Enhancing Clinical Care Framework (ECCF)

Multidisciplinary Working Subgroup Report.

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1.0 Introduction

The Minister of Health authorised a project to develop a Framework to enhance resident clinical care in Northern Ireland Care Homes in June 2020. The Project was commissioned by the then Chief Nurse Professor Charlotte McArdle and presently progressed by Chief Nursing Officer Maria McIlgorm. The challenges experienced in providing safe care in care homes during the COVID-19 pandemic were influencing factors in this decision. We acknowledge many of the challenges experienced have been long standing issues which were exposed during the COVID-19 pandemic.

A robust partnership approach was developed with people living in Care Homes and their families to ensure their voice was central to the development of the framework and to the outcomes.

2.0 Enhanced Clinical Care Framework Project Aim

To ensure that people who live in care homes are supported to lead their best life possible, and their Human Rights and right to access equitable healthcare provision are fully observed. This includes;

- Ensuring access to the right clinical care
- Ensuring that future surges can be dealt with effectively taking the learning from the first COVID-19 surge.

The outcome is the development of a framework available to enable continuing safe, high quality and person centred holistic integrated care within care homes.

This is to include clinical pathways to enhance collaborative working across community, primary, independent and acute hospital sectors with the benefit of a stronger clinical model.

3.0 Enhancing Clinical Care Framework Project Objectives

The project will have the following specific objectives:

- To identify current and future demand for these services taking into account future demographic changes.
- To review the existing policy framework, in NI ROI and UK Countries, the evidence base, developments across the UK and, taking into account service user and clinical staff views, consider how the future configuration of services can adopt advancements in technology, and new frameworks for clinical care.
- To identify the workforce training needs, career pathways, role requirements and associated costs of future framework including the commissioning model of what is planned, purchased and monitored.
- To identify actions required to ensure services are underpinned by effective governance and quality assurance mechanisms.
- To produce a framework with accompanying costed implementation and investment plans setting out a resilient platform for provision of optimal clinical care in care homes.

4.0 Enhancing Clinical Care Framework Project Management Structure

The project was managed using a robust project management approach with the Chief Nursing Officer identified as the SRO and chair of the Project Board. A Project Group was established, chaired by the Deputy Chief Nursing Officer and three Subgroups to lead on the specific work streams.

- Multidisciplinary Working
- Workforce Development and Career Pathways
- Informatics and Digital Technology

This paper contains a summary of the activities undertaken by the **Multidisciplinary Working Subgroup.**

5.0 Multidisciplinary (MDT) Working Subgroup Overview and Summary

The Subgroup was co- chaired by Elizabeth Graham, Assistant Director Corporate Nursing (NHSCT) and Dr. Rose McCullagh, General Practitioner and Associate Medical Director (SHSCT). The group was established to lead on developing Multidisciplinary Working with residents in Care Homes. The subgroup had a collaborative multidisciplinary and cross- sector membership with representatives from DOH, Health and Social Care Trusts, PHA, SSPG, RCN, NISCC, RQIA, Independent Care Home Providers and Primary Care. The members represented Nursing, Allied Health Professionals, Medicine, Clinical Psychology, Dental, Social Care and Pharmacy (Appendix 1).

The expert opinion of people living in Care Homes and their families was represented through specific engagement work with PCC, PCE, engagement events and independent Care Home providers as key contributors.
The focus of the MDT sub group was to articulate ***…" What good resident care would look like in a care home setting, underpinned by an emphasis on***

supporting resident wellness and reflecting what matters to the resident as an individual."

From 2021, various work stream leads from the group membership developed educational tools and resources to assist care staff in assessing resident frailty and detecting residents in early clinical decline. Care staff were thus enabled to articulate these findings to the appropriate professional safely and coherently to invoke an appropriate timely clinical response. As an outcome care staff have reported enhancements in their skills, competence and confidence in identifying a resident's deterioration from their baseline.

A range of proposed products were subsequently tested within the care home setting with an evidence-based outcome demonstrating resident care was positively impacted through implementation of these new ways of working. Examples are the resident blocked catheter and resident falls clinical pathways introduced into care settings regionally, consistently achieving best care for the residents resulting in reducing and avoiding a clinical crisis situation and resident unwarranted attendance to emergency care.

The development of the appropriate MDT to provide wrap around support to the residents based on their unique needs was also explored, with the benefits of active in reach Nursing, pharmacy and Allied Health Professionals agreed as being key contributors in preventing further resident clinical deterioration.

Within the current commissioned General Medical Services (GMS) Contract, General Practice provides a service for their registered patients '…who are sick or perceive themselves to be sick with conditions from which recovery is generally expected, also responsive to patients requiring chronic disease management and general management of patients who are terminally ill'. The subgroup concluded the next pivotal step for the successful implementation of the anticipatory resident care trajectory was to request a process of General Practice (GP's) engagement as the key enabler to this Anticipatory Model of practice.

The MDT subgroup recommend that for meaningful resident Anticipatory Care Planning, working with primary care to establish the options to lead, guide and co-ordinate the delivery of the service is essential. Potential for further development of the current NI proactive care home Local Enhanced Service is one such option. With this, residents in all care settings across N.I. would receive person centred, high quality and safe anticipatory care in their own home. To achieve this objective, the care home residents will require a pioneering MDT service to co-ordinate, promote, provide and guide anticipatory care, early prevention and early intervention principles.

The resulting outcome is a transformation of care in the community setting reflecting the care home population and those providing wraparound anticipatory care as a community of practice, utilising the principles of population health to support and embed resident centered wellness with resulting best outcomes for all those contributing to Care Home living. We would predict this Anticipatory Care Planning Model of practice is transferable to people living in their own domiciliary setting.

6.0 Multidisciplinary Working Subgroup Purpose

The Purpose of the Multidisciplinary Working Subgroup was to develop Multidisciplinary working to include statutory and non-statutory organisations to develop an Anticipatory Care model. This would support care homes residents and staff to maintain and promote wellness and detect early deterioration in the following Clinical Pathways: Rehabilitation, Long term conditions and Palliative care.

Within the context of this MDT subgroup the proposed definition of Anticipatory Care Planning was agreed as…

Anticipatory Care Planning (ACP)

'The process of co designing a dynamic personalised care plan with the resident, family and care staff. The purpose of ACP is to anticipate, avert or delay future decline through early identification of the resident need/s. This incorporates the resident's biopsychosocial needs (which includes physical, emotional, mental/intellectual, social, environmental and spiritual health) with a focus on staying well. It involves a series of recorded discussions between the resident, family and a health professional to understand 'what's important to me in my goals, options and preferences' (resident) and to develop an agreed plan of care. This is a living document reflecting the residents care home living experiences.

Anticipatory Care Planning is distinctive from but may include aspects of Advance Care Planning which usually has a palliative, end of life focus and is typically implemented with irreversible resident functional decline.'

Adapted from Professor Kevin Brazil definition.

A Terms of Reference was agreed by Project Board and the Subgroup was established with subgroup deliverables as follows:

- Streamlined processes and structures to provide safe, effective and person centred clinical care without boundaries in collaboration with the independent sector and HSC organisations.

- A refreshed model of personalised healthcare building on the 'frailty model' focusing on 'What matters most to me" for residents, families and staff. Together achieving the best outcomes possible for each resident as individual situations arise.

- Participation approach to decision making regarding and access to the best suited clinical care, delivered by the right person at the right time, in the right place in their e.g. rehabilitation, long-term condition management and palliative care.

- Enhanced MDT care model that meets the needs of both acutely ill residents and those with chronic healthcare and/or rehabilitative needs.

- Appropriate contribution to the Workforce subgroup to support their work to develop a workforce development policy.

- Promotion and use of data and information technology in the care home setting and contribution to the informatics and digital technology subgroup.

The focus of the ECCF is to further enable and promote good Care Home living with wellness at the core. As an outcome the Wellness Pathway was developed by the sub-group which is underpinned by an Anticipatory Care Model.

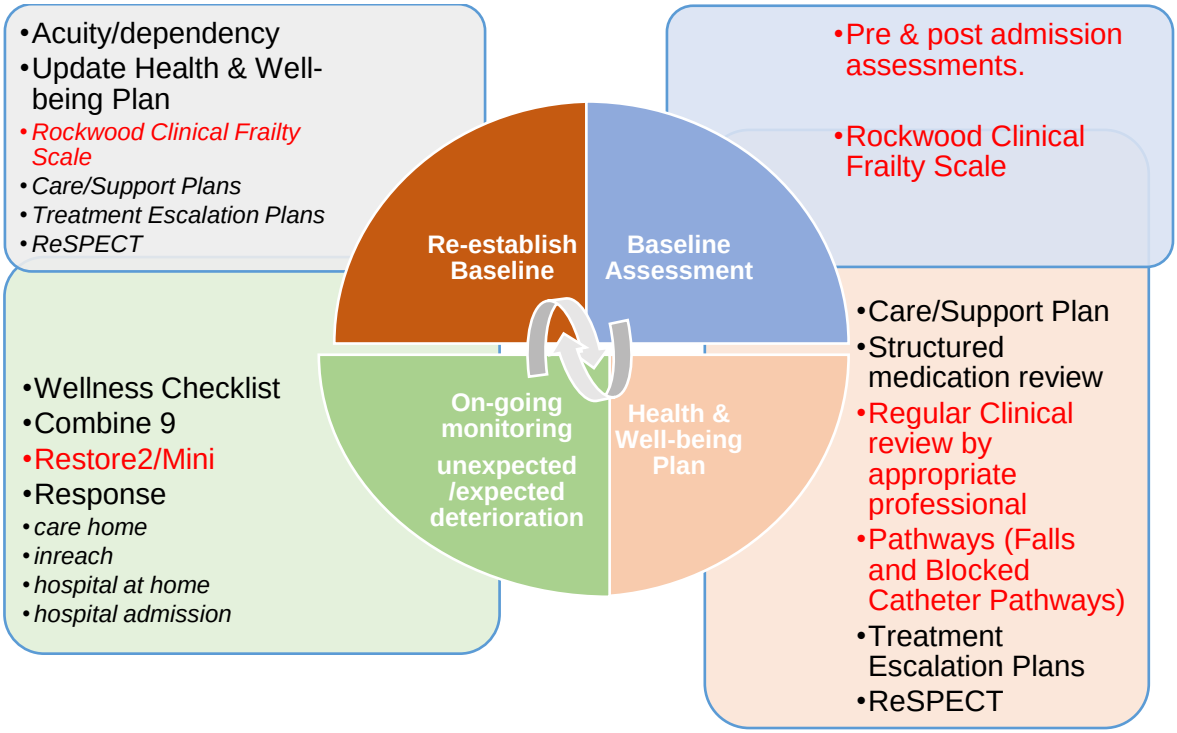
7.0 Development of a Wellness Pathway underpinned by an Anticipatory Care Model

In meeting the deliverable of "…Streamlining processes and structures to provide safe, effective and person centred clinical care without boundaries it was fundamental that collaboration took place across the independent sector and HSC organisations.

Proactive, collaborative, resident centred Anticipatory Care Planning (ACP) evolves over time to reflect the needs and wants of the individual resident. The diagram below illustrates how the Wellness Pathway weaves Anticipatory Care into everyday practice. This embraces the unique and individual needs of people living in Care Homes and involves the collaborative responsibility of clinical and non-clinical staff (including care partners, voluntary and community sectors) contributing to the care of people living in care homes.

It is important to note that not every aspect described in the Wellness Pathway could be tested during the lifespan of the project and a focus was placed on those that would make the timeliest enhancements to the health and wellbeing of residents. These products were referred to as the First Focus Actions and were ably led by nominated Multidisciplinary Subgroup members mentioned in this report (Appendix 2).

The First Focus Actions reported on in this document are highlighted in RED which were felt to prioritise the subgroup deliverable of "… ***Using a Participation approach to decision making regarding and access to the best suited clinical care, delivered by the right person at the right time, in the right place e.g. anticipatory care.***



- Pre Admission Assessment to include Rockwood Clinical Frailty Scale.
- Deterioration of Resident Assessments – Restore2 and Restore Mini
- Regional Falls pathway
- Regional Blocked Urinary Catheter Care Pathway

8.0 First focus Action Outcomes

8i. Pre-Admission Assessment and Rockwood Clinical Frailty Scale

In meeting the deliverable of ***"… developing a refreshed model of personalised healthcare building on the 'frailty model',*** the Multidisciplinary Subgroup agreed to focus on ***'What matters most to me'*** to provide focus for residents, families and staff when making an assessment of holistic needs upon discharging hospital inpatients to a care home setting.

The Development and testing of a new pre- assessment prior to care home discharge document commenced in December 2021. The document format was built on existing care home preadmission assessment documents with a new addition of assessing residents' level of frailty using the Rockwood Clinical Frailty Scale.

Other risk assessments were included in the document which would be completed following the resident admission to the care home. The new Pre-Admission Assessment document provided an increased focus on the centrality and uniqueness of the resident to its completion and encompassed a more holistic approach to both the clinical health and 'what matters most,' contributing to the wellbeing of residents.

8ii. Recommendations from Pre-Admission Assessment Documentation and Rockwood Clinical Frailty Scale

- Care Homes are a complex group and further testing of the Pre-Admission Assessment document is required with residential care homes prior to implementation with provision of 'train the trainer' education at care home level suggested.
- A regional opportunity for families and carers to promote Pre-Admission Assessment document and ensure their inclusion in completion.
- The Pre-Admission Assessment document is a care home facing document however would benefit from its content being mapped against existing community and hospital discharge/transition documents (gap analysis exercises) to ensure connectivity.
- Shared IT platforms required to enable access to resident information across HSC/ Independent Sector.
- Ensure Rockwood Frailty Model eLearning is maintained for new and existing staff and the resident frailty scale recorded and reviewed regularly. Also continued ECHO programmes incorporating Pre-Admission Assessment/Rockwood Frailty Model learning.
- Establish an annual Wellness Pathway (including Pre-Admission Assessment/Rockwood Frailty) event to celebrate and share Learning.

8iii. Testing of Deterioration tools- Restore 2 and Restore 2 Mini

RESTORE 2™ is a standardised evidence based tool for assessing a deteriorating resident in a nursing home. It provides guidance on acting appropriately and timely reporting using residents' physical observations to include provision of a concise escalation history to the most appropriate professional. RESTORE2Mini™ is a condensed version of the full RESTORE2™ tool, primarily suitable in a residential home setting for use to identify "soft signs" of a resident's deterioration. These tools were tested in nominated care homes from June 2022.

- **8iv. Recommendations from -Testing of Deterioration tools- Restore 2 and Restore 2 Mini**

- A collaborative approach to the implementation of RESTORE2/RESTORE 2 mini is required across all HSC services to ensure safe, skilled implementation – to include GP, NIAS, keyworkers, RQIA and community pharmacy. All professionals will have a working knowledge and understanding of use and the provision of ongoing All Systems support as residents will be identified earlier in their clinical decline thus requiring an appropriate, timely clinical response.
- Development of an ongoing RESTORE 2/RESTORE 2 Mini training programme is required by CEC with consideration to Train the Trainer opportunities at a care home level.
- Consideration is needed for the development of electronically accessible versions of RESTORE2/RESTORE 2 Mini as well as a supply of colour printed versions.
- Support from Trust Support Teams is required in implementation of these tools
- Shared IT platforms to enable access to resident information.

8v. Developing a Regional Falls Pathway

Development and Testing of the Falls Regional Pathway commenced in December 2021 with 18 partner care homes. Significant results were found in terms of improving the resident's quality of life, raising staff confidence in supporting safer mobility, post falls management and learning from falls. The Frailty Network have agreed to maintain the outcomes of the work on the Falls Pathway and to make further developments with the existing structures of Oversight and 3 task and finish groups continuing to support this work.

The main outcome is that care homes across NI should formally utilise the regional Falls Pathway products as the project was seen to be successful in; reducing resident falls and NIAS callouts, improving resident experience and quality of life, improving staff confidence in safer resident mobility, with intervention by MOOP improving the optimisation and stewardship of resident medications. This bundle of care is mainly cost neutral, however funding should be considered and identified for equipment, technology, workforce and training.

8vi. Recommendations from -The Regional Falls Pathway

- To have regional implementation and endorsement of the Falls in Care Homes Pathway Bundle across NI
- Care Homes to have Equitable access to core falls teams within Trusts
- Development and/or Sharing of Activity Coordinators
- Care Homes to have Equitable access to equipment and technology -some have experienced RITA but expensive.
- Residents to have consistency in access to timely Medicine reviews and staff training. Good practice examples e.g. Get it in Time medication alerts for residents with Parkinson's Disease
- Access to ongoing eLearning on Falls and care home train the trainer at care home level.
- Shared Learning Platforms e.g. Learning from SAI's letter
- PCC Regional families and carers meeting to share findings and thoughts for next steps.
- Other new homes keen to come on board. Scale and spread plan needed to support implementation and ownership beyond the partner care homes although pathway not mandated.
- Sustainability-Community of Practice-to maintain and sustain the pathway (e.g. Annual Learning events, Clinical care ECHO, RQIA workshop, QI Opportunities)

8vii. Developing a Regional Urinary Catheter Pathway.

This work commenced in May 2022 in partnership with ten care homes who were identified as having frequent resident attendances at the Emergency Department (ED). Participation in the pilot project was identified as a key challenge due to the inability of care homes to fully engage due to the significant and numerous operational issues they faced, however this did not deter from the very positive project outcomes. All care homes in the course of the project were given additional support either by their Trust continence specialist nurse or a member of their Trust care home support team.

Findings were that very often the rationale for the urinary catheter insertion at source was uncertain, with little information from acute on the future catheter care plan for some residents. A Urinary Catheter Passport Tool and Troubleshooting Guide has been developed with complete transferability to residents across Northern Ireland.

A key outcome from this urinary catheter project was the successful engagement across sectors with Consultants and General Practice and in many instances have successfully trialled the permanent removal of urinary catheters.

8viii. Recommendations from – The Regional Urinary Catheter Pathway.

- Regionally brand the new Urinary Catheter Passport and Troubleshooting Pathway with the Introduction of a Urinary Catheter Passport in all acute/non-acute hospitals for use on patient hospital discharge with expected return of the Passport for update if resident presents at ED/Hospital. This passport is transferable to patients in domiciliary care settings.
- Provision of a urinary catheter pack upon resident hospital discharge to accommodate next urinary catheter change and referral made to Trust Nursing Team for support.
- Additional resources to support care homes in the roll out of Urinary Catheter Passports for all Care Homes residents, with access to Trust continence specialists as a buddy model. Access to a cross-sector regional continence group is recommended to share best practice.
- Agree a regional urinary catheterisation training programme and define training frequency with associated Catheterisation Competency Training made available in catheter clinics.
- Care Home staff would benefit from access to details from Northern Ireland Electronic Care Record (NIECR) and other medical records.
- Development of a resident and domiciliary Urinary Catheter database with consideration to trial removal discussions with relevant medical practitioner/s.

8ix.

For completeness, it is noted the work of Advance Care Planning and RESPECT is being progressed by the Department of Health Advance Care Planning Lead. The Chief Medical Officer, Professor Sir Michael McBride launched the regional policy *"For Now and For The Future - An Advance Care Planning Policy For Adults In Northern Ireland*" in October 2022. The policy contains four components: Personal Legal, Clinical and Financial which requires a comprehensive training and education programme plan for staff and public in the implementation of this policy. The ReSPECT element of the policy will "go live" in 2023 and should not be used until further advised by the Department.

9.0 Discussion on Common Themes in Recommendations and Deliverables

The above report highlights that expected deliverables were met in the First Focus Actions which were prioritised by the ECCF Project Group and Working Group. At regular intervals through the life of this work engagement updates were given to the ***"… Workforce subgroup to support their work to develop a workforce development policy".*** And where this emerged ***"…Promotion and use of data and information technology in the care home setting and contribution to the informatics and digital technology subgroup was undertaken".***

A key observation from the various findings and recommendations from each of the First Focus Actions is that these cannot be taken forward in isolation as each of these outcomes interconnect in contributing to the fundamentals of good resident care. Any progression of these recommendations therefore requires a Whole Systems approach to include training, equipment and resources required to implement these good practice products. Cross cutting recommendations are as follows:

- *To regionalise these good practice outcomes and where required some further testing*
- *Residents and Families to be offered the opportunity to be more involved in resident's wellness plan of care.*
- *For Care homes to access Consistency in Regional Training and Equipment*
- *For training and education in the fundamentals of care needs of the resident with dementia and delirium to be consistent and quality driven*
- *An identified Resource is required to embed current good practice in test care homes and to scale and spread to other care home settings*
- *The use of regional networks to celebrate good practice and share learning*
- *The need to share patient information platforms (e.g. NIECR) with the independent sector*
- *Standardisation of language across sectors*
- *Request RQIA to review and refresh Care Home Standards*
- *Link Wellness with Early Years learning with the Department for Education and encourage wellness in older people in public facing messaging*

Whilst all of the Multidisciplinary Working Subgroup First Focus Action outcomes met the deliverable of ***"…Enhanced MDT care model that meets the needs of both acutely ill residents and those with chronic health care and/or rehabilitative needs",*** the group agreed the full visible and consistent connection with General Practice (GP) as a key component and facilitator is essential for this innovative model of anticipatory care and early intervention to progress. At a local level there was genuine feedback from a range of care homes who had effective engagement with their General Practices who had invoked the optional Local Enhanced Service. We were advised directly by both GPs and care home staff involved that this proactive model proved supportive and collaborative, resulting in good resident outcomes.

Following strategic regional discussions (December 2022) there is a collective vision where primary care is commissioned to oversee, lead and co-ordinate a service as outlined wherein the resident retains their personal choice of GP registration. The services would work in a cohesive and collaborative person centred team to provide

preventative, early intervention and anticipatory care for care home residents. The ultimate goal being the service is transferable to older people living in their domiciliary setting.

A further recommendation is the immediate roll out of MDT teams to all GP practices to contribute and assist with anticipatory planning service delivery, enhancing and responding in a timely way to the dynamic and emerging needs of residents.

Finally, for any of these First Focus Actions to be implemented fully requires a shared understanding across our wider Health Care System. Further strategic discussions are strongly recommended to encourage an All Systems integrated approach to the further testing and implementation of these First Focus Actions Products. Going forward this will undoubtedly benefit the health outcomes of the population residing in care homes and wider domiciliary settings.

Appendix 1 - Recommendations

Product	Recommendation
Pre-Admission Assessment Documentation and Rockwood Clinical Frailty Scale	Establish an annual Wellness Pathway (including Pre-Admission Assessment/Rockwood Frailty) event to celebrate and share Learning
	Care Homes are a complex group and further testing of the Pre-Admission Assessment document is required with residential care homes prior to implementation with provision of 'train the trainer' education at care home level suggested.
	The Pre-Admission Assessment document is a care home facing document however would benefit from its content being mapped against existing community and hospital discharge/transition documents (gap analysis exercises) to ensure connectivity.
	Shared IT platforms required to enable access to resident information across HSC/ Independent Sector.
	Ensure Rockwood Frailty Model eLearning is maintained for new and existing staff and the resident frailty scale recorded and reviewed regularly. Also continued ECHO programmes incorporating Pre-Admission Assessment/Rockwood Frailty Model learning.
	PCC engagement: regional meeting for families and carers to promote Pre-Admission Assessment document and ensure their inclusion in their completion
	Establish an annual Wellness Pathway (including Pre-Admission Assessment/Rockwood Frailty) event to celebrate and share Learning.
Testing of Deterioration tools- Restore 2 and Restore 2 Mini	A collaborative approach to the implementation of RESTORE2/RESTORE 2 mini is required across all HSC services to ensure safe, skilled implementation – to include GP, NIAS, keyworkers, and community

	pharmacy. These professionals must have a working knowledge and understanding of use and the provision of ongoing All Systems support as residents will be identified earlier in their clinical decline thus requiring an appropriate, timely clinical response
	Development of an ongoing RESTORE 2/RESTORE 2 Mini training programme is required by CEC with consideration to Train the Trainer opportunities at a care home level.
	Consideration is needed for the development of electronically accessible versions of RESTORE2/RESTORE 2 Mini as well as a supply of colour printed versions.
	Support from Trust Support Teams is required in implementation of these tools
	Shared IT platforms to enable access to resident information
The Regional Falls Pathway	To have regional implementation and endorsement of the Falls in Care Homes Pathway Bundle across NI
	Care Homes to have Equitable access to core falls teams within Trusts
	Development and/or Sharing of Activity Coordinators
	Care Homes to have Equitable access to equipment and technology -some have experienced RITA but expensive
	Residents to have consistency in access to timely Medicine reviews and staff training
	Access to ongoing eLearning on Falls and care home train the trainer at care home level.
	Shared Learning Platforms e.g. : Learning from SAI's letter
	PCC Regional families and carers meeting to share findings and thoughts for next steps
	Other new homes keen to come on board. Scale and spread plan needed to support implementation and ownership beyond the partner care homes although pathway not mandated.

	Sustainability-Community of Practice-to maintain and sustain the pathway (e.g. Annual Learning events, Clinical care ECHO, RQIA workshop, QI Opportunities)
The Regional Urinary Catheter Pathway	Regionally brand the new Urinary Catheter Passport and Troubleshooting Pathway with the Introduction of a Urinary Catheter Passport in all acute/non-acute hospitals for use on patient hospital discharge with expected return of the Passport for update if resident presents at ED/Hospital. This passport is transferable to patients in domiciliary care settings.
	Provision of a urinary catheter pack upon resident hospital discharge to accommodate next urinary catheter change and referral made to Trust Nursing Team for support.
	Additional resources to support care homes in the roll out of Urinary Catheter Passports for all Care Homes residents, with access to Trust continence specialists as a buddy model. Access to a cross-sector regional continence group is recommended to share best practice.
	Agree a regional urinary catheterisation training programme and define training frequency with associated Catheterisation Competency Training made available in catheter clinics.
	Care Home staff would benefit from access to details from Northern Ireland Electronic Care Record (NIECR) and other medical records.
	Development of a resident and domiciliary Urinary Catheter database with consideration to trial removal discussions with relevant medical practitioner/s.

Appendix 2 - ECCF - MDT membership

Elizabeth	Graham	Assistant Director of Person Centred Practice, Nursing Innovation and Development of Nursing, Northern Health and Social Care Trust
Dr Rose	McCullagh	GP (Frailty Network), Associate medical director older people and primary care, Southern Health and Social Care Trust
Brenda	Arthurs	Assistant Director, Nursing, South Eastern Health and Social Care Trust
Tracey	Borthwick	Speech and Speech and Language Therapist, Northern Health and Social Care Trust
Peter	Burbridge	Head of Podiatry, South Eastern Health and Social Care Trust
Veronica	Cleland	Interim Assistant Director Community Health Care, South Eastern Health and Social Care Trust
Sally	Convery	Macmillan Service Lead, Palliative Care, Northern Health and Social Care Trust
Dr Frances	Duffy	Consultant Clinical Psychologist, Northern Health and Social Care Trust
Rosie	Elliott	Head of Learning Disability Services, Northern Health and Social Care Trust
Deborah	Gray	Speech and Language Therapist, Belfast Health and Social Care Trust
Corrina	Grimes	Chief AHP Officer's Office secondment to Department of Lead as Advance Care Planning Lead
Martin	Hayes	Integrated Care Partnerships Project Director
Paula	Heneghan	Regional Manager, Marie Curie Nursing Service
Katherine	Hudson	Dietetics, Northern Health and Social Care Trust
Noel	Irwin	Social Services Policy Group, Department of Health
Ruth	Johnston	Manager, Nicholson House
Dr Rosemary	Kelly	Chief Medical Officer for Northern Ireland Advisor on older people medicine
Rosaline	Kelly	Royal College of Nursing secondment to Nursing and Midwifery Allied health Professionals, Department of Health
Michelle	Laverty	Allied Health Professional Public Health Agency secondment to Nursing and Midwifery Allied health Professionals, Department of Health
Caroline	Lecky	Nurse Consultant Older People, Public Health Agency
Louise	McCuskey	Manager, Longfield Care Home, Healthcare Ireland
Joan	McEwan	Head of Policy and Public Affairs, Marie Curie
Lesley	McKillen	Home Manager (Rathmena House Care Home – Ballyclare)
Gerry	Millar	GP Facilitator Southern Health and Social Care Trust, Macmillan GP Advisor Cancer and Palliative Care Northern Ireland, Vice Chair Northern Irenad Hospice and NI Children's Hospice
Aine	Morrison	Deputy Chief Social Work Officer
Cara	Parker	Home Manager Lansdowne Intermediate Care Centre, Four Seasons Health Care
Gillian	Plant	Pharmacist, Health and Social Care Board
Neil	Sinclair	Assistant Clinical Director (Paramedicine) Northern Ireland Ambulance Service
Mary	Stevenson	Healthcare Ireland Group
Monica	McAlister	Assistant Director of Older People's Services
Yvonne	Murphy	Service Lead for Acute Care at Home and Ambulatory Services for Older People

Jayne	Agnew	Consultant Pharmacist (Older People)
Ceara	Gallagher	Allied Health Professional, Public Health Agency
Wendy	Taggart	Professional Head of Service for Adult Speech and Language Therapy
Cathy	McKeown	Head of Physiotherapy - Falls rep
Wendie	Mc Quillan	Lead Nurse – Enhanced Services - Catheter Rep
Kerrie	Wallace	Home Manager Domnall Intermediate Care Centre, Four Seasons Health Care
Christine	Wilkinson	Divisional Care Home Lead, Commissioned Services, BHSCT
Helen	Mc Connell	Care Home Support Team Manager, WHSCT
Claire-Ann	Jardine	Clinical Nurse Advisor, Care Home Support Team, WHSCT
Pamela	Monaghan	Clinical Nurse Advisor, Care Home Support Team, WHSCT
Kathleen	McBride	Manager, St Francis Care Home
Vincent	Ryan	Assistant Director - Community Nursing, Primary Care & Older Peoples Services, South West Acute Hospital
Jenny	Willis	Home Manager Nightingale Care Home, Healthcare Ireland
Catherine	Glover	Senior Inspector, Pharmacy Team
Dr Mary	McDaid	GP
Kerry	Finlay	Lead General Practice Pharmacist Ards Federation
Julie	Foster	Acting Lead Nurse, REACH, NHSCT
Maura	Corry	Lead General Practice Pharmacist North Belfast Federation
Gerry	McKenna	
Tanya	Carson	
Dr Conor	Barton	Royal College of Psychiatrists NI, Faculty of Old Age Psychiatry and Consultant in Old Age Psychiatry
Kathy	Fodey	Senior Programme Manager, Care Home Transformation, Nursing and Midwifery Allied health Professionals, Public Health Agency
Maureen	Serplus	Head of Mental Health Older People Services, Northern Health and Social Care Trust