

CDI Clinical Practice Guidance Document Cover Sheet

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* Refer to [HSE National Framework for developing Policies, Procedures, Protocols and Guidelines \(PPPGs\)](#)

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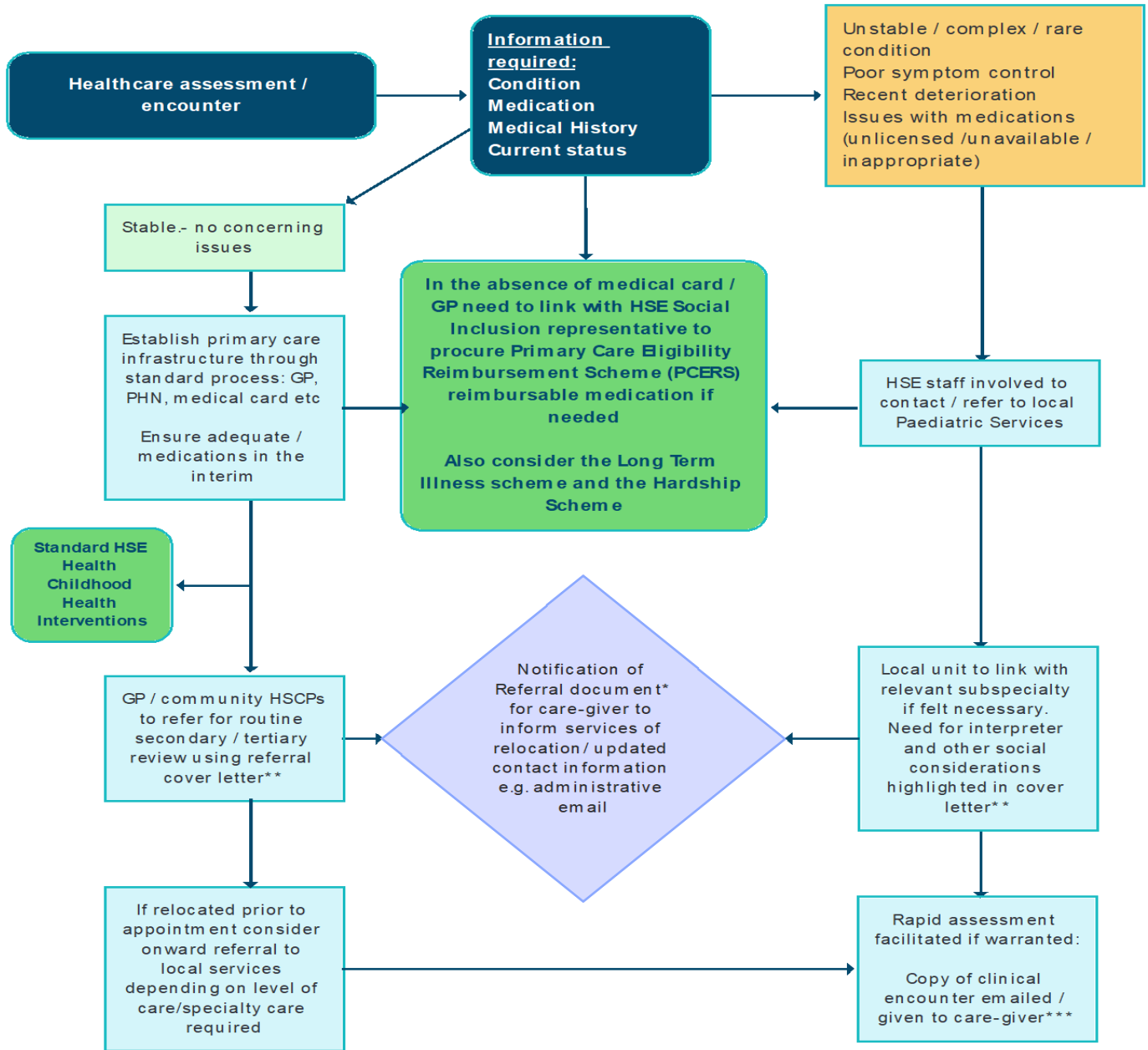


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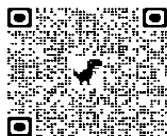
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Otherwise well child with known diagnosis requiring secondary / tertiary Paediatric care e.g. epilepsy, inflammatory bowel disease, anaemia

Consider language, literacy, numeracy and education levels at all stages of this process.



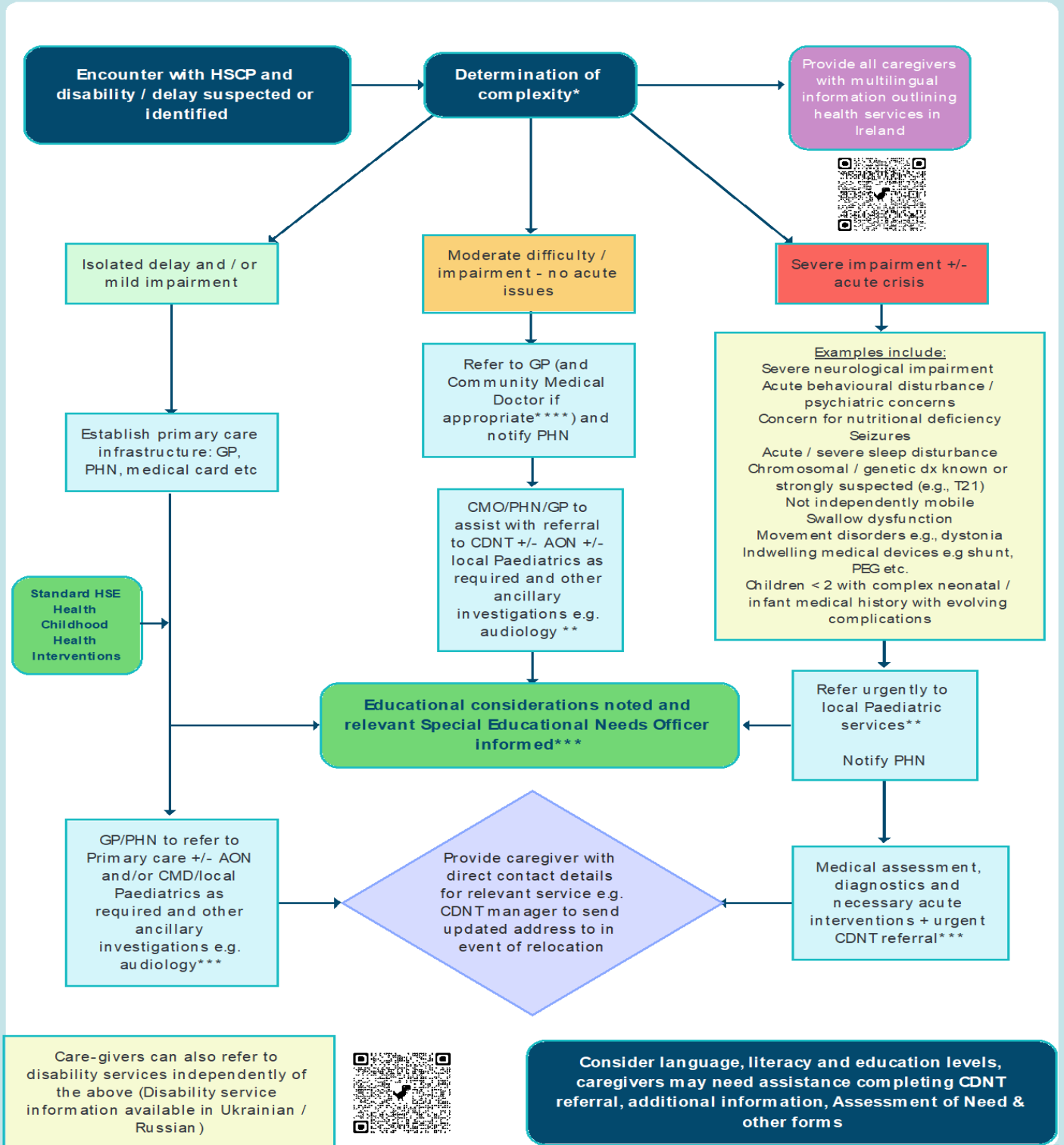
Direct all caregivers to multilingual information outlining child health services in Ireland



If prescribing from hospital:
Hardship scheme (both require medical card and hospital consultant but not GP) to assist with cost
Can also be directed to Community Welfare Officer (Local Intreo Office) to apply for exceptional needs payments to assist with cost

*Appendix 3: Notification of Referral
**Appendix 4: Standard cover letter
***Appendix 5: Healthcare Encounter Summary

Identified or Suspected Neurodisability in Ukrainian Beneficiaries of Temporary protection (Ukr BOTP) / International Protection Applicant (IP) child



*Appendix 2: Forms to assist with decisions on referrals
 **Appendix 4: Standard cover letter
 ***Appendix 6: Disability referrals checklist
 ****Appendix 7: Role of CMD

Practical management considerations for refugees and international protection applicants.

Definition of terms:

Ukrainian Beneficiaries of Temporary Protection (Ukr BOTP):

Created by the EU the Temporary Protection Directive is an emergency provision designed to respond to the mass displacement of Ukrainian people. Ireland participates in this measure and under the terms of the Directive provides Ukrainian beneficiaries of temporary protection (Ukr BOTP) with immediate access to the labour market, along with access to social welfare, accommodation and other State supports including healthcare and education. Accommodation for Ukr BOTP is via private residences mediated by Non-Governmental Organisations or through the Ukraine Crisis Temporary Accommodation Team (UCTAT) via the Department of Children, Equality, Integration, Disability and Youth (DCEIDY): ukrainetempaccom@equality.gov.ie

International Protection Applicant:

Also known as asylum seekers, International Protections applicants (IPs) have left their country and have sought protection in Ireland. While awaiting on the decision of their application for international protection the Irish State currently offers accommodation, food and access to medical care via the International Protection Accommodation Services (IPAS), also known as the Direct Provision system, under the remit of the DCEIDY. During this period IPs are not entitled to many standard welfare payments such as the DCA. Queries around IPs can be directed to ipasinbox@equality.gov.ie

The Irish Refugee Council provides support, assistance and signposting to many other freely available resources for IPs: info@irishrefugeecouncil.ie

Refugee:

If someone is declared a refugee they have been granted international protection by the Department of Justice. This entitles a refugee to the same rights and responsibilities of an Irish citizen including all social welfare payments. Due to the current shortage of accommodation many refugees remain within the IPAS system.

Further information on rights/entitlements on all of the above are available on:

https://www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refugees

Further information on intercultural health, for example multi-lingual resources (Emergency multi-lingual aid, My Health My Language videos, About the Irish Health System) and training for staff in Intercultural Awareness and Ethnic Equality Monitoring via this QR code or at:



<http://www.hse.ie/translated-health-info>

Referral features to note:

1. Address: Hotel / B&B / Transit centre / Industrial or business campus
2. Obvious language / literacy barriers
3. Previous non-attendances (may be under different spelling of name)

Important considerations for available Primary Care:

1. The child may not have a registered GP
2. Do they have a medical card - if not, obtaining standard Primary Care Eligibility Reimbursement Scheme (PCERS) reimbursable medications may be difficult. Consider Hardship scheme for medications not covered by medical card and the Long Term Illness Scheme for children with certain confirmed diagnoses e.g. Type 1 Diabetes

Link to PCERS Reimbursable Medications	Hardship Scheme form	Long Term Illness Scheme information

There are often difficulties receiving postal correspondence especially in communal living environments – consider email and text as preferred method of communication

Clinical Considerations during Paediatric review:

1. Are they from an area at higher risk of communicable disease? If so, consider testing (See Migrant Toolkit: Countries A – Z NHS)
2. Was the child born outside of Ireland? Large variations in new-born health screening worldwide, mother may not have had standard booking serology during pregnancy
3. Vaccination status: If no documentation / reliable verbal history assume to be unvaccinated (search for a country’s vaccine schedule via WHO vaccine portal) and refer to the National Immunisation Office Guidelines for catch up vaccinations in refugee / migrant groups
4. Are they at risk of common nutritional deficiencies (Migrant Toolkit: Countries A – Z NHS)? May not have access to kitchen / cooking facilities and cost of certain foods limits obtainability.

5. Many groups have a higher risk of vitamin D and iron deficiency - please see HSE guidelines re: routine prescribing of vitamin D in high risk groups

For further education see the World Health Organisation Refugee and Migrant Toolkit for e-learning modules

<p>HPSC Migrant Health Toolkit</p>	<p>WHO Vaccine Portal</p>	<p>HSE Vitamin D guidelines</p>
<p>National Immunisation Office – Catch up Vaccination Guidelines</p>	<p>Migrant Health Toolkit: Countries A - Z</p>	<p>WHO Refugee & Migrant Toolkit</p>

Social Considerations:

1. If international protection applicant, obtain the care givers International Protection Office (IPO) number to quote or support / advocacy letters
2. Document consent to share necessary medical information with relevant HSCPs to advocate for necessary resources / services
3. May have named key worker depending on accommodation setting who can assist with engaging in local community supports
4. If assistance required on ongoing basis to support secondary needs e.g. transport to/from appointments, consider referring to local community welfare officer for additional needs payment (via local Intreo office)
5. If child protection and / or welfare concerns arise during any stage of a child's engagement with health and social care professionals a referral to TUSLA should be performed through the appropriate channels

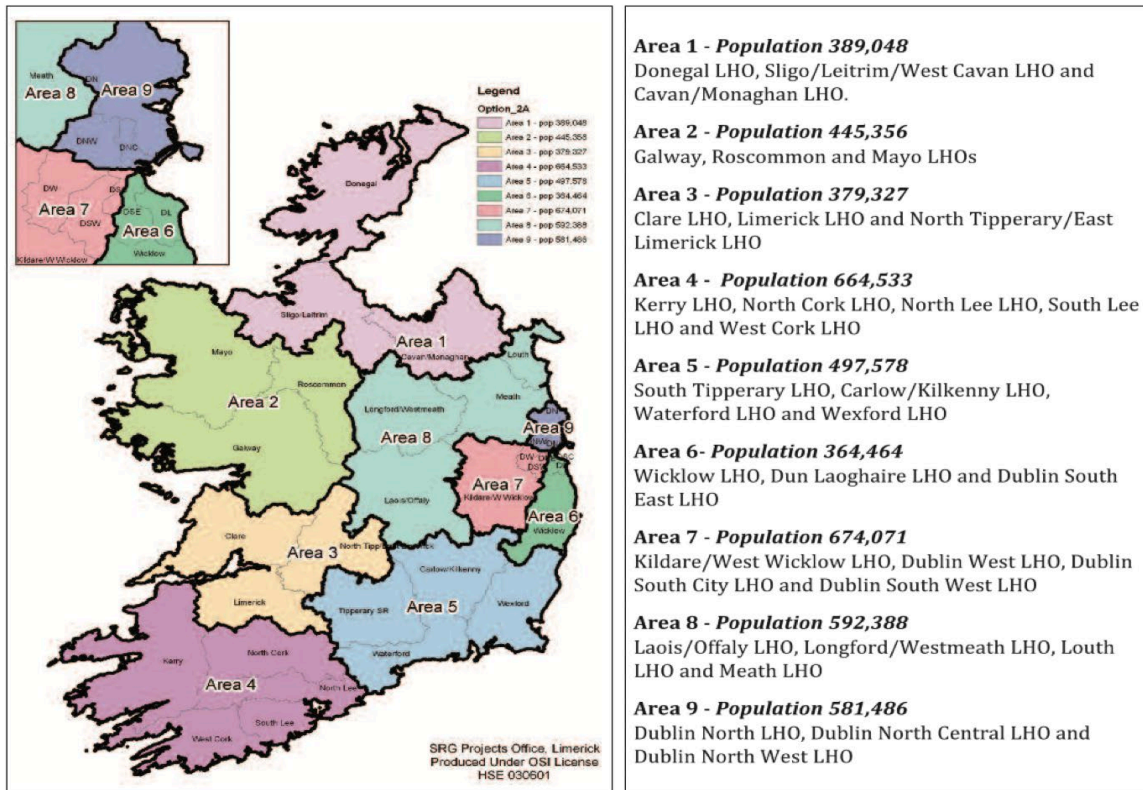
Follow-up care:

1. Give date and time of follow-up OPD during clinical encounter and send to GP, PHN +/- key worker as appropriate
2. Provide caregiver with administrative number and email to inform of change of address
3. Obtain email address of care-giver in case of loss to follow-up / non-attendance
4. Ensure that all prescribing is reimbursable on medical card – if no medical card please see below regional Social Inclusion contacts for assistance.
5. Provide care-giver with Standard Notification of Referral Document (Appendix 4) and Healthcare Encounter Summary (Appendix 6)

Regional HSE Social Inclusion Representatives:

1. Where a child requires medications to treat an acute or chronic condition but has not been yet assigned a medical card or GP consider the following to minimise the financial burden of medications:
2. If known or new significant or complex diagnosis in an inpatient e.g. Type 1 Diabetes / Inflammatory Bowel Disease apply for emergency medical card prior to discharge with the assistance of the Medical Social Work Department.
3. If the child presents to Primary Care or hospital outpatients requiring health-preserving medications in the absence of a medical card please link with the local HSE SI representative for assistance with affordable prescribing. Please note this is not a case management service but rather case-by-case support for access to GMS reimbursable medication whilst medical card application is initiated / in progress. Each CHO has a representative contactable by email during standard working hours. Please see map of CHO regions and relevant contact details below:

The nine Community Healthcare Organisations are outlined below:



HSE Social Inclusion CHO Representatives:

1. CHO 1: Donegal CHN: tara.devine@hse.ie
2. Sligo CHN (incl. south Donegal i.e. Bundoran & Ballyshannon): Sandra.lang@hse.ie
3. Leitrim CHN (incl. west Cavan): Sandra.lang@hse.ie
4. Cavan CHN: suzanne.gunn@hse.ie
5. Monaghan CHN: suzanne.gunn@hse.ie
6. CHO 2: Galway: keith.downey@hse.ie
7. Mayo/Roscommon: harold.slok@hse.ie
8. CHO 3: hsemwukrainesupport@hse.ie
9. CHO 4: eddie.horgan@hse.ie
10. CHO 5: AnnMarie.Lawlor@hse.ie
11. CHO 6: lee.collins@hse.ie
12. CHO 7: Justin.Parkes@hse.ie
13. CHO 8: Michelle.Donnely@hse.ie
14. CHO 9: Debbie.Carroll1@hse.ie

Appendix 1: Neurodisability practical considerations and signposting for community health and social care professionals

The role of a Paediatrician in the assessment and management of neurodisability has a broad scope but in the context of newly arrived refugee/international applicant children referral for early / urgent Paediatric review as per the above pathways should be considered to assist with specialised diagnosis and medical assessment in children with a known, suspected or evolving complex disability who have significant medical needs.

Examples of such clinical scenarios are as follows:

- a) Severe neurological impairment¹
- b) Acute behavioural disturbance (potentially requiring psychiatry services)
- c) Concern for nutritional deficiency / malnutrition
- d) Seizure disorder
- e) Acute / severe sleep disturbance
- f) Chromosomal / genetic dx known or strongly suspected (e.g., T21)
- g) Not independently mobile
- h) Known or suspected swallow dysfunction
- i) Movement disorders e.g., dystonia, severe cerebral palsy
- j) In-dwelling medical devices e.g. shunt, PEG etc.
- k) Children under 2 years of age with significant neonatal history with complex evolving medical/developmental issues arising from prematurity or morbidity in the neonatal / infant period.

The below points are extrapolated from the National Policy on Access to Services for Children & Young People with Disability & Developmental Delay and the National policy on prioritisation of referrals to Children's Disability Network Teams: "Equity of access to services according to needs rather than to diagnosis"

1. Equitability and transparency for all children in Ireland awaiting services is critical
2. Managing expectations of families / care givers unfamiliar with our disability infrastructure and approach, needs to be performed by referrers


¹ Severe neurological impairment describes a group of disorders of the central nervous system which arise in childhood, resulting in motor impairment, cognitive impairment and medical complexity, where much assistance is required with activities of daily living. The impairment is permanent but can be progressive or static (Allen et al, Eur J Paediatr Neurol 2020).

3. Highlighting availability and appropriateness of available disability resources for community HSPCs
 - a. Signposting and supporting of appropriate referrals e.g. AON / Primary Care / CDNT / CMD
4. Who should take responsibility for the referral
 - a. Severe / crisis needs (e.g. SNI / crisis behaviours) –Paediatric services for acute medical needs and onward referrals
 - b. Non – urgent presentations/needs: Primary care professionals e.g. GP/PHN/CMD (*NB: some children may not have assigned GP for months*)
5. How to ensure that referral transferred upon relocation especially in the case of CDNT:
 - a. Give family members the email address of the relevant CDNT/Primary care service
 - b. If referring personnel are made aware of relocation they should also notify CDNT/other service
6. “It is dependent on parents and referrers ensuring that the team/person monitoring the waiting list is kept informed of any changes in needs/circumstances for the child/family”
7. Two categories of referral: Urgent and non-urgent:
 - a. Urgent referrals to CDNT / Paediatrics based on the National policy on prioritisation of referrals to Children’s Disability Network Teams and apparent levels of difficulty across relevant domains with specific examples outlined above. Other general examples given in the policy are outlined below
 - i. Equipment/pressure care breakdown
 - ii. Family in crisis
 - iii. Critical transition stage where intervention/assessment is essential for continuity of a service
 - iv. Choking/aspiration Feeding Eating Drinking and Swallowing issue (if this service is available from the team)
 - v. Critical rehabilitation required post discharge from an acute hospital service following acquired brain or spinal injury
 - vi. Presentations and behaviours which may lead to: Significant risk to health or safety of the child, significant risk to health or safety of others, very severe loss in quality of life or daily functioning of child, school placement breakdown
 - vii. A combination of significant and multiple child and family vulnerabilities likely to lead to severe deterioration in the child’s wellbeing and disability related problem
 - viii. A child who has been on the waiting list for services for a year



8. The response to an urgent referral may be by one or more disciplines for a specific intervention as appropriate to address the child's and family's needs (e.g. replacement of equipment) – can be highlighted clearly in the referral in certain situations e.g. significant physical needs (e.g. wheelchair / adaptive seating)
9. PHN to be made aware of significant additional needs to assist with practical considerations (measured incontinence wear etc.)

Appendix 2: Form to assist with decisions on referrals

 Feidhmeannacht na Seirbhíse Sláí Health Service Executive		<h2>Form to assist with decisions on referrals</h2>	
Childs Surname:		Individual Health Identifier	
Childs First Name:		DOB	Age
Address			
Date Of Referral		Referrer	
Date of Team Referral Meeting			
Please tick the relevant Team making the decisions			
Primary Care Team/Network Services			
Children's Disability Network Team for home address:			
Early Intervention or School Age Team (if applicable):			
Information received:			
Consent signed by parent/legal guardian:		Yes	No <input type="checkbox"/>
Referral form completed		Yes	No <input type="checkbox"/>
Additional information form		Yes	No <input type="checkbox"/>
Clinical reports (list)		Yes	No <input type="checkbox"/>
Comments			
Members of team making decision:			
Please note:			
<ul style="list-style-type: none"> ➤ An infant between 0 and 12 months of age referred with a diagnosed condition associated with complex needs, or clearly at significant risk of disability, will automatically be accepted into a Children's Disability Network Team. ➤ For all other children – see decision making process page 2 			
Recommendation			
1. Service to be offered by:			
2. Further information needed from			
3. Screening assessment to be conducted by:			
Notes/comments			
Signed:			

Identifying complexity of the child's needs

Child's Name: _____ **DOB:** _____

	Area of function and participation (see Explanatory Guide to assist with decisions on referral)	Range & extent of child's functional difficulties and medical needs (put a tick or number in <i>one</i> column only for each row)				
		A	B	C	D	E
		Insufficient information (tick)	No difficulty (tick)	Some difficulty = 1	Significant difficulty = 2	Highly significant difficulty = 3
1	Movement (Gross motor skills)					
2	Fine motor skills					
3	Communication					
4	Social interactions relationships and play					
5	Daily Living Skills					
6	Behaviour & emotions					
7	Learning & applying knowledge and skills					
8	Vision and hearing					
9	Sensory Processing					
	Medical needs		None (tick)	Some Needs=1	High Needs =2	Very high needs = 3
	Summary Totals for each column	██████████ ██████████ ██████████	██████████ ██████████			

Total = _____


All decisions on the most appropriate service for a child must be based on clinical judgment. This form and the suggested scoring is only to be used as a guide.

1-2 Primary Care is likely to be the appropriate service to meet child's needs
 3-6 Decision to be informed by needs for interdisciplinary team and by family, environmental and other factors. Needs may be met by Primary Care Services or Children's Disability Network Team or jointly.
 7 -30 Children's Disability Network Team is likely to be the appropriate service to meet child's needs

Comments



Appendix 3: Explanatory guide for form to assist with decisions on referrals

 Feidhmeannacht na Seirbhíse Sláinte Health Service Executive	<h3>Explanatory guide for using the form to assist with decisions on referral</h3>
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The form is only intended to provide a consistent means of organising the available information about the child at the time of referral and for no other purpose. It is not appropriate for use to determine ongoing intervention or discharge/transfer from a service.

Referral Form

There is one national referral form and four age appropriate forms for additional information (birth to 12 months, 1 year to 5 years 11 months, 6 years to 11 years 11 months and 12 years to 18 years). These forms ask for information about the child and family, what the family's concerns are, what they would like their child to gain from attending the service and details of the child's development. This information will be provided by the parents/family, assisted where necessary by a professional. The level of detail requested supports the decision making process to determine the most appropriate service to meet the child's needs and also provides baseline history and information, which will not subsequently have to be sought by members of the team.

Referrals with insufficient information will not be accepted as services cannot direct the referral to the appropriate service and prioritise the referral. The referral form, additional information forms and local information leaflet for referrers with local contacts should be distributed widely and regularly to referral agents and local Health Centres.

Form to assist decision making on referrals

The form has been developed to assist Primary Care Services, Children's Disability Network Teams and the Integrated Children's Service forums to make consistent decisions on which would be the appropriate service to meet the needs of each referred child. It also provides transparency on how the decisions are made. However decisions on referrals must always be made on the basis of clinical judgement.

Using the information from the referral form and any accompanying reports, the clinician or team will score each domain.

Columns 1 and 2

A tick should be placed in the relevant column i.e. in column 1 if there is insufficient information about that particular area of development or in column 2 if there are no difficulties identified according to the information.

Columns 3 – 5

If the child has some difficulty in communication place a 1 in Column 3, if he or she has significant difficulty place 2 in Column 4, and if there is a highly significant difficulty place 3 in Column 5.

Every domain (row) should have a tick or number in *one* of the columns only.



Decisions:

A score of 1 - 2 indicates the child's needs are likely to be best met at Primary Care level.

A score of 7 – 30 indicates the child's needs are likely to be best met at Children's Disability Network Team level.

The most appropriate service for children with scores between 3 and 6 should be considered in terms of factors such as needs for interdisciplinary disability team intervention and social and family circumstances. Needs may be met by Primary Care Services or Children's Disability Network Team or jointly as agreed by the Integrated Children's Services Forum.

Scoring according to the form must never be regarded as conclusive on its own. In all cases clinicians must use their own professional judgment in deciding the most appropriate pathway for a child.

If after due consideration it is unclear which is the most appropriate service for a child, the referral and all supporting documentation may be brought to the Integrated Children's Services Forum for a decision. (See Section 5.4).

The decision made on referral may be reviewed and changed when the child's needs have been further assessed by a clinician or after a period of intervention.

Definitions of Each Domain

The following definitions should be interpreted in the context of cultural variations and norms that may exist for individual children and their families/communities.

1. Gross motor skills refers to the physical abilities of the person, for example, to access their environment and participate in activities that require whole body movements or movements involving the large muscles of the body. These would include fundamental movement skills; such as walking, kicking, throwing, catching, maintaining balance and jumping. It also involves the person's ability to learn new motor skills or improve upon basic motor abilities.

2. Fine motor skills refer to actions involving the small muscles of the hands, wrists and fingers and the coordination of hand and eye movements. They include smaller actions such as picking up objects between the thumb and finger, playing, holding a fork to eat, using a pencil to write carefully and communicating using gestures or signs.

3. Daily Living skills (Activities of Daily Living) refer to those skills required to do everyday tasks such as feeding ourselves, bathing, dressing, grooming, playing, doing school work and taking part in leisure activities.

4. Communication refers to the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems. Good communication skills are essential to support learning and to develop and maintain social relationships.

5. Behaviour and Emotions

Behaviour refers to the child's observable actions and reactions/responses in various environments

Emotions refer to the child's ability to express (verbally or non-verbally) and recognise, label and regulate the expression of internal states, e.g. joy, sadness, anger.

6. Social interactions and Relationships, Play and Leisure

Social interaction and relationships refer to the child's ability to interact and relate with children and adults, by verbal or non-verbal means.

Play and leisure refers to solitary or interactive games or activities engaged in for enjoyment, including play with objects, social play, pretend play and imaginative play.

7. Learning & applying knowledge and skills refers to the child's ability to gain knowledge or skills by experience, practice or teaching and the ability to retain and access this information when required.

8. Eyesight and Hearing

Hearing refers to the ability to perceive sound and involves the detection, recognition, discrimination, comprehension and perception of auditory information.

Eyesight refers to four levels of visual functioning according to the International Classification of Diseases

1. Normal vision.
2. Moderate visual impairment.
3. Severe visual impairment.
4. Blindness.

Moderate visual impairment and severe visual impairment are grouped under the term low vision. Low vision together with blindness represents all visual impairment.

9. Sensory Processing refers to the process of taking in information from the world and from within our own bodies, making sense of that information, thus making it possible to use the body effectively within the environment.

10. Medical need refers to an impairment or limiting condition that requires medical or nursing management and/or use of specialised services. The condition may be congenital, developmental or acquired through disease or trauma and places restrictions in daily living.

Definitions for Levels of Difficulty

No difficulty

Within the domain under consideration the child is able to participate and function within a typical / age appropriate range.

Some difficulties

This refers to functional difficulties which:

- Result in restrictions in participation in one or more settings (home, school and community).
- Likely to be mitigated by short-term intervention and/or ongoing low level support or strategies.

The child:-

- Experiences mild difficulties in participating in social, educational, family daily activities.
- Needs little assistance to choose, initiate and engage in activities.

Significant difficulties

This refers to functional difficulties which:

- result in the child's ability to perform in this area being delayed or different from peers and
- result in restrictions in participation in most settings (home, school and community) and
- negatively impact performance across some other areas of function and participation.

The child:-

- Experiences moderate difficulties in participating in social, educational, family and daily activities.
- Needs moderate assistance to choose, initiate and engage in activities.

Highly significant difficulties

This refers to functional difficulties which:

- result in the child's ability to perform in this area being markedly delayed or markedly different from peers and
- result in restrictions in participation in all settings (home, school and community) and
- negatively impact performance across multiple other areas of function and participation.

The child:-

- Experiences severe difficulties in participating in social, educational, family and daily activities.
- Requires maximum assistance to choose, initiate and engage in activities.



Appendix 4: Standard Notification of Referral Document (Sample)

Dear Parent/Guardian,

Your child has been referred for the following services:

Service: e.g., General Paediatrics / Gastroenterology / CDNT

Service address: Insert relevant address

Administrative email: Administrative / contact email for service

Contact number: Insert service contact number

If you move residence and are relocated from your current address or your phone number changes please inform the email address above so that you can be notified of any appointments.



Appendix 5: Standard cover letter (Sample)

To whom it may concern,

The attached referral is concerning a child who is currently in Ireland as a refugee / International Protection Applicant. As such there may be additional considerations for their engagement with services and their management such as language & literacy challenges, difficulty accessing GP care, challenges with prescribing if they have not been assigned a medical card, and sudden relocation throughout the country. We have provided them with your contact details and asked that they notify your service if they are relocated. Please note if an interpreter is required.

If there is difficulty with engagement / attendance we advise linking with the Public Health Nurse in their last known address as well as considering text/email as a preferred method of notification.

Child's Name: _____

Name of Next of Kin: _____

Current address: _____

Contact Number: _____

Email address: _____

Interpreter needed: Yes / No

Language(s) spoken: _____

If you are made aware that they have been relocated to an area that is beyond your service remit please arrange transfer of the referral accordingly once you are notified of the new address.

Kind regards,



Appendix 6: Healthcare Encounter Summary

Name:		Parent/Guardian:	
DOB:		Contact No:	
MRN:		Email address:	
GP	Yes / No		
If yes details			
Medical card	Yes / No		
Current address:		Hotel / B&B / Private accommodation	
Interpreter needed	Yes / No	Languages spoken:	
Childhood immunisations: Up to Date / Incomplete / None			
COVID19 vaccination	Yes / No	Booster:	Yes / No
Allergies:	Yes / No	If yes outline:	
Reason for Paediatric review:			
Review as	Inpatient / outpatient	Date of review/discharge:	
Working Diagnosis:			
Medications:			
<i>(NB: please highlight any changes made)</i>			
Management Plan			
Follow-up appointments:	Date:		Time:
Referrals sent:			
Signature of Doctor:		IMC:	
Consultant:		Specialty:	

Appendix 7: Disability referral checklist

1) Disability present / suspected	Yes		No	
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2) Level of difficulty suspected*	Mild		Moderate		Severe	
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**Form to assist with decisions on referrals as reference guide*

3) Language / Literacy / Communication barriers	Yes**		No	
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**Low threshold to complete and send any necessary referral forms for care givers with interpreter assist / consent to ensure they are correct and sent to correct location

4) Referrals sent***: (May be multiple)	Primary Care Services		Community Medical Doctor (via Local Health Office)	
	Assessment of Need (AON)		Children's Disability Network Team (CDNT)	
	Local Hospital Paediatric Services		Special Educational Needs Officer (SENO)	

***Follow QR code for local area contact details +/- referral forms / further information etc.

5) Information on disability services given to care-giver:	General health information for English / Ukrainian / Russian speakers (includes information on disability)		Local area disability services information:	
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6) Contact details of relevant services given to care-giver	Yes		No	
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NB: Inform care giver to notify relevant services if they change address

7) Local Head of Disability informed in the case of child with severe levels of difficulty / crisis behaviour / welfare concerns: Children considered for this merit urgent Paediatric/CMD review	Yes		No	
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8) If specific urgent need within disability services identified (e.g. wheelchair/orthotics) highlight clearly in referral.	Yes		No	
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Appendix 8: Role of Community Medical Doctors

The age limits for referral for CMD services are defined by the Health Act 1970 Section 66: Health Act, 1970:

“A health board shall make available without charge at clinics, health centres or other prescribed places a health examination and treatment service for *children under the age of six years.*”

Child health reviews, screening and surveillance are carried out by PHNs and Community Medical Doctors in some areas, while in other areas the service is PHN-led with secondary referral to Community Medical Doctors. A child health service is also provided in schools by PHNs and Community Medical Doctors and covers screening, surveillance and vaccinations, with some areas having dedicated School Health and Immunisation teams.

With regards to child health concerns that result in referrals to the CMD service from PHN colleagues the key issues of concern are as follows:

1. Surveillance of physical health including Developmental Dysplasia of the Hips, Ocular issues (e.g. Strabismus) and gait issues
2. Developmental Surveillance: Delay in acquisition of milestones
3. Growth monitoring: Failure to thrive and obesity

Appendix 9: Working Group Members

Name and Title
1. Dr Ellen Crushell , Clinical Lead, National Clinical Programme for Paediatrics and Neonatology (NCPNP), Consultant Paediatrician (Chair)
2. Dr Aoibhinn Walsh, Consultant Paediatrician with special interest in Inclusion Health (Principal Author)
3. Ms , Bernie Biesty (Clancy), Clinical Nurse Manager 3, Paediatrics, Sligo University Hospital
4. Dr Ciarán Browne, National Emergency Planning Lead, HSE Acute Hospitals Operations
5. Ms Antonia Bura, Research and Data Officer, Homeless Health, HSE social Inclusion Office
6. Ms Gráinne Begley, Project Manager, Social Inclusion/ Public Health
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Appendix 10: Document Review Process

National Clinical Programme Migrant Children Working Group
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