

# Neurodevelopmental Services – Children

## Internal Audit Report

### 2025/26

Cardiff and Vale University Health Board



Reasonable Assurance

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Review Reference CVU-2526-37

Fieldwork November 2025 – February 2026

Executive Sign Off 27 April 2026

Audit Committee May 2026

Executive Lead Paul Bostock, Chief Operating Officer

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# Executive Summary

## Purpose

The purpose of our audit was to review the procedures for assessing whether children are added to waiting lists, and the subsequent management of those lists to ensure that those referred are assessed in a timely, fair and consistent manner.

## Overview

The original scope of our review covered referrals for both Adults and Children for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD). Due to the significant differences in approach between services for children and adults, we agreed with the Health Board to produce separate reports and so this report relates solely to the services provided for children.

The demand for Neurodevelopmental services, covering both ADHD and ASD, have increased exponentially over recent years (between February 2022 and December 2023 the Health Board experienced an 136% increase in children waiting for an assessment). At the time of our review at the end of 2025 there were 4,700 children on the waiting list, with an expected wait time of 3.5 years for an assessment. Although additional funding is often received from Welsh Government to reduce waiting lists (currently there is funding to reduce the wait to under three years which requires approximately 1,000 children to be seen by the end of the financial year), this is on a non-recurring basis and is often received too late in the year to enable recruitment. Private contractors, weekend waiting list initiatives and outsourcing activity to other Health Boards are currently being utilised to carry out assessments to meet the Welsh Government targets, but whilst this may reduce the waiting list for a diagnosis, it also just shifts the wait along a step to the provision of care plans and medicines.

ADHD diagnosed children are required to be followed up every three months until they reach primary school age and then every six months thereafter until adulthood. So, as more children are diagnosed with ADHD, the number of available appointments for new referrals is reduced. ASD children are generally discharged once they get a diagnosis and care plan and there is a move towards making this a formal protocol for all ASD children apart from those that have severe conditions that impact their ability to function.

The Health Board has introduced several measures to address the surge in demand on services for ADHD and ASD. Children under the age of six and those assessed to have more complex needs are seen by doctors. All other assessments are undertaken by psychologists, speech and language therapists and occupational therapists. Clinics have been rescheduled such that each session is a mixture of new referrals and follow-ups, rather than having a clinic session just for new referrals or follow-ups. This has been welcomed as the new referrals can be quite exhausting and time-consuming and therefore a mix of patients reduces some of the pressure on the service. Most referrals are received via schools and there are standard questionnaires to ensure that all required information is received at the first attempt. Work is also being undertaken on a standard process for the growing number of children that are home-schooled. The Informed Care Pathway aims to make the assessment process leaner and smarter. Referrals to Speech and Language Therapy or Occupational Therapy for children are viewed through a neurodevelopmental lens so that if, as is often the case, there is a subsequent referral for a potential ADHD or ASD diagnosis, relevant information on the child has already been obtained to inform the clinical pathway. Assessment appointments are now being recorded on film, with parental consent, rather than taking manual notes. This not only saves time but ensures that those undertaking the assessment can fully observe the child throughout the assessment rather than having to also take notes.

In the context of the specific objectives of our review, and the overwhelming demand for Neurodevelopmental services, we have concluded **reasonable** assurance on this area. We consider that the Health Board is generally doing all that it can to make the process as effective as possible with the resources that are available to it. The Health Board is unable to address the demand for services on its own – it needs the Local Authority and education providers to also play a role on delivering a whole systems approach.

The significant matters requiring management attention are:

- The team undertaking the triage assessments have not been recruited to the intended full capacity with resulting detrimental impact on resilience and development activities with schools which could help to reduce the number of referrals.
- There is insufficient recurring capacity to undertake assessments and meeting Welsh Government targets can only be achieved currently through a combination of outsourcing and weekend working which is not sustainable over the longer term.

- Significant time savings could be made by a suggested automation of triage outcomes, but the Health Board would need to ensure that these do not become too generic and impersonal.
- Insufficient administrative support results in there being no proactive management of waiting lists, and clinical and nursing staff having to undertake administration tasks thereby reducing the time available to be spent on direct patient care.
- The provision of timely and accurate management information is adversely impacted by the limitations of the current reporting systems, which are approaching end of life.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

## Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Referrals to the service for children are subject to a formal and consistent form of triage.	1	<b>Reasonable</b>
2	All children referred are notified on a timely basis as to whether they have been accepted for inclusion on waiting lists for neurodevelopmental services.	2	<b>Reasonable</b>
3	All accepted patients are added to the waiting lists promptly, and lists are appropriately managed and accurately updated in terms of any changes notified to the Health Board.	3,4,5	<b>Limited</b>
4	Any patients removed from waiting lists due to failure to attend appointments are notified that they have been discharged from the service.	4	<b>Reasonable</b>
5	The process for transition from Children's to Adult Services is formally documented and complied with.	-	<b>Not Applicable</b>
6	Management Information reported to assess the performance of the service is accurate and up to date.	6	<b>Limited</b>

### Management Actions

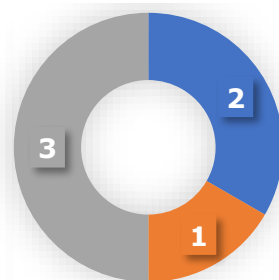


High Priority



Medium Priority

### Themes



■ Communication & Engagement

■ Information, Data Quality & Data Accuracy

### Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

# Findings & Agreed Action Plan

**Objective 1: Referrals to the service for children are subject to a formal and consistent form of triage.**

**Reasonable**

## **Overview / Summary of Observations**

All children referred to the service for either an ADHD or ASD assessment do receive a formal and consistent triage prior to being either accepted onto the waiting list or discharged. The triage, unless very complex, is undertaken by a Clinical Nurse Specialist, who is assisted by an Occupational Therapist. Most referrals are received from schools and initially a high proportion were declined due to missing information which meant that the school had to resubmit the referral. This was very inefficient for both the service and the school, as well as causing unnecessary delays for the child and their family. A standard questionnaire has now been produced which helps to ensure that all the necessary information is received at the first attempt. Work has also been recently completed on standard documentation for children who are being home-schooled, which has seen a significant rise since the pandemic. All information received comes through a single point of access.

The triage assessment is a combination of objective scoring using NICE recognised assessments and review based on the experience of the team. The number of referrals average 250 a month with peaks in July and September around the summer holidays. The team aim to review 80 referrals a week and at the time of our review the backlog in assessments amounted to approximately six weeks. Around 60% of referrals result in the child being accepted onto the waiting list. Urgent referrals, which include looked-after children, those in the youth justice system, and/or where there is a high risk of suicide or self-harm, are triaged immediately by the Clinical Triage Lead. These amount to around 20 referrals a week.

The original intention was for the team to be larger than the current two members of staff and this would hopefully have allowed the Clinical Triage Lead to undertake development work with schools, which might help to identify some early interventions that would negate the need for a formal referral in some cases. However, funding restraints and recruitment freezes have meant that the Clinical Triage Lead spends all her time undertaking triage and is therefore unable to do any of the development work with schools.

Work is being undertaken on a pilot which would allow referrals from schools to go straight onto the PARIS system which is used for the recording and management of the ADHD/ASD referrals. This would remove the need for the separate referral form and the subsequent manual input into PARIS. The system would also be capable of sending automated acknowledgements upon receipt of the referral and could also be used to generate automated notices of the triage outcomes, potentially saving substantial time.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Triage Capacity</b></p> <p>The team undertaking triage comprises a Clinical Triage Lead and one Band 6 member of staff. The original plan for the team had two Band 6 roles to undertake the triage which would have allowed the Clinical Triage Lead to undertake some development work with schools to identify early interventions with children that may have negated the need for a formal referral in some cases. The additional role would also provide cover in the event of annual leave or sickness absence. Having only one Band 6 member of staff results in the development work with schools not being able to be undertaken and provides little resilience in the case of absence of either of the current team members.</p>	<p>The Clinical Triage Team has limited resilience in the absence of one of the current team members on annual leave or absent through sickness, and the development work with schools is unable to be undertaken.</p> <p><b>Medium Priority</b></p>	<p>Acknowledging the financial constraints on the Health Board, the decision to only appoint to one of the two Band 6 posts will be reviewed to consider whether the potential reductions in referrals, and the additional team resilience in the event of absence, would justify the additional cost.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Review of Clinical Triage capacity</p> <p><b>Officer:</b> Rebecca Ingram</p> <p><b>Target Implementation Date:</b> 30<sup>th</sup> June 2026</p>
<p><b>Theme:</b> Resourcing</p>	<p>Control Design</p>	

**Overview / Summary of Observations**

The child and their family are immediately informed by a letter of the outcome of the triage process. For all children accepted onto the waiting list, their parents are sent an opt-in questionnaire which confirms their willingness for their child to be added to the waiting list and to be considered for a formal diagnosis. This also requests their consent for the service to contact other professionals involved in the care of the child for information relevant to the assessment.

If the child is assessed as not meeting the criteria for either ADHD or ASD, the referrer and the parents will be written to using a standard template letter which is tailored to the specific details of the child so that the parents in particular get an informed response as to why their child did not receive a positive diagnosis. They will also be signposted to other services that may be able to help address their child’s needs.

There used to be separate waiting lists for ASD and ADHD, but these have now been combined. This reflects the desire to address the child’s needs rather than to give them a label, and it is often difficult to decide initially whether a child has ASD or ADHD. All letters sent out, whether for a positive or negative diagnosis, will be written by either the Clinical Triage Lead or their assistant. As noted under Objective 1, there is the potential for the notification of triage outcomes to be automated, which would save substantial time. However, it is important to ensure that the information on outcomes is not considered too impersonal or insensitive, particularly given the work done to date by the Team on tailoring the notification letters.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 <b>Automated Notifications</b></p> <p>At the time of our review work was being undertaken on the possible automation of outcome letters from the triage assessment. This would save staff significant time if implemented, but there is a risk that the letters might become too generic and impersonal, particularly where children are not accepted onto the waiting list.</p> <p><b>Theme:</b> Communication &amp; Engagement</p>	<p>Automated notifications would generate significant time savings for staff so long as letters were not regarded as too generic or impersonal which might result in a poorer perception of the service and a possible rise in complaints.</p> <p><b>Medium Priority</b></p> <p>Control Design</p>	<p>The Service will continue to explore the potential for automating triage outcome notifications but also ensure that by doing so, the letter to children and their families do not become too generic and impersonal.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Consideration of whether to issue automated notifications.</p> <p><b>Officer:</b> Rebecca Ingram</p> <p><b>Target Implementation Date:</b> 30<sup>th</sup> June 2026</p>

**Objective 3: All accepted patients are added to the waiting lists promptly, and lists are appropriately managed and accurately updated in terms of any changes notified to the Health Board.**

**Limited**

**Overview / Summary of Observations**

Approximately 65% of child referrals receive a positive diagnosis and are added to the waiting list which covers both ADHD and ASD. As stated under Objective Two, these used to be separate lists but were combined to ensure that there was a focus on the needs of the child, rather than application of a label that may not always be appropriate.

The current length of the waiting list is approximately three and a half years. At present, due to a lack of administrative support, there is no proactive engagement with families until roughly six months prior to their estimated appointment time where families, their GP and their school, are sent a more detailed questionnaire to inform the diagnosis consultation. At present there are approximately 4,700 children on the waiting list and it is hoped that Neurodevelopmental staff will be able to access the Digital Appointment Booking System which is an automated system that could then hopefully be used to send validation letters to those on the waiting list and their families – possibly after a year on the list and then every six months – to confirm that they are still on the list and to ensure that they want to remain on it.

In terms of capacity to undertake assessments, some additional non-recurring funding has been provided to Health Boards across Wales to ensure that no child is waiting longer than three years for an ADHD/ASD assessment as at the end of March 2026. The Health Board should be very close to meeting this target through a combination of outsourcing and weekend working but is likely to face further pressure to stay on top of this target during 2026/27 unless there is further investment in the service.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 <b>Management of Waiting Lists</b></p> <p>A lack of administrative support results in there being no proactive management of the waiting lists which at the time of our review were three and a half years long. There is an automated system called the Digital Appointment Booking System (DABS) which could facilitate the sending of regular update letters to those on the waiting list to confirm that they wish to remain on it.</p>	<p>A lack of proactive waiting list management may result in patients being on the list who no longer require the service or who have moved out of area. Children and their families are also left waiting for an appointment for several years without any communication from the Health Board.</p>	<p>The Health Board will consider the use of DABS to ensure that the waiting lists remain accurate and that children and their families receive some form of update whilst they are waiting for an appointment.</p> <hr/> <p><b>Expected Evidence of Implementation:</b></p> <p>Consideration of use of DABS</p>

		<b>Medium Priority</b>	<b>Officer:</b> Rebecca Ingram <b>Target Implementation Date:</b> 30 <sup>th</sup> June 2026
	<b>Theme:</b> Communication & Engagement	Control Design	
4	<b>Administrative Support</b> The financial constraints and resulting recruitment freezes have meant that there are gaps in numbers of administrative staff. This results in tasks either not being able to be performed, or by clinical and nursing staff having to undertake the tasks, thus reducing the capacity for direct patient care.	The capacity to treat patients, and the effectiveness of the approach is reduced.	Acknowledging the financial constraints on the Health Board there are opportunities for the service to be delivered more efficiently and cost-effectively, and these will be considered alongside competing priorities.
			<b>Expected Evidence of Implementation:</b> Formal consideration of structure of current service provision.
		<b>Medium Priority</b>	<b>Officer:</b> Rebecca Ingram <b>Target Implementation Date:</b> 30 <sup>th</sup> September 2026
	<b>Theme:</b> Resourcing	Control Design	

## Assessment Capacity

The Welsh Government has provided additional non-recurring funding to help ensure that no child in Wales is waiting longer than three years for an assessment by the end of March 2026. To meet this requirement the Health Board estimated that it needed to deliver approximately 1,000 additional assessments and that the funding received from Welsh Government (approx. £800k) was insufficient for this number of appointments. The Health Board approached Welsh Government to increase the funded amount, but no further funding was forthcoming. The Health Board has therefore had to absorb the additional costs (approx. £500k) and should be close to meeting the March 2026 target by a combination of the use of private contractors, weekend waiting list initiatives and outsourcing some assessments to a neighbouring Health Board.

This neighbouring Health Board has already met its target through processes that are considered quite lean, and feedback from some Mental Health professionals suggested that a focus on waiting list reduction can often be at the expense of best practice in ASD/ADHD assessments. However, there are some lessons that can be learned from their approach and the Health Board has already adopted a number of its own initiatives including recording assessments rather than taking notes, placing more reliance on Educational Psychologists in schools rather than undertaking its own school observation visits, and promoting an Informed Care Pathway where referrals to Speech and Language Therapy and/or Occupational Therapy are conducted with neurodevelopmental concerns in mind. This results in any subsequent referral for an ASD/ADHD diagnosis being better informed. However, based on current assessment capacity and demand the service predicts that it will again fall short of Welsh Government targets by 1,000 children during 2026/27.

The Health Board has insufficient capacity to cope with projected demand and will fail to meet Welsh Government targets.

Acknowledging the financial constraints on the Health Board there are opportunities for the service to be delivered more efficiently and cost-effectively, and these will be considered alongside competing priorities.

### Expected Evidence of Implementation:

Review of Clinical capacity

**High Priority**

**Officer:** Rebecca Ingram

**Target Implementation Date:** 30<sup>th</sup> September 2026

**Theme:** Resourcing

Control Operation

**Objective 4: Any patients removed from waiting lists due to failure to attend appointments are notified that they have been discharged from the service.**

**Reasonable**

**Overview / Summary of Observations**

The DNA rate is relatively steady at around 15% but every missed appointment is a valuable resource that has been wasted. The requirement to complete an updated pre-assessment questionnaire and the length of the waiting lists encourages a degree of commitment to attendance at the assessment appointment. As noted under finding 4, the lack of administrative support has meant that there is little proactive management of the waiting lists but the aspiration to use the Digital Appointment Booking System would also help in this regard.

**Objective 5: The process for transition from Children's to Adult Services is formally documented and complied with.**

**Not Applicable**

**Overview / Summary of Observations**

The Children's service covers children up to the age of 18. Given a waiting list that is approaching four years for an appointment, there is therefore a risk that a teenager added to the waiting list might not be seen for an assessment appointment by the time that they reach 18 years of age. In planning for the audit, the issue of transition to Adult Services was one that the Children's Service were keen to include as at the time there was a reluctance from Adult Services to receive children (i.e those aged 17 who were still awaiting an appointment) on to their waiting lists particularly as all additional funding has been transferred by the Welsh Government to Children's services at the expense of Adult Services. Equally, for the child, they were potentially leaving a Waiting List with a three and a half year wait to one where they might have to wait a lot longer for a consultation, albeit that their date of original referral would be used to determine where they would sit on the adult waiting list.

Since commencing the audit, Children and Adult Services agreed to work together to find a solution to a better transition for both ADHD and ASD cases. The Children's Service identified all those children currently on the waiting list that are likely to turn 18 and who will have been waiting for more than three years as at April 2026 and April 2027. This information was shared with Adult Services so that the potential impact on their waiting lists could be assessed. It was estimated that the transfer of older teenagers to adult waiting lists will increase the wait for those adults towards the end of the list by a further year, and this would occur every time the transfer is made, which was assumed to be annually. We have now been advised that Adult Services including the Integrated Autism Service have not agreed to the transition and these teenagers will remain on the children's list even though they may potentially be over 20 by the time that they are seen. The Children's Service is hoping to be able to recruit practitioners who are experienced in dealing with this age group. Children that already have a diagnosis are however transferred to Adult Services on reaching 18 for the ongoing provision of their medication and follow-up.

Given the changes in process and discussions around the transition arrangements, we are unable to provide assurance for this objective.

## Objective 6: Management Information reported to assess the performance of the service is accurate and up to date.

Limited

### Overview / Summary of Observations

Management information is currently very limited and is dependent on the PARIS system which is nearing the end of its life with the contract due to expire in 2028, although it is likely that the Health Board will be able to agree a one-year extension to March 2029. Any slight amendment to the reporting requirements for the system requires a development request to be submitted and the chances of it being actioned are slim. There is one member of staff providing IT support for the whole of Community Child Health and her remit covers everything to do with IT including the provision of new and replacement laptops. There is an in-house support and development team for PARIS which is estimated to have 4,000 users across the Health Board. The Health Board are the only users of PARIS across NHS Wales and there was originally a plan to procure a system for community and primary care on an all-Wales basis, but this is no longer viable due to differing contract end dates. The procurement exercise to replace the system is to start shortly and the Health Board currently has external consultancy support, funded by Welsh Government, to help the Health Board plan for the migration of data from PARIS and also to process map the in-house developments that have been added to the current system which are estimated to be around 1200 developments.

There is no business analysis support available to the Neurodevelopment Service and consequently the reporting from the system is very labour intensive requiring a lot of manual intervention which is very inefficient and increases the opportunity for error. Timing delays with PARIS also results in some reported information having to be estimated although this is corrected retrospectively. There is also an issue that different audiences, including Welsh Government, require the information reported in different ways and to different timescales so that reports cannot be produced once and then used for multiple purposes. The limitations of the system and the frustrations that it causes are shared by both management and clinicians who were interviewed during our audit. Welsh Government are currently undertaking a consultation exercise on Neurodevelopmental reporting requirements for children which will see changes to current reporting using a phased approach starting from 1 April 2026 and to be fully implemented by 31 March 2027.

### Key Findings

### Risk & Impact

### Agreed Management Action

#### 6 Management Information

Management information is very limited, and the limitations of the current system make reporting very labour intensive and difficult. Different information needs of Welsh Government and the Health Board means that the same information cannot be used for multiple reporting purposes. The PARIS system is nearing the end of life with the contract due to expire in 2028, although it is likely that the Health Board will be able to agree a one-year extension to March 2029.

The current systems for management information are extremely limited, leading to an inefficient and time-consuming process with a greater

Acknowledging that the current PARIS system is approaching end of life, and that there are many different service users to accommodate in any replacement system, the Health Board needs to ensure that where possible, reporting of management information is enhanced and that any internal reporting can make use of the specific reporting requirements of Welsh Government in order to avoid any unnecessary duplication of effort.

	propensity error.	for <b>Expected Evidence of Implementation:</b> Updated Management Information Reports
	<b>High Priority</b>	<b>Officer:</b> Rebecca Ingram <b>Target Implementation Date:</b> 30 <sup>th</sup> September 2026
<b>Theme:</b> Information, Data Quality & Data Accuracy	Control Operation	

# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

## Prioritisation of Findings

Priority	Explanation
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Cardiff and Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

## Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

