United Kingdom who face significant barriers to accessing healthcare services. These children often face health risks and therefore have complex health needs. Hence, it is vital for healthcare professionals in the emergency department to adopt a holistic approach to their care as this can have widespread positive implications beyond their clinical presentation and may shape their transition into a new country. This opinion article was undertaken with the aim of highlighting and summarising current best practice recommendations for addressing the needs of this complex patient group.

**Method and Design** A step-by-step screening tool (figure 1), CCHILDS (Communication, Communicable diseases, Health – physical and mental, Immunisation, Look after (safeguarding), Deficiencies, Sexual health) was formulated. This was created following a review of the literature, consultation with paediatric emergency clinicians and the use of current protocols in related disciplines (e.g. HEADDSS assessment tool). This tool can be used in the emergency setting by healthcare professionals in the assessment of refugee and asylum-seeking children and can serve as an aide memoire to cover the key aspects of a consultation.

**Results and Conclusion** This opinion article summarises three main aspects in the assessment of a refugee or asylum-seeking child in the paediatric emergency department. Firstly, the key considerations regarding the child’s background prior to entering the UK and the barriers they may encounter to accessing healthcare. Secondly, the healthcare assessment upon arrival to the emergency department and a framework that could be used for clinical assessment. Finally, the consideration of their long-term healthcare needs and the importance of empowering these young individuals to lead a healthy lifestyle.

Data were obtained from the MTC trauma office and clinical records were independently reviewed by two authors. The Royal College of Radiologists guideline for paediatric trauma was used to assess the appropriateness of the CT imaging strategy. Combined data were stored in a Microsoft Excel sheet and analysed in Prism 9 for macOS (GraphPad). Data are reported as number (percentage), and median [inter-quartile range]. Proportions were compared with a Fisher’s Exact test; differences between median values were compared with a Mann-Whitney U test.

**Results and Conclusion** In the study period n=315 patients were identified. 229 (72.7%) underwent CT <12hrs and were included in the analysis: n=93 MTC, n=136 TU, table 1. CT imaging was judged as appropriate in n=77/93 (82.8%) MTC and n=104/136 (76.5%) TU scans, p=0.32. The median time to first CT was 35.0 [26.0–75.0] minutes MTC, and 76.0 [48.0–109.0] minutes TU, p<0.0001.

We have demonstrated room for improvement in paediatric CT trauma imaging appropriateness across the network, but this is not significantly different between the MTC and TUs. However, time to initial trauma CT was significantly shorter in the MTC.