unless it’s factual accuracy’ (Phoebe) and ‘I don’t know that there’s been anything that they’ve [the health board has] ever challenged … that actually the Ombudsman’s said “Okay I agree with you. That actually we’ll change that”.’ (Emma).

This was particularly the case when there were disagreements about the clinical advice. Firstly, there was concern about the clinical advice received by the SPSO and its role in determining the outcome of the complaint. It was not uncommon for clinicians within a health board to have a differing clinical view from that of the clinical advisor employed by the SPSO. Many participants picked up on the fact that there can be several legitimate yet differing clinical judgements, ‘there are lots of experts in the field [that] may have a different view’ (Fiona), ‘sometimes there’s no right or wrong answer’ (Emma), and, ‘they (the clinical advisor] are one person, they’re not sense testing with others’ (Meg). Relationships between clinicians and the SPSO ‘become quite tense’ (Deirdre).

Where health boards tried to challenge the clinical advice received by the SPSO it was felt by participants to be pointless: ‘We have challenged it [the clinical advice], and we’ve been told, this is the clinical advisor for the panel,

and this is the outcome, so, therefore, there you go' (Rhoda) and, 'You've not got much grounds if you've got, "I disagree with your clinical advisor". They'll [the SPSO] go "tough"' (Jackie). This occurs even where a health board may respond to the SPSO citing clinical guidelines which it believes support their clinician and his or her actions, but felt that they 'did not get anywhere' (Isobel). One participant provided an interesting example where her health board obtained two independent reviews of their clinician's actions, one of which was obtained from a clinician completely independent from the health board. Both independent reviews were supportive of the health board's clinician, but the SPSO was unmoved: 'we didn't really get anywhere' as the SPSO relied on their original, sole piece of clinical advice.

To compound matters for health board staff, participants claimed that the SPSO lacked transparency, not only on the identity of the clinical advisor, but also on their expertise in the area about which they were providing advice. Clinicians, and health boards, were in the position of having to accept clinical judgements, with which they did not agree, without being able to assess whether the clinical advisor had the experience or status to provide such advice. This concern was exacerbated when the SPSO's clinical advisor was critical of clinicians who were recognised as clinical leaders in the area concerned (Donna) but where it was unclear about the experience and status of the clinician providing the advice. Finally, it was reported that the SPSO would not allow health boards to discuss the clinical issues involved with the clinical advisor to aid better understanding by both parties, on why the clinician took the actions that they did, or why the advisor provided the advice that they had submitted (Fiona, Eleanor, Jessica and Jackie). The result was to leave clinicians feeling unheard and 'undervalued' (Isobel).

A second issue raised by participants was their concern about whether the SPSO understood the complexities and context of delivering healthcare

which may affect both decisions and recommendations. Jessica was exercised as,

> … we've had some [reports] where medical staff have been really quite exercised about some of the things that have been said, because at the end of the day, we're a district hospital and maybe the advisor – I don't know where they came from.

Meanwhile Trish was equally exercised, 'you think, "You're just not getting that. We don't have whatever it is you say is on tap, as you say, because we're not a tertiary hospital full of lots of different specialities"'. These are examples of the frustrations expressed by staff within district hospitals who felt that the advice provided to the SPSO did not make sufficient recognition of the realities in providing healthcare in a Scottish district hospital. They expressed concern that the clinical advisor had an unrealistic understanding of what was deliverable within such a setting.

In their research on the response from hospital complaint managers to their Australian health complaint oversight bodies, Smith-Merry et al. (2016) found that complaint managers would welcome a collaborative approach between ombudsman and health organisation with more discussion and negotiation as they felt that this would enable the production of more feasible recommendations and realistic timescales. Hertogh (2001) found that staff from the Netherlands ombudsman also adopted a collaborative approach and had regular communications with bodies in jurisdiction about the investigation and recommendations as well as regular interactions out with investigations. During these discussions, Hertogh (2001, p.57) found that the bodies may make alternative suggestions to the ombudsman about proposed recommendations and cited one respondent as saying 'there are many roads that lead to Rome' and that the discussions with the ombudsman allowed the body to 'select the road that is most efficient'. Hertogh (2001) suggests that, what was most effective about discussions between ombudsman and bodies in jurisdiction, was that such discussions could enable the ombudsman to

overcome the potential blocks to implementation that he had identified in his research. Hertogh (2001) suggests that a facilitative, collaborative approach used by ombudsman may allow the body to implement the recommendations in ways that are consistent with their reality, thus improving compliance and delivering greater improvement.

At the time of the interviews with SPSO participants, the SPSO had relatively recently introduced a new approach to making recommendations with this drive for change coming from within the SPSO: 'I think it came out of a concern from CRs[26] a couple of years ago that we were making the same recommendation to the same body about the same thing and that, that didn't seem to be being particularly effective … Before, we kind of sat there, at our desks, and tried to think what has gone wrong and what can fix it' (Ellie). In the revised approach it was 'really up to the organisation to work out how they achieve that [the appropriate response to the upheld failing] … so, we are putting the onus back on the organisation and saying, you, we have noticed some mistakes but it is still your system, so you take ownership of it and fix it, and tell us how you fixed it' (Ellie). In some ways this appears similar to the many 'roads to Rome approach' used by the Netherlands ombudsman.

The rationale behind this change in approach was that 'we [the SPSO] may not always be best placed to make a recommendation that is appropriate because we might not know fully the extent of the organisation's structures and resources and so on. So, we might make a recommendation that we think is quite an appropriate and straightforward recommendation and, but it may have quite an impact on the organisation' (Mary). This suggests that the SPSO is trying to adopt a more cooperative approach with health boards in the formulation of recommendations, moving from an approach where it, the

[26] CRs are complaint investigators – the SPSO calls them case reviewers

SPSO, detailed the recommendation, to an approach which provides for a greater role in the determination of an appropriate recommendation. However, as discussed earlier in the chapter, the new approach from the SPSO to recommendations remains fairly prescriptive and lacks genuine discussion.

A commonly voiced concern related to appropriateness of SPSO recommendations. Donna expressed concern about their 'lack of general understanding about how the system works these days', while Isobel suggested that implementing recommendations across a health board area may be difficult due to differing local circumstances, 'so, I think that some of the complexities of what we have to deal with is quite difficult'. In fact, Isobel was even blunter, describing some recommendations as 'wild stuff' to which she thought 'Okay. Right. Move on'.

The consequence of this lack of cooperation between the SPSO and health boards was the development of negative views about the SPSO from health board participants 'I think they're more dictatorial' (Jackie), 'they almost seem to be in a place where they're untouchable' (Jessica), 'it actually feels quite aggressive … it feels really persecutory at times' (Rhoda), and, 'very much a kind of stick approach as opposed to engagement, working collaboratively' (Fiona). This belief, that the SPSO is distant, uncooperative and potentially aggressive, combined with a need for health boards to be seen to comply with the SPSO for fear of adverse publicity or the laying of reports before the Scottish Parliament engenders a view from health board participants that there was little that appeared to be cooperative about the relationship between the SPSO and health boards, but, rather, a coercive relationship predicated upon the authority of the SPSO where the obligations on health boards to comply are explicit. This is interesting as it contrasts with Hertogh's finding of a cooperative approach from the Netherlands Ombudsman and indicates that different ombudsman institutions may adopt differing models of

administrative control and that it would be wrong to assume that only the cooperative model of administrative control applies to ombudsman.

This perceived lack of a cooperative approach from the SPSO led to comments about the SPSO as being ‘dictatorial’ (Jackie), ‘they almost seem to be in a place where they’re untouchable’ (Jessica), ‘it actually feels quite aggressive … it feels really persecutory at times’ (Rhoda), and, ‘very much a kind of stick approach as opposed to engagement, working collaboratively’ (Fiona). This belief that the SPSO is distant, uncooperative and potentially aggressive, combined with a need for health boards to be seen to comply with the SPSO for fear of adverse publicity or the laying of reports before the Scottish Parliament engenders the sense of powerlessness and obligation to comply that was demonstrated by many participants. The lack of a cooperative approach from the SPSO increases the three barriers to change identified by Hertogh (2001), those of lack of clarity, policy tension and defensive behaviours.

7.6.5.1 Defensive behaviours

Both the negative consequences to health professionals that arise from being subject to a complaint, and the manner by which the SPSO conducts its complaint investigations are likely to increase defensive behaviours from health professionals. When investigating and adjudicating on complaints, the focus of the SPSO is on errors. The SPSO uses the language of adjudication, upheld and not upheld, and also uses language such as ‘failings’ and ‘unreasonable’, language which reinforces the idea of error. In addition, this research found that clinicians were left feeling frustrated, not only due to the fact that they were not able to discuss the clinical issue involved with the SPSO’s clinical advisor, but also because they felt that the clinical advisor did not take sufficient account of the nuance and complexities

of the situation central to the complaint. As several participants reported, the result of these factors, for many clinicians, is defensive behaviours. Hertogh (2001) argues that defensive behaviours from people in bodies in jurisdiction impedes the implementation of ombudsman recommendations.

It was noted in the literature review that clinicians do not always respond positively when the subject of a complaint (Zengin et al. 2014), with Siyambalapitiya et al. (2007, p.108) stating that clinicians may experience a 'sense of indignation towards the patients, frustration, doubts about their competence and fear of litigation'. Many clinicians perceive complaints to be personal attacks which should be resolved by some other person (Douglas and Harrison 1996). Such attitudes by professionals were described as a matter of concern 'representing 'a fundamental breach of patient-centred care' (Gallagher and Levinson 2013). Cunningham (2004, p.1) suggests that clinicians exhibit both short- and long-term adverse psychological responses. The psychological responses experienced by doctors appear to adversely affect their practise of medicine. Far from being a trigger to improve clinical practice, the receipt of a complaint may well have a negative impact upon clinical practice and defensive behaviours were likely to be enhanced by a focus on errors (Gray and Williams 2011). And, of course, a focus on errors is exactly what the SPSO does. In its investigation reports, the SPSO uses the language of adjudication, such as upheld and not upheld, and also uses language such as 'failings' and 'unreasonable', language which reinforces the idea of error.

One factor that may worsen the experience for clinicians who receive a complaint and which may encourage defensive behaviours is the complaints process that is utilised. Nash et al claim that doctors wanted the complaints process to be transparent and for the complaints process to be overseen by competent staff (Nash et al. 2004). Bourne et al. (2016) found that particularly stressful for doctors was the uncertain duration of the

investigation, poor communication between clinician and complaint handler, the unpredictability of the complaints process and procedures, with many viewing the complaints process being biased in favour of the complainant. As a result, doctors ‘felt neglected and betrayed by complaints procedures’ (Bourne et al. 2016, p.2). This reinforces the negative response from doctors and it is here that the SPSO performs badly. The SPSO does not set out in advance how long an investigation may take and its performance standard is to complete 85% of investigations in 12 months (SPSO 2020), during an investigation there is, generally, little in the way of communication between the SPSO and health board, that health boards are unaware of exactly what is happening during an investigation and there is this frustration, previously noted, at not being able to discuss the clinical aspects of the case.

Defensive behaviours from clinicians and other staff was seen to be a potential problem by participants, ‘we can all be quite defensive when we’re responding to complaints’ (Eleanor), ‘I have witnessed other folk …getting quite defensive and feeling that some of the recommendations or commentary is personal’ (Deirdre), and, ‘nobody wants their care criticised at all, which is very difficult’ (Isobel). As several participants reported, the result of all these factors for many clinicians is defensive behaviours.

7.6.5.2 Policy tension

The acceptability of an ombudsman decision is determined by the difference between a decision and the existing organisational program and the level of commitment to that program by the body so that the greater the change the less likely it will be implemented. This is Hertogh’s (2001) policy tension.

Concerns were raised by participants about the achievability of the recommendations proposed by the SPSO. Concerns ranged from, failures by

the SPSO to understand the implications of the recommendations in terms of the necessary work to see the recommendation implemented, which was memorably described as 'industries around the SPSO' (Darcie), the deliverability of the recommendations through a failure to understand the complexity of the modern healthcare system, nor the importance of local context, 'a health service is a health service is a health service. It is to a certain degree but local context is important' (Meg), allied to an unwillingness to listen to the service (Donna). In addition, as previously discussed, in many cases health professionals will be unconvinced by the clinical advice used by the SPSO and its subsequent decision. When this occurs, there will lesser acceptance of the need for change and commitment to make change. Organisations may implement changes for 'symbolic' rather than for 'instrumental' purposes, that is, without making significant operational changes (Heimer 1999). Making symbolic changes is the result of organisations seeking to maintain legitimacy in the eyes of their oversight body while, in practice, making as little change as possible (Heimer 1999).

These concerns reflect the policy tensions that can arise where health boards and people within them assess the implications arising from a recommendation made by the SPSO to what it means for the health board. Hertogh (2001) suggested that the greater the gap between the recommendation and the existing organisational approach the less likely will the recommendation be fully implemented. As participants clearly thought that, on occasions, recommendations were unrealistic and not rooted in their everyday reality, it is clear that policy tensions will, inevitably, arise.

7.6.5.3 Clarity of recommendations

The final barrier described by Hertogh (2001) was that proposed recommendations needed to be clear. It was evident from the results that

many participants did not always find recommendations to be clear in their intent, with over a quarter of participants, without prompting, describing SPSO recommendations as ‘woolly’. Other issues raised include: ‘some of them [recommendations] will be very, very generic. And the generic ones are the ones that are harder for us’ (Isobel), ‘some of these things you think, “Well we’ve sent them the policy, so what’s wrong with the policy? … If we’ve to review, what is it in the policy that you think needs reviewed? That’s not clear. It just maybe says, “Policy should be reviewed?”’ (Jill), and, ‘you’d love to see them in the boardroom to say “What do you mean by that? Explain what you actually want us to do, because again in black and white, I can read that and think “I don’t know how I can deliver that …?”’ (Darcie),

This lack of clarity in the reports and recommendations can be a challenge for participants, ‘it’s very difficult to know, sometimes, what she’s expecting of us. It would be good to have a clearer picture of what he or she feels we should be doing differently’ (Jill). A lack of clarity from the SPSO about what is intended will clearly make it more difficult for health boards to deliver the intended changes.

A lack of clarity from the SPSO about what is intended will clearly make it more difficult for health boards to deliver the intended changes. Hertogh (2001) suggest that reports and proposed recommendations from ombudsman need to be clear in order to facilitate their implementation. It is clear from the responses from health board participants that they did not find the SPSO’s recommendations to always be clear.

The triad of obstacles identified by Hertogh (2001) is, therefore, exhibited. The purpose behind recommendations may be unclear, a significant policy tension may arise between what is proposed and what the health board may consider deliverable, and clinicians and managers may demonstrate

defensive behaviours. Any of these obstacles would be a significant block, but it is possible that all three will exist for any given SPSO report. If it is only the fear of sanction that may arise from non-compliance that drives action it would realistic to expect that the response from health boards will be diminished and that they may deliver little more than the minimum change. Therefore, the motivational postures that are adopted by health organisations and professionals will be important in understanding how they respond.

7.6.6 Motivational postures

The novel conceptual model identified in this research indicates that the motivational postures adopted by individuals and organisations will affect how individuals and organisations interpret and respond to an ombudsman's report. Braithwaite (2014) describes five potential motivational postures: commitment, capitulation, disengagement, game playing and resistance and noted that they were applicable in a wide range of settings. Smith-Merry et al. (2014) investigating the motivational postures adopted by hospital complaint managers in response to their ombudsman found three motivational postures were demonstrated, those of commitment, disengagement and resistance. However, in this research, while three motivational postures were also identified from the responses made by participants, they represented a different grouping of motivational postures from those found by Smith-Merry et al. (2014). In this research, two of the motivational postures that were identified, those of commitment and capitulation, were the dominant motivational postures, while, in addition, there was a degree of disengagement that was voiced. But, as will be discussed, although participants voiced little in the interviews about disengagement, it will be suggested that disengagement is more widespread within health boards than may be thought from the responses of health board participants.

Typical views supportive of the motivational posture of commitment were the need to take the ombudsman seriously and reflect on what they have said (Trish), the fact that an independent investigation has been undertaken by the ombudsman supporting their opinion (Fiona), and a thorough investigation has taken place highlighting a failure that needs to be addressed (Justine). Jessica noted that an upheld complaint, while a shock and upsetting for some staff was important for the health board as it enabled it to learn, a view shared by Trish, who described receiving an upheld report as 'sore' but also an important source of learning. Meg viewed investigation reports as 'gifts'. Several participants saw the ombudsman's role as important, as an external reviewer (Phoebe), in driving improvement (Tess), and, as an organisation from which to learn (Trish). The view was, perhaps, best summed up by Jackie, who said that the most important objective was 'to make the patient, the complainant, whoever it may be, feel better and feel that we've properly listened to the recommendations and are acting upon them'.

The second dominant motivational posture described was that of capitulation. In this situation, participants talked of seeing the SPSO as a threat (Vicky), people being in fear (Vicky and Darcie), being told to comply with the SPSO by their managers (Darcie), taking action because of fear of sanction should they not do so, but lacking commitment to this action (Yvonne) and, 'the minute you hear the ombudsman, you think "Ugh"' (Isobel). In this situation, people complied with ombudsman reports for fear of sanction. The sanction of which most participants appeared to be concerned about relates to the health board's reputational risk: 'We have to deliver on the recommendations. And, if we don't, they [the SPSO] don't close the case, and they write to our Chief Executive, and that comes back to reputational issues' (Jackie), 'We probably risk assess it [the SPSO report]. What's going to have the biggest impact for us, because you don't want to end up on the front page of the

Daily Record'[27] (Jill) and, 'I guess the thing is, there's a pretty clear message around these kind of … there's that whole bit around reputational risk' (Tess). This feeling of fear led to some interesting characterisations of the SPSO: 'everyone says, "the Ombudsman". It's like the grim reaper' (Darcie), 'It's like Big Brother watching you a wee bit' (Trish), and 'It's keeping the wolf away from the door' (Eleanor).

A third motivational posture, that of disengagement, was identified, but to a lesser degree in terms of participants responses. While there were comments such as, 'the SPSO? Who? I don't really care what they [say], you know' (Vicky), or, 'other things we think, "Really?" It's almost making recommendations for the sake of it rather than genuinely understanding what happens in the system' (Donna), two issues were repeatedly highlighted by participants and detailed in the results chapter. These were concerns about the clinical advice obtained by the SPSO and the SPSO's understanding of the complexity involved in the delivery of modern healthcare.

Firstly, where health board staff disagreed with the SPSO's clinical advice, they were not able to discuss this advice, leaving health board staff frustrated and unheard, and secondly, health board staff did not believe that SPSO staff always understood the complexities and nuances of the delivery of modern healthcare. This was considered earlier when the nature of the relationship between the SPSO and health boards was discussed. The consequence of these issues is that clinicians and managers may not be convinced by either the investigation decision or the subsequent recommendations and this creates problems for implementation: if the clinicians do not agree with report 'how do we deliver the action plan for improvement?' (Meg). The risk is that clinicians, and perhaps some managers too, become disengaged from the process. As it is clinicians who are responsible for developing and

[27] The Daily Record is the largest circulation daily newspaper in Scotland.

implementing clinical guidelines, if they become disengaged from the process then there is a risk that changes that are made will be cosmetic, engineered to demonstrate apparent compliance with the recommendations rather than prompted by commitment.

It is in this regard that Braithwaite’s (2014) five models of motivational postures becomes rather problematic as it might be considered that the boundaries between the five models are clear and absolute. In the above scenario, are disengaged clinicians, who appear to comply with recommendations they do not support, demonstrating disengagement, capitulation, as they are only taking action for fear of consequences should they not do so, or game-playing, where they appear to accept the ombudsman’s authority but are changing as little as possible? An argument can be made for both capitulation and game-playing.

In this situation, the sense of the researcher is that the motivation that compels compliance is that of capitulation. The SPSO will normally identify the health board as the subject of its investigation and, as such, it is the health board and not individual healthcare professionals which has to decide whether or not to accept the SPSO’s adjudication. Participants were clear that health boards did not want to be on the wrong side of the SPSO and, while the SPSO has no direct powers over health boards and clinicians, the threat of adverse publicity and possible professional sanctions from referrals to regulators will be enough to secure apparent compliance. Complying, through a fear of sanctions of whatever type, rather than through a sense of commitment, is, however, liable to result in informational learning with the minimum possible actions undertaken to appear compliant.

It also appears that the motivational posture that is demonstrated by any one individual is not absolute, either for health boards or for individuals within

health boards. This indicates that the motivational posture adopted by a person or body can be contextual, specific to the immediate situation, and, personal, where different people may adopt differing motivational postures when faced with the same situation. Individuals within the health board will review the SPSO investigation report and recommendation(s) and decide with how much they agree. If the findings of the investigation and associated recommendations are accepted then commitment to implementation of the recommendations is likely to be greater. If the SPSO findings and recommendations are not really accepted by health boards, a motivational posture of capitulation will be adopted and there will be a lesser commitment to implementation. Thus, the dominant motivational posture exhibited by individuals may well change dependent upon the result and implications of individual reports and recommendations. This is a significant finding. Previous research looking at the impact of ombudsman by examining the responses by bodies in jurisdiction to the output of their ombudsman tends to look at the issue at the level of the body and not at the level of individual cases. At this lower level, the situation is messier. The result of some ombudsman investigations will be fully accepted by health board staff and, potentially, deliver significant change while the outcomes of other investigations will not be really accepted and have little effect on service delivery and which is likely to be temporary.

7.6.7 Types of change that result from SPSO recommendations

Stuhmcke (2006) suggested that ombudsman can make recommendations for two types of change – large policy changes or smaller process changes. Participants indicated that, while the SPSO did make both type of recommendations, the smaller scale recommendations predominated (Fiona, Phoebe). In all three health boards, the greater majority of recommended changes were small-scale in nature, and sometimes just requires 'the bash[ing] out of a memo (Rhoda), a tweak to a policy (Millie), changes which

focus on procedures rather than policies (Jessica), or, are specific to 'local conditions … or client[s]' (Phoebe). However, the fact that the majority of the proposed changes were seen to be small in character was viewed to be different from the potential impact of any change, 'but [some] would actually make a huge impact' (Yvonne), and, 'the small changes can have a big effect on somebody and a big effect on what we do' (Justine).

The small changes were seen to be easier to implement although, sometimes, even policy changes may be fairly simple to make, 'to some extent policy changes can be reasonably easy, providing it's not, you know, a complete rewrite. It sometimes just requires a tweak' (Millie). However, there were concerns when more significant changes to policies were required: such changes are likely to require consultation with partners and stakeholders (Fiona) and, this difficulty can be exacerbated when recommendations apply to regional services such as cancer treatments which involve multi- health board clinical networks (Donna). A need for consultation may cause delays or may even create a block should the partner organisations disagree with the proposed change.

7.6.8 Organisational learning

Many health board participants questioned the sustainability of the changes that arose from implementing SPSO recommendations. As Yvonne put it, 'why do we keep getting the same type of complaints, and with the same themes?' The research found that the difficulty in securing sustained change within health boards lies in an approach to organisational learning that is principally based upon an informational learning mode, focused upon incremental change and the sharing of information to individuals within an organisation, and is compounded by the challenges health boards face in ensuring that the information is adequately shared and understood across their entire organisation.

The recurrence of similar complaints indicates a failing of organisational learning within health boards as the nature of the learning that takes place within health boards is a significant factor in the type and sustainability of organisational learning that occurs. Gnyawali and Stewart's theory from the field of organisational learning helps us understand why health boards continue to receive complaints of a similar nature. Gnyawali and Stewart (2003) argue that there are two broad approaches to learning: informational learning which focuses on the provision of detailed information to individuals within the organisation, and interactional learning, which is directed at the development of new processes or routines. An informational learning mode is simpler for organisations to manage as interactional learning can create 'organizational upheaval and fundamental management paradoxes' (Gnyawali and Stewart's 2003, p.81). Vos et al. (2008) argue that the appropriate response to learning from complaints is interactional learning as this approach focuses on resolving the tension between current and required future practice.

The initial response by health boards does suggest an interactional approach. The ombudsman's report is sent to a lead manager within the ward or department which is the subject of the complaint. The lead manager is then responsible for pulling together a team to produce and implement an action plan that ensures compliance with the recommendations. The action plan will be signed off by management and by the relevant clinical governance committee. This group will then implement agreed changes.

However, this work is undertaken by a small group of people, composed of people from an organisationally junior level, for example, at ward level, and focused on resolving the immediate, usually local, issue. As such the scope of the work is limited to the immediate resolution of the SPSO's recommendation. A particular problem arises where the motivational posture adopted by the group is that of capitulation. In this circumstance, there is no

great commitment to make a change. Sujan and Furniss (2015) claimed that complaints often emphasise what has gone wrong which creates a set of negative implications and, from this, a negative learning culture. Gray and Williams (2011) argue that where there is a focus on error and failure the associated learning culture is affected by defensive behaviours which aim to pretend that learning has occurred and leads to superficial learning. As it is likely that the motivational posture adopted by the ad hoc working group will be that of capitulation, for the reasons set out above, there is every chance that this group will demonstrate defensive behaviours and, as a result, the organisational learning that arises be diminished.

Most learning across the participating health boards is informational learning, in keeping with Gnyawali and Stewart's (2003) claim that the most likely form of organisational learning within large hierarchical organisations is informational learning and a focus on the reduction in errors in current processes. Firstly, the ombudsman report is cascaded down the organisation to the ward or department concerned. At this level of management, it is likely to be emailed to the staff within that ward or department, due to the number of staff involved and the complications of shift and rota working. However, as Millie, Darcie, Donna and Jackie said, emailing reports does not mean that they are read, as staff are too busy to read all their emails (Jackie) or question their relevance (Fiona). Health boards do try to share information across the organisation and will use existing mechanisms such as inter-speciality clinical governance meetings or quality and performance groups but, even then, the ombudsman report(s) will be just one agenda item among many. And, as Jessica noted, your learning 'depends [upon] which meetings you go to'.

The difficulties of sharing information across wards or departments is clear, but as all health boards have a wide range of units such as multiple hospitals, community services and mental health services this creates additional

challenges for sharing information. Even within a hospital it is not clear that information will be adequately shared across the differing departments: participants felt comfortable that information was shared across their own department but could not vouchsafe that it was shared across other departments within the hospital. Fiona admitted, ‘that’s where we fall short’ and noted that if it was directly relevant to you then you are more likely to take note than if it concerned other areas as ‘there’s hundreds of learning out there for us’. The difficulties in sharing information was identified by many participants with Millie, Deirdre and Emma specifically pointing out that they believed that their health boards had more to do in this area.

Many participants also noted the limitations inherent within the sharing of information. Meg suggested that if only one team is aware of the information then no real learning will take place while Rhoda went further, ‘just telling someone to do something … doesn’t make a difference’, ‘we don’t use the information … to the level that we should’ (Fiona) and ‘you just do a wee bit of everything not very well (Deirdre) leading to a view that ‘looking at those SPSO letters that do come through and action plans, from the improvement side I see no improvement’ (Yvonne). This leads back to the lack of sustainable change identified by many participants with Fiona, Jackie, Meg and Rhoda all conceding that securing sustainable change was not successful.

Huber (1991) described a four-stage process concerning organisational learning: the acquisition of knowledge, the distribution of knowledge, the interpretation of the information and the storage of this information in the organisational memory. For health boards responding to SPSO reports these can be a challenge. Where the motivational posture adopted by health professionals is that of capitulation there will be decreased commitment to acquire the necessary information to respond appropriately to the SPSO recommendation. The difficulties faced by health boards in sharing

information has previously been discussed. Health boards do attempt to provide a common interpretation of this information through clinical forums and clinical governance arrangements but the weaknesses of these approaches were recognised by health board participants. Health boards will also have problems in ensuring that this information is stored within its organisational memory. Huber (1991) states that this storage can be negatively affected by factors such as staff turnover, and the failure of staff to appreciate the importance of the information that they receive. Health board participants did comment on the high rate of staff turnover, particularly among junior doctors who are typically on rotation schemes as part of their training. In addition, health board participants made the point that many staff may receive an email containing the information but they may not appreciate its relevance to them and, thus, pay insufficient attention to the contents.

7.6.9 Barriers to change

The most significant barriers facing health boards with their compliance with SPSO recommendations were time and staff capacity. The pressures that participants suggested face the NHS in Scotland, means that compliance with SPSO recommendations was seen as an extra duty that needed to be fitted into exiting busy workloads. This helps explain the fact that in only 48% of cases were bodies able to comply with the timescale for implementation of recommendations set by the SPSO.

Thomas (2015) provides further reasons why public bodies are not learning organisations. These included bureaucratic structures with complex subsystems, each of which may only be partially aware of issue or its resolution, that change in large organisations often necessitates substantial change programmes while the organisational capacity to manage is limited, together with ineffective resources and mechanisms to encourage learning.

This research found that these potential blocks exist within health boards. The difficulty in sharing information across health board structures has already been noted, as has the belief of some participants that many staff may not be fully aware of the messages that are being shared. Concern was raised by participants about industries being required to manage SPSO outputs and there was the issue about the lack of resources mentioned above. Taken together, these challenges indicate why organisational learning within health boards may be superficial (Gray and Williams 2011) and unsustained.

7.7 Conclusion

In the consideration of the approaches taken to administrative justice it was seen that the SPSO is a variegated ombudsman which takes a bureaucratic rationality approach to complaint investigations which are predominantly coercive in nature. The OHOQ, inevitably, takes a coercive, legal model approach to its regulatory activities because it is a statutorily based co-regulator of the Queensland healthcare system, and a contrasting cooperative approach in which professional judgment dominates for its systemic investigation activities. It was found that the OHOQ is not an ombudsman but a health complaint entity.

The SPSO and the OHOQ take different approaches towards their contribution to system improvement. The SPSO relied principally upon its use of recommendations arising from upheld complaints to contribute to system improvement, while the OHOQ focused on the prosecution of individual health professionals and, to a lesser extent, systemic investigations.

A new conceptual model was presented to explain how health organisations and professionals respond to their health ombudsman. Key to implementing

change were the motivational postures adopted by individuals and health organisations which, in turn, were created by the nature of the relationship that exists between the health ombudsman and health bodies. The nature of this relationship was strongly influenced by the dominant institutional logic adopted by the health ombudsman.

Three dominant motivational postures were identified for the SPSO, those of commitment, capitulation and disengagement, created by a relationship between SPSO and health boards that was more coercive than cooperative in nature, this relationship being influenced by a dominant accountability logic within the SPSO.

Chapter 8 Conclusion

The underpinning thesis that this research examines is that health ombudsman make an important contribution to the improvement of the healthcare system as a result of the roles and activities that they undertake together with the way that they work with bodies in jurisdiction. Previous research, much of which was equivocal, indicated that ombudsman had little impact on system improvement. The aim of this research was to describe the approaches used by health ombudsman that are intended to contribute to the improvement of the healthcare system and to understand how these approaches are received, and acted upon, by that system. One outcome from this research was the development of a novel conceptual model, built upon both previous academic research into ombudsmanry and the theoretical constructs of both organisational learning and institutional logics, and which provides a means by which the responses of health boards to the SPSO can be explained.

8.1 OHOQ

The research found that by directing its activities on the prosecution of healthcare professionals, which it believes have committed serious professional misconduct, and referring almost all of its complaints back to the body concerned or to AHPRA or other external body, the OHOQ does not meet the accepted definition of an ombudsman but is a health complaints entity. The OHOQ utilises two main approaches in contributing to improvement of the healthcare system. Its dominant approach, the prosecution of healthcare professionals can be seen as a negative approach to system improvement. The focus is on reducing poor or dangerous behaviours by sanctioning healthcare professionals. The threat of sanctions is intended to act as an incentive to health professionals to act appropriately.

However, it was noted that this approach is not without its downside. There is a significant adverse psychological impact that arises through this approach which can lead to anxiety, depression and even suicide. Doctors are likely to adopt defensive medical behaviours which may, in themselves negatively impact on patient care.

The second main approach adopted by the OHOQ in its system improvement work is its systemic investigation work. The ability to conduct systemic investigations is seen as important by both academics and ombudsman, enabling ombudsman to make significant contributions to system improvements. In this area of work, the OHOQ has developed collaborative models which move away from traditional investigations to approaches based on the highlighting of problems and facilitating work with bodies in jurisdiction to analyse the cause(s) of the problems and to create solutions. In addition, the OHOQ is active in ensuring compliance with agreed outcomes, visiting the health organisations concerned and talking with staff to assess compliance, rather than simply accept documentary updates from health organisations.

The OHOQ also has two secondary approaches by which it attempts to contribute to system improvement, those of local resolution and conciliation. The research found it hard to assess how effective these approaches are at securing system improvement but, tentatively, concluded that they were likely to be of limited success. In local resolution over 20% of cases are closed as unresolved and, even where the case is resolved, the OHOQ is unaware of the resolution agreed or whether any agreed change is actually implemented. Only a small number of cases are resolved by conciliation and, again, the OHOQ is unaware of the agreement reached nor whether any change results.

The dominant administrative justice model adopted by the OHOQ is the legal model. Although, as stated above, the OHOQ does undertake some systemic activity in a manner in keeping with the professional judgment model, this is a secondary activity. The model of administrative control is, necessarily, coercive. The OHOQ requires health organisations and health professionals to comply with their activities, particularly relating to prosecutions. Where it believes that professional misconduct has occurred, the OHOQ will seek to sanction the professional. One outcome of this coercive approach is that, in response, as Lydia explained, health professionals were uncooperative with the OHOQ. However, this combination of the OHOQ's role to protect the Queensland public through taking disciplinary action against healthcare practitioners suspected of serious professional misconduct together with the healthcare practitioner's desire to protect their professional reputation and livelihood perhaps make this lack of cooperation ineluctable and a feature with which both sides must reconcile themselves.

8.2 SPSO

The SPSO undertakes many activities which are aimed at contributing towards the improvement of the healthcare system. However, much of this work appears to bypass the attention of health board staff. Out of seven broad areas of SPSO activity, the greater majority of participants could only recall between two and four areas. Only half of participants recognised the SPSO's role in contributing towards system improvement and, even then, only half of these participants identified recommendations as the driver for system improvement. These low indicators of awareness demonstrate the challenge to the SPSO of cutting through all the potential inputs and responsibilities faced by healthcare staff. Healthcare staff see the SPSO as a complaints body with the potential for damaging the reputation of healthcare professionals and health boards.

It was noted in the literature review that multiple institutional logics are likely to coexist within a single organisation but that one will ultimately dominate. It was also noted within the literature review that attempts to combine accountability and learning logics has been attempted within the fields of alternative dispute resolution in the United States of America and in the field of healthcare quality and patient safety within the NHS in England. As was also noted, Dodds and Kodate (2011) concluded that the conflict that arises when using these two competing institutional logics in relation to patient safety was harmful to patients.

The principal approach used by the SPSO to contribute to system improvement is through its complaint investigation reports and associated recommendations. In undertaking this activity, the SPSO attempts to utilise both the accountability and learning forms of institutional logics but where the accountability logic dominated. Both forms of institutional logic are legitimate choices for the SPSO. However, the dominant accountability logic utilised by the SPSO results in a dysfunctional relationship between the SPSO and health boards with a negative consequential impact upon the motivational postures adopted by health boards in response to the SPSO's investigation reports and recommendations. But it need not be like this. It would be perfectly legitimate for the SPSO to adopt either an accountability logic or learning logic as its dominant institutional logic when investigating complaints. In doing so, with both institutional logics, the SPSO would need to change the way in which it conducts its investigations.

Should the SPSO adopt a dominant accountability logic then it would need to review the manner in which it undertakes its investigations. In *Miller and Howarth v the Health Service Commissioner*, the Court of Appeal found problems with both the standard used by the PHSO when making its judgment and in the procedures used by the PHSO when conducting its investigations. This research found that similar criticisms could be applied to

the approach adopted by the SPSO when investigating complaints. And here lies the opportunity for the SPSO to improve its complaint handling if it models its complaint investigations upon best practice within the field of justice theory. Adopting an approach to investigations based upon best practice in the areas of distributive justice, the reaching of a decision, procedural justice, the procedures used when investigating complaints, and interactional justice, how the SPSO interacts with health boards and healthcare professionals during an investigation, would help improve the relationship between the SPSO and health boards and, the motivational posture adopted by health boards towards the SPSO and their subsequent commitment to implement SPSO recommendations.

An alternative approach that is available to the SPSO is to adopt a dominant institutional logic consistent with a learning logic. In doing this the SPSO could adopt an approach similar to that used by the NHS to investigate significant adverse clinical events[28]. With this method, the focus would be on investigating complaints to maximise learning and would take into consideration the broader context in which healthcare practitioners operate. Such an approach may be appreciated by complainants. As Carney et al. (2017) stated, complainants are often interested in the quality of services, and that making simple binary decisions, such as upheld or not upheld, can be less than satisfactory to complainants, and may also oversimplify complex, multi-faceted issues. In addition, as both Bismark et al. (2011) and Friele et al. (2013) found, an important outcome sought by health complainants is for lessons to be learned. An approach similar to that used in investigating significant adverse clinical events is more likely to be able to secure these outcomes and also take into account the complex nature of health complaints.

[28] For details of this approach, see, for example, M Woloshynowych, S Rogers, S Taylor-Adams and C Vincent (2005)

While health boards did undertake some interactional learning as a result of SPSO recommendations, the informational mode of organisational learning was the dominant mode of learning within health boards. The informational learning mode promotes incremental change, rather than a fundamental review of underlying problems together with a focus on the sharing of information. However, the complex structure of health boards and the delivery of healthcare act against this sharing of information with health board participants recognising that more work needed to be undertaken to improve the situation. Even then, as the primary focus of health boards is on informational rather than interactional learning, there is no guarantee that the solutions identified by health board staff to comply with SPSO recommendations will be adequate or sustainable. This explains why health boards and the SPSO repeatedly see similar complaints.

The underpinning thesis that this research examined is that health ombudsman make an important contribution to the improvement of the healthcare system as a result of the roles and activities that they undertake together with the way that they work with bodies in jurisdiction. In summary, health ombudsman do contribute to system improvement although this is likely to be very limited in nature and, to a significant extent, case dependent. Together these factors help explain why health boards and the SPSO continue to receive complaints of a similar nature.

8.3 Strengths and limitations of the research

The research has the following strengths:

1) The context in which both health ombudsman and bodies in jurisdiction operate is complex. Using a case study design allowed the researcher to take account of this complexity through an ability to

undertake a deeper investigation than would be possible using other methodologies.

2) Recruiting participants from three different health boards and from different levels and departments within each health board allowed for a wide range of views to be collected. This, in turn, facilitated the research's intention to understand the beliefs, attitudes and behaviours of health board personnel.

3) The researcher's insider-outsider status facilitated the collection of data. The ability of the researcher to show understanding and/or empathy encouraged trust from participants who then revealed some very honest views. The openness gained by the researcher from participants allowed for the collection of thick data.

4) The researcher's use of a critical realist research paradigm to identify underlying mechanisms to explain the observed phenomena and, which, facilitated the development of the new conceptual model that help explains the response of bodies in jurisdiction to their ombudsman.

This research has the following limitations:

1) It was disappointing that the researcher could not interview staff from bodies in jurisdiction in Queensland. It would have been of interest to understand how HHS in Queensland responded to the OHOQ.

2) Although the researcher is very grateful to the participants from Scottish health boards, and for the fact that they were drawn from a number of disciplines and organisational levels, there was only one doctor that agreed to participate. Given the responses from participants about the unhappiness expressed by doctors about the SPSO's clinical advice it would have been interesting to discuss this further with doctors, particularly, those doctors who have been involved in a complaint. This would help clarify the motivational postures that they adopted and how they learned from complaints.

3) The research focused on documentary evidence and interviews. There was an attempt at case analysis of published cases but this was not entirely successful. It would have been helpful to have been able to discuss published cases with the health professionals involved in the case and their responses to the reports.

8.4 Scope for further research

This thesis is descriptive research and one of the outcomes is the development of a new conceptual model to describe how bodies in jurisdiction respond to their ombudsman. The model needs to be tested further to ascertain its validity. In particular, this model looked at health ombudsman and health organisations, does this model work in non-health related areas?

Given the role that doctors play in the delivery of healthcare and their centrality to many clinical complaints it would be helpful to establish whether the views of doctors are similar to those found in this research from other health board participants.

It would be helpful to follow the path of an SPSO complaint investigation report upon its publication. This would include interviews with relevant SPSO staff involved in its production, such as the caseworker, relevant healthcare staff involved in the complaint, and staff involved in producing the health board response. In addition, observation of relevant committees and working groups may add important insights.

Academics suggest that the dominant institutional logic in the field of healthcare quality are now the accountability and learning logics with the professional logic now diminished. Participants' comments suggest that the professional logic maybe stronger than thought and it would be interesting to

research the relative strength of these three logics and whether there are any additional institutional logics to be identified, for example, relating to patient centredness.

The SPSO utilises a dominant accountability institutional logic while, for health boards, the learning logic and perhaps the professional logics were more dominant. These logics would, in theory, be in competition for dominance. It would be interesting to research how competing institutional logics between organisations in an accountability relationship interact and are resolved.

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Appendix 1 – Positionality statement of the researcher

As an experienced medical practitioner, health service manager and a former senior member of staff at a health ombudsman I have a strong belief in the importance of the role of health ombudsmen in contributing to the improvement of health services. This belief is strengthened by the fact that health ombudsmen will have, either in the statute that underpins their existence, or their business strategy, the objective of contributing to the improvement of healthcare. The powers that health ombudsmen hold, the discretion awarded them by Parliament, and the insight that should be gained through their investigation of complaints should enable them to be a powerful stimulus for system improvement. The powers held by health ombudsmen should counteract the sizeable power imbalance that exists between healthcare users and healthcare providers. However, there is very limited research into ombudsmen generally, and health ombudsmen in particular, especially in relation to the means used by ombudsmen to improve the system. I am interested in the approaches adopted by health ombudsmen in their system improvement role. Are these approaches a considered proactive approach or a secondary benefit to be gained through complaint investigation and the remedying of any identified individual service failure? Is the undertaking of these activities by health ombudsmen and any concomitant publicity in themselves considered to be suitable evidence of delivery of system improvement or does the system actually react and respond to these activities? My background is both a strength and a weakness. Potential strengths include participants being more willing to be open to me during data collection as they see me as ‘one of their own’; I may understand when they are trying to pull wools over my eyes; and, I may be more able to challenge them accordingly. Potential weaknesses include the fact that potentially access may be more difficult because of my previous experience and I am at risk of introducing preconceptions or biases into the research process and of making assumptions during data collection and analysis. As Willig (2001, p.10) suggests, it will be impossible to remain external to the

research and it is inevitable that I am likely to ‘contribute to the construction of meanings throughout the research process’. These will need careful managing throughout the research process.

Appendix 2 – Research memoire

My research has explored the role of health ombudsman in system improvement and how bodies in jurisdiction respond to the outputs of their health ombudsman. Fieldwork took place in both Scotland and Queensland, Australia. The SPSO and the OHOQ both agreed to act as case studies and, while no health organisations in Queensland agreed to participate in the research, three health boards in Scotland did so agree. In this research memoire, I will consider my position as an insider-researcher and its influence on this research. My background as a medical practitioner, director in NHS organisations in both Scotland and England, as a director at the PHSO and previous research undertaken for my LLM, all influenced my interest in this research area, influencing my research questions, research design, data collection and analysis, and reporting of the research. See Unluer (2012) for a description of the approach used in this research memoire.

The insider-researcher

In my positionality statement, written at the outset of this research, see Appendix 1, I acknowledged my background as a medical practitioner, director of health organisations and as a director in the PHSO. Although none of these roles involved my employment by either the SPSO or the OHOQ, my position as an experienced and senior member of similar organisations to those being researched, with similar responsibilities and objectives, provides me with insider-‘lite’ status in terms of ombudsman organisations. Insider-researcher status arises when a researcher has personal experience of being a member of the ‘group’ under investigation (Attia and Edge 2017). In addition, my medical and health service management backgrounds also provided me with insider-researcher status. Insider-outsider status is not a

binary division but is, rather, a continuum from total insider status to complete outsider (Adler and Adler 1994).

‘The “insider” role is a powerful reflexive position used to gain deeper engagement and insight into participants’ understanding of lived experience’ (Cooper and Rogers 2014, para2.1). While this sounds positive, there are advantages and disadvantages that arise from being an insider-researcher. Advantages include greater awareness of the phenomenon being studied, a shared familiarity with participants that can aid the sharing of information and judging its veracity, and ease of access (Bonner and Tolhurst 2002, Greene 2014). However, insider status may result in a loss of objectivity that arises from prior knowledge of the phenomenon, potentially leading to bias and the making of assumptions (Unluer 2012, Greene 2014).

While the insider-researcher can helpfully take advantage of the positives arising from insider-researcher status, the researcher must be careful to be aware of, and acknowledge, the potential downsides. One approach to doing this is reflexivity. Where positionality refers to the researcher’s knowledge, reflexivity refers to what the researcher does with this knowledge (Educational Studies 2017). Reflexivity ‘is a critical ethos and set of dispositions which enable the researcher to reflect on the basis for their claims to know the social world’ (May and Perry 2017, p.150). Adopting a reflexive approach can help highlight the limitations of the data and how the researcher’s personal positions can be used, when interpreting the data, to justify those positions (May and Perry 2017, pp.160-161). Reflexivity has been described as an ongoing process ‘to continuously construct (and shift) our understanding and social realities as we interact with others and talk about experience’ (Barrett et al. 2020, p.10). It is, therefore, ‘important to tell your reader how interpretations were formed … that influenced the write-up and conclusions of your study (Barrett et al. 2020, p.11).

It is this that I now attempt to do and, in doing so, I will use a similar structure to that describing the methodology contained within the Methodology chapter.

At the outset of this research, my view of what was an ombudsman, was rather old-fashioned in nature, with a view similar to that of the International Ombudsman Institute, based upon the classical interpretation of ombudsman and in keeping with the definition produced by the International Bar Association. In this definition, there is a focus on complaints against government agencies and where an independent ombudsman scheme is established by, and accountable to, parliament. My view was strongly influenced by my limited ombudsman experience working for the United Kingdom's Parliamentary and Health Service Ombudsman (PHSO).

However, during the period that this research was undertaken, but unrelated to this research, I was involved in reviews of three Australasian private sector ombudsman schemes. In doing so, my view of ombudsman schemes changed, driven, in large part, by the views of service users and bodies in jurisdiction of the Australasian ombudsman schemes. I realised that what was important was that the legitimacy of ombudsman schemes came from the consideration of complaints that they received, their independence from the parties involved, and that the ombudsman schemes enabled an equalisation in the balance of power between the parties involved, although I recognised that this last feature is always likely to be partial, given that bodies controls the information and sometimes expertise. These are similar to the essential characteristics of an ombudsman described by Gottehrer and Hostina (1998).

This change in view brought me to a position more in line with the later definition produced by the American Bar Association, see p.24. This

definition allows for a broader consideration of what is an ombudsman and focuses upon the importance of complaints, the independence of ombudsman schemes when carrying out their functions, and allows for a plurality of approaches to complaint handling. This conclusion is contrary to what I believed at the start of the research. However, discussing with participants from the OHOQ, their views on the objectives of the OHOQ, and the emphasis from all participants on issues of professional misconduct with little emphasis on in-house complaint handling caused me to review my ideas. I had to move away from the name of the organisation and its headline activities to focus on what the OHOQ actually did in practice which was more restricted.

Issues relating to research design

I adopted a case study approach to this research allied to a critical realist research paradigm in this research and case studies lend themselves to this research approach (see Methodology chapter). In understanding how health ombudsman contribute to system improvement, and, how health organisations respond to their ombudsman, requires a detailed understanding of the motives, thoughts and behaviours of individuals within these organisations. It will be the agency of individuals that dictates what happens and why. Adopting a case study approach to this research, using a qualitative approach, provided me with the opportunity to secure a full understanding of participants thoughts and motivations and which could be supplemented and corroborated through documentary analysis.

Determining the case

I worked for many years at the PHSO. Within the PHSO, and public service ombudsman in the UK more generally, there is an assumption that

ombudsman contribute towards system improvement. At the PHSO it was seen through the recommendation for action plans in response to upheld complaints and in the thematic reports that the PHSO intermittently published. At a personal level, I was sceptical about the ability of action plans to bring about sustainable change due to my experience as a health service director. I was aware that the health service was capable of producing action plans that appeared to resolve the issue, yet did not actually result in the necessary change.

I had more hope that change would arise from thematic reports. Thematic reports involved the compilation of similar cases looking for root causes. While it was true that thematic reports garnered the PHSO some high-profile publicity, it was less clear that they resulted in significant change as the PHSO continued to receive complaints about the same issue.

I also undertook a Masters in Law where my thesis was on the role of the PHSO in the regulation of healthcare. My research found that the PHSO's belief that it contributed towards system improvement was more aspirational than real. From this insight, I wanted to investigate how did health ombudsman contribute to system improvement and how did health organisations respond. It was clear that there was little empirical evidence to support the ombudsman's claim of this 'ombudsman dividend' (Abraham 2012).

When I began this research, I did approach the PHSO to enquire whether they would be willing to for me to include the PHSO as a case study. However, this would have been potentially very problematic. Not only would it have entrenched more deeply my insider-researcher status, it may well have increased the possibility of subjective research. At that time, I was a director of the PHSO and being an employee would significantly complicate the

relationships with participants, not only within the PHSO but also with bodies in jurisdiction. In addition, should the research make findings with which the PHSO would be uncomfortable, I may subconsciously try to sugar coat the findings.

In determinising the case I therefore used criteria sampling, using English language ombudsman, health ombudsman that considered a sizeable number of complaints, and, ombudsman which had an objective of contributing towards system improvement. For United Kingdom ombudsman, having ruled out the PHSO, it left me, effectively with the SPSO. In my ombudsman role, I had worked with the SPSO, not always with ease but a relationship enacted with respect and some friendliness. The relationship between the SPSO and Queen Margaret University was also helpful in securing the agreement of the SPSO to participate. In Australia there were two contenders. The NSW HCCC and the OHOQ. I approached both but the NSW HCCC did not reply. The OHOQ did reply and, following a meeting with the then ombudsman, the OHOQ agreed to participate.

Identifying the research questions

Three research questions were identified to enable me to answer my research aim.

1) What approaches do the OHOQ and the SPSO take to administrative justice?
2) What approaches do the OHOQ and the SPSO, with their differing statutory functions, use as they seek to secure system improvement?
3) How do those in the healthcare system receive and respond to these approaches?

In relation to question one, concerning ombudsman approaches to administrative justice, this was a concept that I acquired as a result of my Masters in Law thesis. I was interested in this idea, as it was unclear whether the PHSO adopted the model of bureaucratic rationality or professional judgment and the academic literature, suggests that the dominant model of administrative justice adopted by ombudsman would influence both their priorities and how they deliver their responsibilities.

The intention was to discuss this with ombudsman participants to understand their thoughts about this aspect of ombudsmanry and also with participants form Scottish health boards. But neither this concept, and certainly not the associated models of administrative justice, had any resonance within the PHSO. This is not to downplay the importance of the models as they are helpful in understanding how ombudsman approach the delivery of their functions, but, rather, a recognition that the language and ideas of academia may not be in wider social usage.

I did test this out when I trialled the semi-structured interview schedule. I found that I had to explain the concept and models and people needed to have time to reflect. I thought this line of questioning would not work in an actual research interview. Apart from the time issue, the question may make the participant feel ignorant or suggest that I was living in an ivory tower. I therefore decided not to include this line of questioning but focus on answering it through questioning participants on the role and objectives of their ombudsman office along with how they undertook and reported their work. This applies, particularly, with healthcare where models of administrative justice have no immediate resonance with participants.

In relation to question two, I was aware that differing ombudsman offices had differing statutory responsibilities. This knowledge was of particular interest to

me as I wanted to know how these differing responsibilities affected their activities. To this extent, this was a question to which I did not know the answer.

However, by the time of the interviews with participants from the SPSO I had undertaken desk research on the activities that the SPSO undertook which augmented my understanding from previous personal experience. As a result, I entered the interviews believing that I had a good understanding of the activities, such as complaint investigations, reports, newsletter and educational activities, that the SPSO undertook in pursuit of system improvement. This led to a challenge in formulating questions for the interview. I did not want the interview to feel as if it were a test but, rather, I wanted it to be an understanding of how different parts of the SPSO understood the role of the SPSO to system improvement and what they believed the SPSO did to succeed in that role. Dependent upon their organisational position within the SPSO, participants may have different understandings and responses to these questions. I therefore tried to have questions that were as open as possible and avoided any question that seemed to be suggestive of a list. This approach did run the risk that participants may provide only incomplete answers, where further prompting may have produced fuller answers. I felt that this was an acceptable trade off as, I thought that, if the participant needed prompting to answer the question, then this was indicative of prioritisation. Responses could be fleshed out by asking open questions about roles, objectives and processes and by triangulation with published material.

This was less of an issue for the OHOQ as they provided less information about their activities on their website and was, to me, a new organisation. Nonetheless I adopted a similar approach as for the SPSO.

In relation to question three, a similar issue arose when asking participants about their awareness of ombudsman activities intended to contribute to system improvement. In practice, I adopted a similar approach as to questioning ombudsman participants about their activities aimed towards system improvement. That is, I asked open questions without prompting in order to identify those activities of which participants were immediately aware. Again, this ran the risk that incomplete answers would be provided, or that answers would focus on something that had only recently been brought to the participant's attention but, again, it was felt that this approach would provide a more accurate answer of everyday awareness.

In the end, I think that the approaches to questions worked effectively. While I accept that participants from both ombudsman and health boards may have been able to provide fuller answers if prompted, I do think that prompting would have maybe provided answers that were not an accurate reflection of their everyday life.

Data collection

Adopting a case study approach necessitates the collection of in-depth data. A variety of data sources are available (see Methodology chapter) and in this research the kay data collected was semi-structured interviews with participants from both health ombudsman offices and three Scottish health boards and documents published by the offices of the two participating health ombudsman.

Being an insider-researcher brought some advantages to the interview process. With my background in ombudsmanry, clinical practice and health service management, I entered the interviews with a good knowledge of how

the systems broadly operated, the language used and was able to demonstrate this understanding with participants.

However, being an insider-researcher also has disadvantages. Familiarity with the material may mean I overlook certain comments or not play sufficient attention to what was being said; I may make assumptions about what was said and, therefore, fail to ask clarifying questions, participants may assume I know certain facts about which I am unaware, and, my closeness to the data may prevent me from seeing the entirety of the picture (see Unluer 2012, p. 6). To overcome these potential disadvantages, I undertook the following steps: I had a set interview schedule to which I adhered. I did not follow this slavishly but rather allowed the natural contours of the conversation to shape the discussion. However, before closing the interview I checked that all interview areas were covered. At the start of the interview I stressed to participants that there were no right or wrong questions but what was needed was full answers even if this was a 'don't know'. The interview schedule was prepared before the interviews with participants commenced, and was based upon the research questions, literature review and desk research. As the interview process progressed, it became clear that certain points were being raised about which I wanted to know more. The later interviews included these additional areas.

During interviews, researchers often need to adopt positions which encourage appropriate replies, particularly if such replies are sensitive (Sim and wright 2002). As a result of my insider-researcher status, I was able to demonstrate empathy to participants about the issues that they faced and a shared understanding of issues by, perhaps, citing an example from my experience at the PHSO. Such approaches may encourage participants to be more open and feel confident about sharing their views. Doing so, 'can increase the credibility of the research' (Darawsheh 2014, p.562). For example, eliciting views of the SPSO such as the SPSO being the 'grim

reaper' or the other evocative views of the SPSO may have been harder to gain if I was not an insider-researcher.

Attia and Edge (2017) discuss a four-stage iterative approach to data collection from participants. There is a need for the researcher to establish *trust* with participants, that encourages participants to *collaborate* with the researcher. Close collaboration between researcher and participant encourages the production of credible data, including the provision of 'insider information' which helps *corroborate* the data provided. Finally, the researcher demonstrates their *trustworthiness* by behaving ethically towards the participants.

To facilitate trust, before the interviews, I sent each participant an information sheet explaining the purposes of the research, the role of the participant in the research, how their information may be used and that they can withdraw at any time up to the submission of the thesis. Before the interview commenced, I went through this again and, only then, was informed consent obtained. By providing details about the research and their role and powers, I attempted to develop a cooperative approach. This was emphasised by stressing that there were no right answers to any questions and that, a 'don't know' response may be very helpful indeed. I tried to adopt an interview approach that was open and would not come across as a test. By using multiple participants and other sources of data corroboration of participant accounts was obtained. Finally, I tried to establish my trustworthiness by stating that participant statements used in the thesis would be anonymised and every effort made to ensure that the health boards could not be identified. No objections were raised. By doing so I wanted to ensure that I did not provide right accounts through inadvertently doing wrong to participants (Richardson 1992).

As well as obtaining ethical approval from Queen Margaret university, a health board in Scotland and also from a HHS in Queensland, I tried to behave ethically by being aware of the importance of the contribution made by participants and keeping to the commitments made by me to them. I did not share responses between participants, even anonymised. On several occasions, participants made comments after the tape recorder was switched off, and which would have been useful in the thesis. I have not used this data as this would breach the commitment made to the participants prior to the interview.

The first set of interviews undertaken were with participants from the SPSO. I was actually quite nervous at the start of the first interviews. This was a new role for me in my relationship with the SPSO. How would my previous relationship play out in this new relationship? In the event, the interviews went very well. All participants answered readily and without hesitation. The flow to the interviews seemed unstilted. Participants appeared happy to talk about what they do and proud about it as well. I came away from the interviews very impressed with the SPSO and what they were trying to achieve. The impression was of an office committed to delivering the best service that they could to complainants while also trying to help health organisations be successful. My note at the time describing the SPSO was that they were less big brother and more big sister.

During the interviews with participants from the SPSO, the researcher was struck by their determination to try to improve the healthcare system and recognised that their new approach to recommendations was an attempt to correct the challenges that he had identified from his experiences. This positivity very much impressed the researcher. As a result, at the end of the interviews with SPSO participants, the researcher was less sceptical and cynical about the ability of recommendations to bring about service improvements. However, the interviews with the SPSO participants predated

the interviews with health board participants and so the researcher was unaware of the less positive views expressed by health board participants.

These thoughts, arising from the first set of interviews, reinforced my positionality statement of health ombudsman being able to contribute towards system improvement.

My second set of interviews were with participants from the OHOQ and took place a few weeks after the interviews with SPSO participants. Prior to my arrival for the first interview I had been informed that the Ombudsman was no longer able to participate, but it was only explained to me upon my arrival for the first interview that the reason that the interview had been cancelled was that the Ombudsman had been recently suspended by the Minister for Health. Nevertheless, directors were willing to honour his commitment to participate and I remain very grateful to them for doing so. Participants were all very helpful. They were brave enough to discuss frankly some of the problems that had been experienced by the office since its establishment, such as inherited backlogs of cases, funding issues, difficulties with understanding the reach of its legislation. There was a sense obtained through the interviews of a commitment to delivery. The interviews went well but my reflection, post- interviews, was of discussions that I could have had with directors from any ombudsman office. The one thing that did surprise me post-interviews was my view that the ombudsman was not an ombudsman. Rather, I thought, it to be a health regulator. Which it is, but only in part.

There was a gap of between six to eight months with my interviews with participants from the three health boards. There had been a restructuring of health services since my time as a health service director in Scotland and I had an initial misconception that a unitary health board was a unitary organisation. In reality, they were multi-unit organisations. Hospitals appear

to be run as independent units with their own management team within an overarching health board structure. There was replication of roles and structures within these semi-autonomous units. Participants were aware of my background, particularly at the PHSO, yet they answered readily and frankly. They were open about what they believed that they had done well and things they believed that had performed not so well. There was no attempt to portray themselves as without fault. They expressed mixed views about the SPSO although, overall, it was more negative than I anticipated prior to the interviews. Despite my lack of knowledge about health board structures, the delivery of care in Scotland faces the same issues as I experienced in England. This understanding of the pressures that they faced when undertaking their job enabled me to probe them in an informed and sensitive manner. Some of the language used by health board participants did surprise me, such as grim reaper and talk of being in fear. Their sense of the SPSO was at variance with what the SPSO informed me that it wanted to project. The concern about the lack of communication between the SPSO and health boards was not a surprise. It is typical of public service ombudsman to conduct desktop paper-based investigations.

Data analysis

Due to my insider-researcher status there is a risk of bias affecting my analysis of the data. To overcome this potential bias, I have used multiple sources of data, using triangulation for corroboration, offered a detailed description of the research settings and participants, provided thick description in the results section and reflected on notes taken during the research process.

A thematic analysis approach was adopted to analysing the data. In undertaking this analysis, a theoretical approach was utilised in order to test

out the conceptual model arising from the literature review and theoretical considerations. A list of potential themes derived from the model was developed and the data analysed at the semantic level. Adopting this approach was intended to provide a rigour to the data analysis by providing a framework which linked the data to the extant literature and to the developing theory. During the data analysis, it became evident, and as was suspected before the data analysis commenced, that not all data could be fitted into the pre-determined themes and additional themes were developed as the data demanded.

During the subsequent analysis, some themes were collapsed into others where it was felt that the differences between themes was too small or where there was very little data contained within a theme. This was an iterative process which aided the analysis.

Conclusion

At the beginning of this memoire it was noted that the positionality adopted by the researcher can affect the entire research process from design to conclusions. But this effect is not unidirectional. The act of conducting the research, analysing the data and drawing conclusions will influence the positionality of the researcher. Positions can shift during the research process (May and Perry 2017).

During this research, the positionality of the researcher has, indeed, shifted. In my original positionality statement, I stated, ‘I have a strong belief in the importance of the role of health ombudsmen in contributing to the improvement of health services’ and that their roles and powers ‘should enable them to be a powerful stimulus for system improvement’. However, I am less optimistic now than I was when I began the research. While health

ombudsman are able to contribute to system improvement, it is not as I thought. It is patchy, dependent upon the nature of the relationship between health ombudsman and health organisation. This relationship drives the motivational posture adopted by the health organisation. However, the relationship is, in turn, driven by the institutional logic adopted by the health ombudsman. As both the SPSO and the OHOQ are driven by an accountability logic, and not a learning logic, their ability to catalyse change is impeded.