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Presentation by IOI President Peter Tyndall
on international best practice of how to be more effective

Improving services?

I want to start by saying a little about the IOI. The IOI is the only global Ombudsman organisation. We have almost 190 members in more than 90 countries worldwide. The Headquarters are in Vienna. The Secretariat is provided by the Austrian Ombudsman Office and funded by the Austrian Parliament.

Last year, the IOI and the Ombudsman Association signed a Memorandum of understanding at the Annual Meeting in Dublin. There has been extensive co-operation between us, for example, in the field of training. In the coming year, the IOI will be considering the adoption of global service standards based on the OA's work.

IOI membership fees are devoted to providing services for members. These include training, research, small regional grants, conferences on current challenges and best practice papers. The training provided by the IOI has included courses run by Queen Margaret University based on the initial work of the Ombudsman Association and this training has recently been provided in Spanish in Latin America and will shortly be delivered in the Caribbean. Small grants have included support for the Northern Ireland Ombudsman's Human Rights toolkit and the Conference at which it was launched. The IOI has worked to make sure that this best practice developed in these islands is spread internationally.

IOI voting membership is open to all public service Ombudsman offices. This includes specialist offices such as those dealing with complaints about the Police or armed forces as well as the general public service ombudsman schemes. As with the Ombudsman Association, there are strict criteria especially regarding independence for full membership. The IOI will shortly be introducing tiered membership fees to be more accessible to smaller offices. The IOI also works to support offices under threat and has actively intervened in support of members, for example, in Poland.

The aspect of the work of the IOI I want to touch on today is the production of Best Practice Papers. The first in the current series concerns best practice in establishing and reforming Ombudsman schemes. It seeks to supplement the Bylaws by addressing how to ensure that the schemes developed or reformed can fully comply with them and reflect best practice. I would suggest that the OA might do well to adapt it to the circumstances of these islands and in particular, to cover schemes in the private sector.

There are two new papers planned. The first is about own initiative investigation. It will address topics such as how to choose the subject of the investigation, resourcing, investigation techniques and maximising impact. The draft is being developed by my Office in conjunction with the Ombudsman of Ontario.

The other paper is particularly relevant today. It's about being effective in achieving systemic change. We have started with some simple research and I will refer to that later. I want to particularly thank Emer Doyle in my Office for her work on this to date.

Every Ombudsman will talk about the dual functions of the Office – resolving injustices suffered by individuals and improving services. However, how sure are we that the changes we recommend to service providers are implemented, and if they are implemented, that they have secured the desired outcome – that the injustice suffered by our complainant is not being suffered by subsequent users of the service.

I want to start with a cautionary tale. When I was PSOW, I dealt with a complaint about poor end of life care in a hospital in North Wales. The characteristics are all too familiar, little respect shown for the wishes and dignity of the patient, poor palliative care meaning unnecessary suffering, a failure to provide food and drink in line with the agreed schedules, poor record keeping, and insufficient attention to toilet requirements leaving patients wet and soiled. When you get a case like this, it's obvious that what happened to one person will almost certainly be happening to others, so the recommendations are designed to address the systemic issues. They will include requirements to review or change procedures, re-training, questions about staffing levels and qualifications and so on.

In this instance, the Office received a comprehensive response, and an action plan was drawn up and signed off and confirmation was given that the agreed actions had taken place. I was happy with this outcome, and thought little more of it until two near identical cases turned up at the Office with the events having taken place after the agreed changes had been made. This was further reinforced by a letter I received from the daughter of a man who had died in the hospital ten years previously and a copy of the then Ombudsman's report and the press coverage it had received at the time.

I stepped up my engagement with the management of the health service in Wales within the Welsh Government, the media and the Welsh Assembly. Ultimately, the Chair and Chief Executive of that Health Board resigned.

That did not, however, solve the problem. The culture of neglect was endemic in that context. I don't want to suggest it affected the whole hospital, but some wards and some shifts simply did not have the kind of culture which is compassionate, professional and respectful of the rights and dignity of the patient. Neither the management nor the Board were capable of exercising the effective leadership required to bring about sustainable change. They too accepted reassurances that action had been taken, without checking whether it had brought about the desired outcomes. I will return to this case later but it does illustrate the difficulties involved in changing culture, as opposed, to policy, process or even the law.

That's enough depression for now! Some positive examples are also worth considering. Last year, my Office dealt with many complaints from Leaving Certificate students. This exam is the one that governs access to higher education like A levels or the Scottish Highers.

Students who need support because of a disability were able to access the Reasonable Accommodation at Certificate Education (RACE) scheme. Through this they could obtain necessary supports such as a reader, scribe or access to a word processor. The criteria were set out reasonably clearly and the application process was straightforward. However, at the Junior Certificate level the decision on eligibility was made by the school. At the Leaving Cert, it was made by the State Exams Commission, who tended to apply the criteria more rigorously.

The effect of this was that students who had had support in the run up to the exams were denied that support for the exams themselves. Many appealed the decision and in some instances, they learned that their appeal had been refused very shortly before the exams took place. We worked very hard to deal with their subsequent complaints to my Office, as did the Ombudsman for Children. Some complaints were resolved as late as the weekend when the exam started.

We resolved to ensure that the same thing didn't happen this year by requesting significant changes to the scheme. As a consequence, the decision on whether a pupil is eligible for support will now be made in advance of the Junior Certificate, and that decision will determine eligibility for support in the Leaving Certificate. It's a bit early to be entirely sure that the changes have had the desired result, but all the indications suggest that they have.

I'll come now to Emer's initial research on effective recommendations. We received 7 submissions on this issue and also took account of a paper published in 2015 by the Office of the Toronto Ombudsman on The Impact of Ombudsman Investigations and spoke with the Office of the Scottish Public Services Ombudsman and the Northern Ireland Public Services Ombudsman. We also looked at reports from the Ombudsman of Western Australia which highlighted steps taken on the implementation and follow-up of recommendations while the Federal Ombudsman of Belgium provided extracts of a publication from 2011 on the consolidation of the Ombudsman in the 21st century.

We have considered the findings under a number of headings - relationship building, the investigation, framing recommendations, sharing the recommendations, follow-up and enforcement.

Relationship building

The process of getting recommendations accepted begins before they are even presented – Ombudsman of Ontario

Ontario emphasized the importance of starting from a position of trust. The relationships established in the day-to-day interactions between the Ombudsman's Office and bodies in jurisdiction will have an impact on the effectiveness of systemic investigations and making recommendations for change in policy procedures. However, fundamentally, the Ombudsman must be fair in the investigative process. This should involve providing advance notice of the investigation – ideally with a meeting. The purpose of this meeting is not so much to try and mediate a settlement but instead to explain the reasons for the investigation, to commit to a fair and impartial investigative process and to invite input from the body at any time.

The investigation

The Parliamentary Ombudsman of Malta said that the ability to secure results depends exclusively upon the quality of the arguments, the respect the institution enjoys and the moral authority it exercises.

According to Ontario, the credibility of the investigation affects the recommendations and, in particular, the likelihood that they will be accepted. This involves compiling irrefutable evidence and employing a procedurally fair and thorough investigative process. New South Wales now focuses on ensuring that its draft investigative reports clearly demonstrate that there is a problem and why it

needs to be addressed. [Likewise the report from the Ombudsman of Toronto advised that the Ombudsman should rarely conduct an investigation if the problem was already being addressed provided it was an appropriate fix. Resources should not be used to address problems that the public service is already solving].

In the context of securing meaningful change, I would add that your investigation must irrefutably establish that the injustice arises from a systemic failure rather than a one off occurrence.

Framing recommendations

A critical element of the accountability and learning process inherent in recommendations implementation is the framing of clear, concise and practical recommendations arising from investigation and audit reports to agencies – Ombudsman for South Australia

South Australia uses the SMART goal setting method as a well-established project management tool to identify criteria relevant to the setting of objectives. In other words the recommendations must be –

Specific – what will the recommendation accomplish?
Measurable – how will we measure whether the recommendation has been implemented?
Achievable – Is the recommendation possible?
Results-focused – What is the result of the recommendation?
Time-bound – What is the completion date for the recommendation?

According to South Australia, the principal advantage of this is that they are easier to understand, to do and then be confirmed as having been done. For Ontario, the recommendations must be doable, feasible and grounded in the realities of any given situation. To ensure this, it is important to listen to the views of those who will have to implement the recommendations and to make all affected parties feel part of the process. In Scotland, the focus is on outcomes-based recommendations rather than process-based ones and linking specific findings to recommendations. Finally, when circulating a draft report to the body concerned, New South Wales asks for its suggestions as to how the identified problems could best be addressed. If these suggestions are accepted, bodies appear to have a greater sense of ownership of the recommendations in the final report.

Sharing the recommendations

By discussing the recommendations, the parties addressed can comment on their feasibility and how to achieve them. The result of this method is that recommendations are more realistic and at the same time creates a dialogue on the progress of implementation – National Ombudsman, The Netherlands

New South Wales has always provided draft recommendations to bodies for comment prior to finalising reports and will take any reasonable suggestions for changes into account in the final report. Ontario also provides its proposed recommendations along with the preliminary draft report to the body concerned as, more recently, do the Netherlands and Northern Ireland – Northern Ireland referred to it as “owning the learning”. Ontario advises that explaining to the body that it will have the opportunity to review and comment on draft recommendations prior to them being finalised and made public promotes buy-in. [The report from Toronto also highlights the significance of discussing the recommendations to ensure that they are achievable].

Follow-up

In some cases [implementation] requires liaison with agencies to encourage and support actions to address recommendations made by the Ombudsman – Ombudsman for South Australia

Ontario incorporates a robust post-investigative monitoring process. Key elements of this strategy include a recommendation in every report that the body report back to the Ombudsman – in writing and at specific intervals – on its progress in implementing the recommendations, analysing these reports and reporting publicly on the body's progress as well as monitoring relevant information from other sources, for example from other complaints. (Scotland also referred to the importance of internal casework knowledge management in this regard). Launching another investigation is considered to be a last resort to be used only when key problems identified in the initial investigation have been ignored or not dealt with effectively. However, the Netherlands has completed a number of retrospective studies which can make visible the practical problems of implementing recommendations. New South Wales always includes a requirement in its final reports that the body provide detailed advice as to the actions taken on recommendations.

Likewise, in Austria, bodies are obliged (under the Austrian Ombudsman Act) to comply with recommendations within a period of 8 weeks and to give reasons in writing why the recommendation has not been complied with within that timeframe. In Northern Ireland, compliance is time-bound and actions plans are developed. It is the responsibility of the investigator who conducted the investigation to follow up on compliance in the first instance with possible escalation to the Director and then the Deputy Ombudsman / Ombudsman. However, in South Australia, a small Recommendations Implementation Team is responsible for documenting progress and implementation of recommendations. Similarly, in Scotland, a Learning and Implementation Unit monitors the implementation of any recommendations made. In Pakistan, independent advisors are assigned the task of following-up on the implementation of recommendations. Both Scotland and Pakistan also referred to the use of their IT systems as an effective way of classifying and tracking recommendations.

Enforcement

While we do not have the power to compel acceptance and implementation of our recommendations, we do have an important and effective tool in the power to publish. Ultimately, our power is in our voice – Ombudsman of Ontario

With the exception of Pakistan, where in cases of non-implementation, notice of defiance proceedings (and, in some cases, contempt proceedings), can issue, there does not appear to be any legal mechanism of enforcing implementation of recommendations. (There is a provision in Northern Ireland to request the Attorney General to apply to the High Court for relief but this provision has never been used). New South Wales can make a default report to Parliament although this mechanism has not been used for at least the past two decades. Malta can also report on non-implementation by sending a copy of the report to the Prime Minister and thereafter report to Parliament. However, this procedure has had very limited success and does not attract a high level of publicity. Ontario uses media engagement and the power to publish in an effort to secure implementation of recommendations. Likewise, in Austria, the television programme BürgerAnwalt (Advocate for the People) and the media exposure involved creates incentives for the authorities to find solutions.

Conclusions

Securing effective change can best be achieved with a number of key steps.

- A clear focus for the investigation
- Thorough and objective consideration of the issues
- The identification of a systemic cause
- Recommendations which are specific, clear and time-bound, and which relate explicitly to the findings
- Recommendations agreed with the body in jurisdiction
- An action plan setting out the steps to be taken
- An agreed reporting timetable
- Follow-up if necessary

My example earlier where change was not achieved relates to a case where there were cultural as well as procedural issues. In such cases, reassurance that procedural steps have been taken is not sufficient. Evidence that Board Members and Senior Managers are satisfying themselves on the ground that the steps have been taken **and** that they are securing the designed outcome are essential. Quality control mechanisms need to be in place which do not rely on the people who caused the problem to confirm its solution. Sometimes too, you have to change the people!

Peter Tyndall

Emer Doyle

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