NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

AFC Reference:	COMM/0160
Job Title:	Community Matron
Band:	8a
Division/Service:	Community - Long COVID Tier 3 Service.
Accountable to:	Place Lead
Responsible to:	Operational Lead

Job Outcomes:

As a result of the post-holder being effective in their role, The Trust would expect to see the following outcomes for the Trust, service users and the wider community:

1. Mersey Care NHS Foundation Trust as a leading provider of community services, mental health care, physical health, addiction services and learning disability care.
2. Service users receiving a high-quality service and one which is free from stigma, discrimination, and harm.
3. Staff engaged with the delivery, innovation, and continuous improvement of services to benefit service users.
4. Visible and responsive leadership, setting the standard for others and role-modelled throughout the division for all managers
5. The Trust values of Continuous Improvement, Accountability, Respectfulness, Enthusiasm and Support will be embedded across the division for all staff and evident to service users.

Job Purpose:

As an autonomous practitioner the post holder will have an advanced clinical role with responsibility for assessing, planning, managing, and coordinating the care of people, in the Long COVID Tier 3 service, with highly complex needs and long-term conditions within a defined caseload. The practitioner will provide comprehensive holistic care sensitive to the needs of the population using advanced clinical assessments and case management techniques to reduce unplanned hospital admissions.

The post holder will be a key enabler in meeting the Mersey Care Foundation Trusts strategic agenda. They will have enhanced/advanced skills, knowledge and competencies in non-medical prescribing, critical thinking, history taking, clinical examination, diagnostic skills, case management, long-term condition management, frailty, and acute episode management with the ability to relate theory to practice.

The post holder will provide clinical leadership, professional role modelling, mentorship, supervision, education, and clinical expertise as an independent and interdependent practitioner, developing and leading relationships within the integrated nursing teams and integrated care teams.
The post-holder must be educated to MSc degree level in Advanced Clinical Practice or have equivalent qualifications and experience.

Principal Responsibilities:

1. To be responsible for planning, reviewing and renegotiating programmes of care to promote health gains and maximise independence within a defined caseload in conjunction with the Long COVID Tier 3 service.
2. Develop and maintain communication with people about complex issues and/or in difficult situations.
3. To use advanced skills and expert knowledge to access the physical and psycho-social needs when there are complex and/or undifferentiated abnormalities, diseases, and disorders of a defined client group, instigating therapeutic treatments based on best available evidence in order to improve health outcomes.
4. To play a lead role in the Long COVID Tier 3 service to improve holistic assessment and approach to health and social care needs of patients.
5. To play a lead role in improving the access to health care within care home settings.
6. To be professionally and legally responsible and accountable for all aspects of own work, including the management of patients in your care.
7. To accept clinical responsibility for a diverse and often complex caseload of patients, to organise this efficiently and effectively with regards to clinical priorities and use of time.
8. Demonstrates advanced listening, communication, and negotiation skills to understand what matters to each individual patient, to ensure the patient is at the centre of all decisions and to agree and work towards appropriate goals for every patient.
9. To work closely with medical, nursing, allied health professional and volunteer services across primary care, secondary care, and community settings to ensure patients receive appropriate investigation, intervention, and care planning to ensure their physical and mental health is optimally and safely managed to afford them the best possible for basis for rehabilitation, reablement and recovery.
10. To develop / maintain advanced specialist clinical skills and knowledge to identify changes in a patient's condition through clinical examination.
11. To undertake interventions consistent with evidence-based practice, transferring and applying knowledge and skills to meet client needs.
12. To use the skills and knowledge to make referrals for diagnostic tests.
13. To evaluate the effectiveness of interventions in meeting prior agreed goals and making any necessary modifications.
14. As a non-medical prescriber (NMP) take necessary assessments, medicines review and prescribe within the Prescribing Framework.
15. As a supplementary prescriber, actively manage the polypharmacy and other medication issues associated with chronic disease management and care home residents in conjunction with the patient's medical practitioner, through the use of clinical

management plans.

16. To be responsible for ensuring the provision of planned intervention in all aspects of chronic disease management with appropriate input from the multidisciplinary team in order to reduce the risk of complications and deterioration of the patient's condition.
17. To improve the patients "self-management" of their condition wherever possible taking into account the functional and cognitive patient assessment.
18. Ensures that the care provided, and services delivered are in line with local and national guidelines and policy.
19. Maintaining accurate and legible patient notes in accordance with Trust and national professional policies and guidelines.
20. Use advanced clinical skills and expert knowledge to provide proactive monitoring and provide timely intervention.
21. To work as an integral part of the integrated community nursing, multidisciplinary and multi- agency teams.
22. To actively participate in projects designed to improve the proactive management of patients.
23. Make operational judgements.
24. Develop own skills and knowledge and contribute to the development if others within the guidelines of the NMC Code of Conduct.
25. Clearly identifying the wider benefits that developing knowledge, ideas and work practice will bring.
26. Challenging tradition and take risks, accepting joint responsibility for any arising problems and tensions and using these to inform future practice.
27. To work independently managing own caseload in conjunction with the General Practitioner, Community Consultant Geriatrician, Social workers, Medicines Management, Mental Health teams, Learning disability teams, Integrated nursing teams, AHPs and secondary care teams as appropriate.
28. Demonstrates professional responsibility for adherence to Trust and NMC policies and procedures.
29. To work directly with multi-professional teams to assist in the management of risk, facilitation of complex case reviews and the immediate crisis management.
30. The post holder may be exposed to frequent distressing or emotional circumstances with patients who are terminally ill or suffering end of life events and will be required to deal with this situation in a professional manner.

<u>Leadership</u>

31. Inspires others and encourage them to seek advice and solutions to problems.
32. Challenge's others to take an active part in developing knowledge, ideas, and work practice.
33. Challenge's tradition and takes clinical risks based on evidence, accepting responsibility for their decisions and uses this to inform future practice ensuring best practice is shared.
34. Promotes the service and encourages the Integrated Nursing Teams to disseminate good practice both internal and external to the Trust.
35. Challenge's professional and organisational boundaries to ensure that Case Management role development is focused on meeting the needs of service users, thus

promoting continuity of high-quality patient –centered health and social care.

36. Identifies clear benefits to the developing role of the Community Matron and communicate these effectively within the organisation, primary care, secondary care, other agencies, and communities.
37. Take the lead role in case discussions / case conferences concerning service users on their caseload.
38. Acts as an advocate and champion for patients in a variety of forums and professional groups and, where necessary, challenge against attitudes.
39. Effectively communicates at all levels of the organisation to a variety of health professionals, service users and carers, to provide the best outcomes for patients.
40. Provides the interface between secondary, primary, and social care settings.
41. Maintains a high level of performance when faced with opposition or working under conditions of pressure.
42. Communicates the vision and benefits of case management and enhanced health in care homes to a variety of forums.
43. Leading in complex issues and helping to make complex decisions.
44. Communicating highly sensitive, complex, and confidential information to patients, relatives, carers, and multidisciplinary and multi-agency team.
45. To promote the Trust's vision and public health priorities.
46. The post holder will have responsibility for any staff that they supervise to ensure they are adhering to all the required health, safety and security tasks as set out in their Job descriptions and report any risks to the relevant persons.
47. Undertake investigations as required.
48. Contribute to policy and guideline development and review.

<u>Responsibilities for Physical and Financial Resources / Analysis & Data Management</u>

49. Takes responsibility for the management of the clinical environment and is accountable for the use of resources contained therein.
50. Alerts managers to resource issues, which affect learning, development, and performance in prompting evidence, based care, taking into account, financial and budgetary considerations.
51. Accurately maintaining the necessary records of resource used.
52. Identifies caseload through interpretation of the information available on the health needs of the locality in which they are based.
53. Contributes to the collection of data to monitor outcome measures for the caseload.
54. Evaluating legislation, policies and procedures and communicating their effect on work and other service provision in the Trust.
55. Agreeing with others the outcomes of evaluations and the implications of this for services.
56. Meeting statutory requirements, professional requirements, and EC directives.

<u>Training & Education</u>

57. Be proactive in developing own professional practice, demonstrating evidence of increasing autonomy, clinical judgement and decision-making skills and contribute to

the development of others.

58. Monitors own performance and identify personal development needs in relation to gaps in clinical skills and knowledge. Take measures to ensure that deficits are addressed within PACE.
59. Integrates theory into practice by bringing knowledge from academic courses into the practice environment.
60. Contributes to the development of a learning and development culture within the workplace.
61. Works with the multidisciplinary, multi-agency team to co-ordinate the development, implementation, and evaluation of teaching programmes for patients and their carers that provide them with the necessary knowledge and skills to gain independence, safely manage with their circumstances, plan for unavoidable progression in their conditions and effectively access health and social care.
62. Develop personal development plans and participate in the appraisal process.
63. Understanding own role and that of other multidisciplinary team members.
64. Keeping up to date with developments in quality in own and associated areas including portfolio building.
65. Staff should attend mandatory and statutory training, report incidents, access risks, report unsafe occurrences and follow Trust policy.
66. Proposes and implements case management protocols and policies that impact beyond own area and service development.

Clinical Governance/Research and Audit

67. Critically evaluates and interprets evidence-based research findings from diverse sources making informed judgements about their implications for changing and/or developing services and clinical practice.
68. Continually evaluates and audits the practice and self of others, selecting and applying a wide range of valid and reliable approaches and methods that are appropriate to the needs and context.
69. Contributes to the evaluation of the Community Matron role.
70. Audit and evaluate the quality of own work and where necessary make appropriate improvements.
71. Access and manage the risks to quality.
72. To take a lead in research and clinical audit as required by the Trust within own specialty.

Communication

73. Work in partnership with the multidisciplinary and multi-agency team to establish diagnosis, formulate a plan of care and initiate referrals as appropriate.
74. Work in partnership with the patient and informal care givers to plan individual roles and responsibilities in relation to the delivery of care, respecting patient choice and autonomy throughout the process.
75. Develop excellent working relationships with key contributors to the development of care pathways for patients and participate in the review of these pathways.
76. Establishes a network that can be used to streamline care pathways.

77. Negotiates and agrees with patients, carers and other healthcare providers, individual roles, and responsibilities with actions to be taken and outcomes to be achieved, referring on to other services as appropriate.
78. Manage conflicting views and reconcile inter and intra-professional differences of opinion.

Generic Responsibilities for all staff:
All post holders will agree to:

- Commit to the vision of supporting Mersey Care in becoming a leading organisation in the provision of community services, mental health care, addiction services and learning disability care, and in doing so fully utilise their skills and experience to support the objectives of the Trust.
- Role model the values of the Trust – Continuous Improvement, Accountability, Respectfulness, Enthusiasm and Support– in all activities and interactions with employees, service users and other stakeholders
- Challenge the stigma associated with mental health and learning difficulties.
- Comply with the Duty of Candour, defined by Francis as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.'
- Work across professional and organisational boundaries to improve services for all.
- Maintain their specific knowledge base and develop new skills.
- Value the contribution of the patient/ service user voice.
- Operate within any organisational codes of practice or those from a relevant professional body.
- Respect equality and diversity across all areas of working practice and communications with staff, service users and other stakeholders.
- Take responsibility for the accurate and timely collection and recording of data and ensuring all personally identifiable information is protected and used only for the purposes for which it was intended.
- Comply with all health and safety legislation and local policies and procedures.
- Adhere to all organisational policies.
- Have knowledge and understanding of technology in the workplace which is sufficient to maintain their efficiency and also how technology can empower service users in a digital environment.
- Comply with the NHS Constitution in relation to the staff responsibilities that it sets out for NHS employees.

- Attend a one day Just and Learning & Civility and Respect training workshop.
- Be an ambassador for Just & Learning and Civility & Respect following the training.
- Positively advocate the just and learning culture within your team.
- Be a confident supporter and implementer of the Trust CARES Values including Civility & Respect within your team.

- Support their team/services to create a positive environment for Just and Learning Culture.
- Participate in Just and Learning Culture events.
- Bring Just and Learning Culture updates/information to the attention of team members and other MCT colleagues they work with.
- Support and encourage the sharing of concerns about the safety and quality of care with senior leaders with the aim of improving safety and quality.
- Actively participate in creating an open culture within your team so that concerns and difficulties can be discussed safely and respectfully.
- Speaking up in the event that they are exposed to incivility between colleagues in the workplace #iwillspeakup.
- Listening and understanding others who have concerns and taking a collaborative approach to work towards a solution to improve civility and respect.

This job description is intended as an outline indicator of general areas of activity and will be reviewed in light of the changing needs of the Trust in consultation with the postholder.

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PERSON SPECIFICATION

	ESSENTIAL	DESIRABLE
QUALIFICATIONS:	• MSc Advanced Clinical Practice or Clinical equivalent MSc qualification • Clinical Diagnostics • Advanced Clinical Skill • Non-Medical Prescribing • Up to date professional portfolio	• Post graduate certificate in long term conditions • Masters level post graduate qualification in appropriate area
KNOWLEDGE/ EXPERIENCE:	• Demonstrate post registration experience at senior level • Evidence of working collaboratively with other disciplines / agencies • An understanding of systems in health and social care that are wider than immediate role • Experience of a mentoring / teaching role • To demonstrate an awareness and understanding of the factors that contribute to good health and the importance of promoting these in line with the Trust's public health aims • Able to balance service and educational demands, good time management • Understanding the principles of governance, particularly in relation to their service area. • Must have constructive, enquiring, flexible approach to others and to their work	• Have evidence of leadership of some aspects of a service development • Knowledge of long-term conditions management and acute episode management • Sound understanding of the expectations of the Community Matron role particularly in terms of service outcomes
VALUES:	• Continuous Improvement • Accountability • Respectfulness • Enthusiasm • Support	

	• High professional standards • Responsive to service users • Engaging leadership style • Strong customer service belief • Transparency and honesty • Discreet • Change oriented	
SKILLS:	• Good computer literacy, including skills for using internal based communications and literature • Must have the self-confidence and negotiation skills to challenge traditional practice, and the persistence to address difficult enduring issues • Organisational skills to be able to plan proactively, manage and evaluate their own workload and learning, to negotiable learning opportunities, establish learning contracts • Demonstrate excellent written and verbal communication skills • Advanced Clinical and diagnostic skills • Demonstrate strong leadership skills across the integrated nursing workforce	