COMMUNITY MATRON JOB DESCRIPTION

JOB DETAILS

Directorate	Operations
Service	Community Matrons
Post Title	Community Matron
Staff Group	Nursing
Band	7
Reports to	Community Matron Service Lead
Accountable to	Community Matron Service Lead
Number of Direct Reports	None (although may line manage a support nurse in future)
Overall Headcount Responsibility	None
Budget Responsibility (£)	Nil

KEY RELATIONSHIPS

Internal:

- Head of Nursing
- Clinical Leads for District Nursing Teams
- Community Matron Service Lead
- Associate Director of Operations
- BHC Services
- Safer Care Team
- BHC Geriatrician

External:

- GPs and practice nurses
- Intermediate Care services Secondary care providers
- Allied Health Professionals
- Emergency services
- Out of hours providers
- Social Services care managers in primary and secondary care
- Prescribing team
- Public Health Directorate
- PALS
- Expert patient facilitator
- Voluntary sector
- Service users and carers
- Mental health providers

JOB SUMMARY

The Community Matron will work as a key member of the Integrated Care Networks Proactive Care Pathway. The proactive Care Pathway aims to successfully manage frail and elderly patients in the community through a multi-disciplinary approach to care and through the application of case management.

The Community Matron will work closely with Primary Care to identify patients through risk stratification and develop proactive patient centred care plans, actively implementing and following through on the care plan to establish and monitor its implementation. The Community Matron role is a key role in the Proactive Management and Integration of Services for the Elderly

- The Community Matron will proactively holistically assess and case manage a caseload of patients with highly complex needs, working closely with GP practices to identify patients that would benefit from preventative interventions in the community using clinical judgement and a risk stratification tool. The role will complement the generic district nursing and specialist roles in chronic disease management across primary and community services.

- The Community Matron will provide clinical care and clinical leadership, co-ordinating the care and case management of risk stratified patients within the Integrated Community Teams preventing unnecessary admissions and facilitating appropriate ones.

- The Community Matron will have/will be expected to develop high level skills in physical assessment and diagnostic reasoning including prescribing within their scope of practice.

- The Community Matron will work collaboratively across health, social care services and the voluntary sector to identify vulnerable older people with complex needs.

MAIN DUTIES AND RESPONSIBILITIES

Leadership/Managerial

1. To act as the key point of contact within the ICN proactive care pathway. The Community Matron will carry out an initial holistic assessment for all patients identified for the pathway and will then discuss the care plan generated at a MDT discussion.

2. To be responsible for the management of a caseload and maximise efficiency and effectiveness in the role to secure the best service to patients. This will include the analysis and management of complex changing clinical situations.

3. Act as a change agent and innovator, planning, implementing and evaluating change to facilitate high quality health outcomes, pioneering new services where gaps exist.

4. To provide expert advice on Long Term Conditions and suggest strategies to improve and develop services across organisational and professional boundaries.

5. To provide expert advice on frailty and ceilings of care, liaising with a local geriatrician as needed to move the patient through appropriate care pathways/into end of life pathways, when appropriate.

6. To support in the development of the Integrated Community Teams including upskilling colleagues (including colleagues outside of nursing) by mentoring, feedback and teaching.

7. To assist in the development of policies, procedures and guidelines to support the case management process.

8. To participate in the evaluation of the service and service development including relevant audits and research, providing reports as and when required.

9. To ensure that all necessary records are maintained in line with Bromley Healthcare and NMC requirements.

10. To have an awareness of budget management and be responsible for the efficient and effective use of resources within own practice e.g. equipment supplies and time management.

11. To act at all times as a positive role model and an advocate both for individuals and the service, networking with a variety of forums as appropriate.

Clinical

1. Be responsible for an identified caseload of patients, taking referrals from relevant health professionals in line with the current Bromley Healthcare guidelines.

2. To use advanced clinical practice skills and expert knowledge, using nationally recognised assessment tools. Undertake in depth holistic clinical assessments, including a full physical examination and identifying patient's medical, social, psychological and spiritual needs.

3. To negotiate and develop a personal care plan with the patient, health/social care professionals, carers and/or relatives. To ensure these care plans are patient centred and that the patient signs up to the care plan and feels fully involved in its development.

4. To diagnose, instigate and review therapeutic treatments based on best available evidence to manage and improve health outcomes.

5. To provide expert clinical care and health promotion interventions.

6. To regularly monitor and review the patient's condition to identify subtle changes in that condition, proactively manage these to enhance well being and promote independence and teach relatives and carers to recognise these changes.

7. To manage individuals with chronic disease through an advanced level of autonomous practice including taking managed risks.

8. To use appropriate benchmarks to drive standards of performance in management of longterm conditions, aligning to the GP ‘QoF’ and other national frameworks as appropriate.

9. To develop therapeutic relationships with patients and carers, enabling and supporting them to be active partners in the care planning process for their current and future needs.

Bromley Healthcare
community first

Working with NHS

10. To develop and use expert knowledge and skills to order diagnostics e.g. blood tests and interpret and act on results, using clinical guidelines and policies to support clinical decision making.

11. To work in partnership with GP's, nurse practitioners, relevant hospital consultants and others to determine a diagnosis when required.

12. To take responsibility to formulate a plan of care and follow-up, ensuring the multi-disciplinary team within the ICN is fully involved.

13. To work collaboratively when patients are admitted to any in-patient facility, and provide base line health data for the receiving team to support integrated and consistent care and facilitate discharge or end of life care.

14. To refer appropriately and in a timely way to other services and health/social care professionals.

15. Working closely with the CPNs in the community teams including supporting shared care management of long term mental health conditions such as dementia and depression

16. To manage high risk patients pro-actively and minimise the risk of hospital admission ensuring they are in the most appropriate care environment.

17. To co-ordinate and evaluate additional support as needed, such as home care, intermediate care, palliative care teams or geriatricians.

18. Provide advice to patients and their carers on medicines and their management

19. To prescribe as an independent prescriber, or a supplementary prescriber using a clinical management plan in accordance with DoH and Bromley Healthcare guidelines on non-medical prescribing.

20. To undertake medication reviews and to prescribe within competencies to ensure that patients are on optimal disease specific medications as per NICE and Local Guidelines.

21. Supporting the implementation of the dementia screening programme across the community teams, and supporting patients with dementia

Education and Training

1. Develop own knowledge and skills within the national case management competency framework in order to function as an advanced clinical practitioner.

2. Take an active part in the organisations review process identifying own learning and developmental needs against the Knowledge and Skills Framework (KSF) outline for the post and produce a Personal Development Plan (PDP) to meet those needs.

3. Take an active part in the organisations clinical supervision process.

4. To act as a mentor to other staff where appropriate, providing education, training and support.

5. Ensure the quality of the local learning environment is maintained and constantly improved

6. Critically evaluate evidence based research and integrate theory into practice.

Professional

1. To maintain NMC registration/revalidation as required and work within NMC guidelines relating to current nursing practice e.g. code of professional conduct, standards for the prescribing and administration of medicines, scope of professional practice and guidelines for records and record keeping.

2. Remain updated and ensure that clinical practice is evidence based.

3. Be aware of and comply with all relevant Bromley Healthcare policies and procedures.

MANDATORY REQUIREMENTS FOR ALL ROLES

Safeguarding

All staff must be familiar with and adhere to Bromley Healthcare's child/adult safeguarding procedures and guidelines, in conjunction with the multi-agency policies and procedures of the relevant borough's Safeguarding Children Partnership and Safeguarding Adults Board.

Staff must be mindful of their responsibility to safeguard children and adults in any activity performed on behalf of Bromley Healthcare in line with the requirements of the Children's Act 1989 and 2004 and the Care Act 2014.

Staff are required to attend child/adult safeguarding training relevant to their position and required for their role.

The post holder is expected to demonstrate the values of Bromley Healthcare including;

The post holder is expected to embody the 4 values:

• Compassion

• Health and Wellbeing

• Continuous Learning and Innovation

• Wellbeing

The post holder is expected to work within the requirements of the 6 C's – Care, Compassion, Competence, Communication, Courage and Commitment.

The post holder is expected to comply with all Bromley Healthcare's relevant policies, procedures and guidelines; including the appropriate code (s) of conduct associated with this post.

PERSON SPECIFICATION
ESSENTIAL AND DESIRABLE CRITERIA

	Essential	**Desirable**	**Mode of Testing**
Qualifications	Education to first level degree or equivalent. Completion of the following courses as a minimum: Independent prescriber V300 or be willing to undertake this. Enhanced Physical Assessment Skills and history taking in Primary Care	Masters level study Recognised Nurse Practitioner qualification and or Credentialing. ENB 998/997 or equivalent mentoring training Case Management of people with LTC module	
Professional Registration	First level registration Current NMC registration		
Training	Evidence of Continuing Professional Development		

Specific Skills	• Teaching and assessing skills and supervision of staff • Ability to undertake advanced patient assessments, implement appropriate nursing care and treatment and evaluate Outcomes • Able to prioritise and work flexibly • Able to function as an advanced practitioner with expert clinical skills • Computer literate, able to understand and interpret relevant clinical data and information • Car driver with current license with access to vehicle	• Experience of undertaking audit (benchmarking and evaluation of services) • Advanced assessment of care planning skills • Presenting skills – PowerPoint, Excel etc	

Experience	• Evidence of post registration education e.g. specialist practitioner, nurse practitioner, post registration courses or portfolio of evidence • Demonstrable evidence of post registration experience • Demonstrable Primary Care experience in care of people with long term conditions • Experience of working in Community services • Experience of interagency and collaborative working • Experience of managing complex and rapidly changing clinical conditions • Experience of clinical audit, benchmarking and evaluation of services • Ability to assess acutely unwell patients and demonstrate ability to manage them effectively and in a timely manner	Experience of leading of policy/service development	

Personal Qualities	• Knowledge of our Business • Committed to improving services • Committed to hitting targets • Treats others as would like to be treated • Committed to 6 C's • Good Interpersonal Skills • Able to work individually and as part of a team • Flexible approach to meting service & client needs • Time management skills and ability to prioritise • Excellent communication skills • Ability to cope with change and open to innovation • Effective role model, able to lead and motivate others • Team player – able to work across organisations and structures • Able to work autonomously and show initiative • Ability to challenge and manage difficult situations		

	• Assertive with good problem solving skills • Ability to write concise, comprehensive reports		
Information Technology	• Experience of using Excel, Word, • Understanding of clinical templates and their use to drive systematic care • Comfortable with paperlight working	• Experience of EMIS • Experience of coding systems • Experience of paperlight working • Experience of UCP	

DETAILS OF PERSON COMPLETING JOB DESCRIPTION AND PERSON SPECIFICATION

JD and PS completed by (job title):	Vicky Sanderson, Lead Community Matron
For an existing JD and PS - date reviewed:	Last updated October 2022
For a new JD and PS - date completed:	