Hywel Dda University Health Board

Review of PADR Process

FINAL INTERNAL AUDIT REPORT

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Assurance Rating

LIMITED Assurance

Previous Assurance Rating:
Audit not undertaken previously

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Auditor/s:	Rhian Williams & Arthur Burke
Executive sign off:	Lisa Gostling Director of Workforce & OD
Committee:	Audit and Risk Assurance Committee

ACKNOWLEDGEMENT
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1. Introduction and Background

The assignment originates from the Internal Audit Operational Plan 2018/19 and the subsequent report has been submitted to the Executive Director and Audit & Risk Assurance Committee.

The relevant lead Executive Director for the assignment is the Director of Workforce & Organisational Development and the operational lead is the Assistant Director of Workforce & OD.

Personal Appraisal Development Review (PADR) forms part of the mandatory management process established within the Health Board. PADR is a means by which managers are able to ensure employees understand their value to the organisation and their team, and give them the opportunity to discuss ways in which they can be more personally fulfilled in their role. It assesses an employee's skill and competence to undertake their role as described in their job description, but also takes into account the way in which their behaviour in their role reflects the values of the Health Board.

2. Scope and Objectives

The overall objective of this audit was to review the quality of completed PADRs ensuring they provide a meaningful appraisal for both the employee and manager.

The scope of this review has focused on a sample of wards and departments based at Bronglais and Glangwili General Hospitals, Corporate, Community and Mental Health Directorates.

3. Associated Risks

The approach to audit assignments is risk based, where the risks are identified with the lead manager. Controls would then be identified to manage those risks and the assignment scope designed to provide assurances on those issues.

The risks considered during this review are as follows:

i. Poor and/or incomplete PADR documents; and
ii. Inaccurate performance figure submissions.

The outcome of this review can be linked or contribute towards the Board Assurance Framework and Health and Care Standards 7.1 (Workforce).

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

Concluding fieldwork, we can confirm PADRs had been undertaken for all sampled employees, with their appraisals held locally. However, a high priority finding was identified with the lack of SMART principle objectives being consistently set for individuals and objectives not being relevant to the overall department.

We also noted two medium priorities relating to managers and leads not having received PADR training to aid them in undertaking appraisals, and discrepancies identified by ward/department leads in regard of PADR compliance figures recorded in ESR, with one team continuing to maintain a local record.

Therefore, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the review of PADR processes is **Limited** assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual risks is described in the table below:

Assurance Summary					
Audit Area					
1	Quality of completed PADRs		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design of the PADR process.

Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weaknesses in the operation of the designed system/control of the PADR process. These are identified in the Management Action Plan as (O).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

PERSONAL APPRAISAL DEVELOPMENT REVIEW

An Electronic Staff Record (ESR) report was obtained from the Workforce Intelligence Team that detailed the PADR compliance levels of organisational cost centres as at 28th February 2019.

A sample of 11 wards and departments were chosen based upon their PADR compliance levels, focusing on Bronglais and Glangwili General Hospitals, Corporate, Community and Mental Health Directorates.

A total of 56 PADRs were reviewed to ensure personal objectives set for each employee complied with the SMART (Specific, Measurable, Achievable, Realistic & Timely) principle set out in the *Performance Appraisal and Personal Development Plan Policy*.

Of the 56 PADRs reviewed, 249 personal objectives had been set. Whilst we noted that the majority of objectives were achievable and realistic, there were a large number of objectives across the departments audited that were not specific or measureable – see Table A below for a breakdown of each cost centre tested.

We only noted three instances where an explicit timeframe had been included against objectives. Whilst the Health Board's PADR template specifies the setting of personal objective to be achieved over the year, in some instances this may take longer to complete, such as a professional qualification, and therefore a designated timeframe should be recorded.

Whilst reviewing the documented personal objectives, we noted a number that did not link to the organisational, departmental or team objectives as per the *Performance Appraisal and Personal Development Plan Policy*.

See Finding 1 at Appendix B.

TRAINING & COMPLIANCE

A log of all individuals that have received either bespoke PADR training or training via the NHS Passport Scheme was obtained from the Education & Development Manager. Of the 11 wards and departments tested, we noted that no employees had received bespoke PADR training from the following wards and departments:

- Blood Sciences BGH
- Blood Sciences GGH

- Catering BGH
- Endoscopy BGH
- Ceredig Ward BGH
- Finance
- Pharmacy BGH

Whilst visiting the sampled wards and departments, we discussed with the manager and/or lead to establish whether the PADR compliance figures were accurate – see table below.

Organisation	Assignment Cou	Reviews Complete	Reviews Completed
100 CAR GGH Flying Start (HV) 1208	24	0	0.00
100 CER BGH Endoscopy 0570	12	8	66.67
100 CER BGH Blood Sciences 0408	39	13	33.33
100 CAR GGH Blood Sciences 0204	64	24	37.50
100 HDUHB Finance Department 0372	74	51	68.92
100 CER BGH Ceredig Ward - General Surgery 0558	25	24	96.00
100 CER BGH Pharmacy 0418	30	29	96.67
100 CAR GGH CDU 0069	46	45	97.83
100 CAR GGH SCAMHS Primary Mental Health 1110	14	14	100.00
100 CAR PPH Community Dental 0132	20	20	100.00
100 CER BGH Catering 0535	30	30	100.00

We noted three instances where the ward/department lead contested the compliance figures recorded in ESR.

- We were informed by the Blood Science Locality Lead at Glangwili General Hospital that they believed approximately 83% of their staff had received a PADR review, rather than 37.5% as noted in ESR.

- The Flying Start Team at Glangwili General Hospital retained their PADR compliance figures on a local spreadsheet and did not record the information into ESR.

- We were informed by the Staff Nurse at Ceredig Ward Bronglais General Hospital that only six PADR were compliant at the time of testing rather than the 24 (out of 25) as reported in ESR.

See Finding 2 & 3 at Appendix B.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	**1**	**2**	**0**	**3**

Table A – Breakdown of Sampled PADR Reviews

WARD/DEPT	NO. OF PADR REVIEWED	TOTAL OBJECTIVES REVIEWED	SPECIFIC		MEASURABLE		ACHIEVABLE		REALISTIC		TIMELY	
			Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
Blood Sciences WGH	5	19	8	11	9	10	18	1	18	1	0	19
Catering BGH	5	17	5	12	5	12	17	0	17	0	0	17
Ceredig Ward BGH	6	22	5	17	1	21	22	0	22	0	0	22
Endoscopy Dept. BGH	5	26	12	14	10	16	26	0	26	0	0	26
Pharmacy Dept. BGH	5	20	4	16	4	16	19	1	19	1	1	19
Community Dental PPH	5	20	7	13	4	16	18	2	18	2	0	20
Finance Dept.	5	22	10	12	4	18	21	1	21	1	1	20
SCAMHS Primary Mental Health	5	17	1	16	0	17	17	0	17	0	0	17
Blood Sciences GGH	5	37	25	12	17	20	36	1	36	1	0	37
Flying Start Team	5	28	12	16	1	27	21	7	21	7	1	27
CDU Ward GGH	5	21	14	7	6	15	20	1	20	1	0	21
TOTAL	56	249	103	146	61	188	235	14	235	14	3	246

Finding 1 (O) – SMART Objectives	**Risk**
A review of 56 PADRs, noted that the majority of objectives were achievable and realistic. However, there were a large number of objectives were not specific, measureable or timely across all the departments audited. Whilst reviewing the documented personal objectives, we noted a number that did not link to the organisational, departmental or team objectives as per the *Performance Appraisal and Personal Development Plan Policy*.	Non-compliance of individual personal objectives with the SMART principle.
Recommendation 1	**Priority level**
Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
Following receipt of this audit, the Director of Workforce and OD has reviewed and inspected all 56 PADRs audited as part of this review. In response, the Organisational Development team has already begun to review the PADR Policy, process and training provision. Specifically the layout of the documentation will be reviewed as reflecting on the audit findings the layout is not conducive to the recording of SMART objectives as per the Policy. Having reviewed all PADRs 89% are of very good quality with a high level of detail around objectives however to comply with the policy they must be documented differently.	Head of OD 30th November 2019

There were some (6) examples of particularly poor PADR documentation and all Executive Directors have been made aware of the content of these and have been asked to cascade to managers that the University Health Board does not tolerate poor performance management. It should be noted they were all from the same department. All objectives should be appropriate and lead towards the delivery of University Health Board Objectives.	Director of Workforce & OD Completed – 17th May 2019
Individual PADRs will be shared with appropriate General Managers so that they can be reviewed further and amended.	Director of Workforce & OD 31st May 2019
One particular PADR contained an unacceptable objective and this has been discussed with Director of the service and a further meeting will take place with the manager who approved the PADR. A discussion with Service Director has been undertaken with a meeting to be arranged before 30th June 2019.	Director of Workforce & OD 30th June 2019
As part of the regular performance management meetings not only will the quantity of PADRs be discussed but the quality will also be questioned and managers will be asked to quality check a percentage of all team managers PADRs moving forward. Change to performance management meetings have begun. This will also be built into the PADR policy.	Senior OD Manager 30th November 2019

Finding 2 (O) – PADR Training	Risk
Concluding a review of the bespoke and NHS bespoke passport training register maintained by Workforce & OD, we noted staff from seven of the 11 wards and departments tested during this review had not received PADR training.	Lack of PADR training could result in non-compliant personal objectives being set for employees.
Recommendation 2	**Priority level**
Management should ensure managers and leads across the organisation receive PADR training in order to aid them in undertake appraisals in line with Health Board expectations, thus increasing the quality of the reviews.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
PADR training is included in the managers' passport; however, since the publication of the audit report drop-in sessions have been arranged across the organisation to support the PADR process. The first session in Carmarthen was well attended with 20 individuals receiving refresher training.	Senior OD Manager Completed – 17th April 2019
Alternative methods of providing PADR training will be explored to include Webinar type training to provide increased coverage this will be monitored by Workforce & OD Sub Committee.	Senior OD Manager 30th September 2019
Further sessions will be scheduled throughout 2019/20.	Senior OD Manager 31st March 2020

Finding 3 (O) – PADR Compliance Figures	**Risk**
We noted that the Flying Start Team at GGH were maintaining PADR compliance figures on a local spreadsheet rather than on ESR, whilst the Blood Services Department at GGH disputed the 37.5% compliance figure stating it was approximately 80%. Ceredig Ward at BGH stated that their compliance figure was 24% rather than the 96% recorded in ESR.	Inaccurate compliance figures held within the ESR system.
Recommendation 3	**Priority level**
Management should undertake a periodic sample verification of PADR compliance figures to ensure accuracy of reported information.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
As noted above this will be built into the PADR policy and revised process moving forward. A random sample will also be selected by the OD team on a quarterly basis and findings reported to managers as necessary. Areas of concern will be discussed as part of the Chief Executive performance review process. As noted above this will also be included in future updates provided to Workforce & OD Sub Committee.	Senior OD Manager 31st July 2019
The ESR team will also be in contact with the areas noted above who stated they did not use ESR to record PADRs to rectify this and ensure ESR is updated moving forward.	Workforce Intelligence Manager 30th June 2019

Appendix B - Assurance opinion and action plan risk rating

2018/19 Audit Assurance Ratings

Substantial Assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable Assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Limited Assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows:

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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