**Specialist Neighbourhood Nurse Job Advert**

**Spalding PCN.**

The post available is 0.8WTE (30 hrs/week) with an offered salary of £43,858 (Pro rata)

The development of Integrated Neighbourhood working is supporting Providers to work in a joined-up way. and Primary Care plays a key role in the success of Integrated Neighbourhood working, supporting patients to self-manage their condition or be assisted to manage their health needs closer to home, in their local communities. This approach enables more people with health and social care complexities to achieve a greater balance in all round health.

Please send your CV and cover letter outlining why you are suitable for this role and to be considered for this position.

if you want to discuss the role, please contact Lisa Jones, PCN Manager for Spalding PCN (email lisa.jones30@nhs.net)

**Job Description**

The role of the Specialist Neighbourhood Nurse is to support both the practice staff and members of the Neighbourhood Team to identify and support people to reduce the risk of unplanned hospital admissions and to effectively support those individuals in the community.

To work dedicated hours to focus on proactively case managing people and being the preferred point of contact for the patient and Neighbourhood Team in order to achieve the following objectives:

* To be a pro-active member of the Neighbourhood Team
* To pro-actively engage with people deemed to be at a high risk of hospital admission
* To pro-actively engage with the in-reach teams to reduce length of stay in hospitals
* To pro-actively engage with people living in care homes
* To pro-actively engage with housebound people
* To be the key contact for people at the practice

**3. Role summary (as per Service Specification)**

To liaise with the registered GP and other practice-based staff in addition to all other providers and services utilising, where appropriate, a multi-disciplinary approach.

To implement and review individual care plans, a self-management plans and to agree trigger thresholds to contact Case Managers / GP’s.

Plan visits to housebound people, undertake every 3-6 months, and arrange care plans where necessary

Provide enhanced support to Nursing and Residential home with a focus on strengthening relationships and improving access through information sharing, education and advice.

Planned visits to Nursing and Residential homes to be undertaken every 3-6 months, providing training as required.

To ensure all people in Nursing and Residential homes have care plans (including dementia where needed) and to provide a holistic review of all people in these homes with updates of their care plans.

To contact people where necessary to advise them of the role of Specialist Neighbourhood Nurse

Visit people at home following the identification of urgent clinical need including those escalated by EMAS or a member of the Neighbourhood Team, undertake a personalised comprehensive assessment, in order to diagnose, treat and prescribe within the limitations of your registration and competence

Visit people at home following an unplanned hospital admission and those with a history of repeat admissions, within 2 weeks.

Contact those that have suffered a bereavement.

Arrange dedicated appointments in practice, for those who wish to visit, with flexibility to expand up to 30 minutes, or as needed.

Ensure all people with dementia have a care plan.

**4. Key Responsibilities**

Act as a point of contact between GP, Neighbourhood Team, people and their carer’s.

Develop and maintain a detailed knowledge of local services to enable supported signposting of people with identified need, sharing information with the Neighbourhood Team.

Liaise with GPs and practice teams to identify people who are elderly, frail or who have long term health needs and support.

Liaise with primary, secondary and specialist care services as required.

Work with the Neighbourhood Team to help identify people at risk of loss of independence or admission to hospital as a result of inadequate social support.

Provide these cohorts of people signposting to identified services in order to maintain their independence and improve their health and well-being.

Visit people in community, home or care home settings to assess and discuss their care needs involving carers as appropriate.

Implement personal care plans for individual people, ensuring preventative actions are detailed to support the appropriate use of services.

Communicate the care plan to the GP and any other members of the Neighbourhood Team involved in the person’s care and upload to the relevant records.

Ensure that identified people receive the right level of help at the right time and help them to experience a joined-up service by liaising with relevant members of the Neighbourhood Team.

Work with patient, carers and the Neighbourhood Team to encourage the patient to adopt effective self-management and self-help seeking approaches to reduce unnecessary hospital admissions.

Liaise with other agencies to ensure timely and appropriate engagement as required.

Support people to access community care assessments as well as carers’ assessments.

Where a personal healthcare budget is allocated provide advice as required regarding the key choices the patient will need to make.

Identify unpaid carers and direct them to access services as appropriate to provide them with support.

Identify when urgent action or a step up in care is required and promptly alert the relevant member of the Neighbourhood Team, highlighting any safety concerns.

Follow up on communications from out of hospital and in-patient services regarding changes in condition of people to support the practice to respond proactively to potentially unmet needs.

Undertake visits or telephone contact to manage people on the SNN’s case load following any unplanned hospital admissions where appropriate.

Participate in Practice multi-disciplinary meetings to discuss Practice people actively being managed by the Neighbourhood Team and any other people from the SNN’s case load needing discussion.

To attend Neighbourhood Team MDT meetings at the Practice plus any other meetings where there is a need to discuss Practice patients.

Undertake visits or arrange appointments at the Practice for people on the SNN’s case load or otherwise as directed by the Duty Doctor following identification of urgent and non-urgent clinical need to assess, diagnose, treat, prescribe and refer appropriately according to the patient’s health needs and acting within the SNN’s clinical skill set.

Maintain accurate and up to date records of patient contacts using GP record systems and other IM&T systems relevant to the role i.e. entering notes onto Systmone / EMIS using agreed read codes and VMDT

To run regular patient searches using Systmone / EMIS in order to have an up-to-date record of progress of achievement of Key Performance Indicators.

Work with South Lincolnshire ICB, Neighbourhood Teams and other agencies to support and further develop this role.

Support the Practice Manager in providing KPI reports for submission as requested.

**5. Key Working Relationships**

Practice teams

Neighbourhood Team

Community health services

Specialist teams – heart failure, diabetes etc.

Specialist nursing services e.g. St Barnabas

Hospital teams including ward, A&E, discharge and AIR teams

Social Prescribers

Health & Wellbeing Coaches

Safeguarding agencies

Pharmacists

South Lincolnshire ICB

Adult Social Care

Voluntary Services

Independent Care Homes

Local Authority teams

Independent living teams

**6. General duties**

**Health and Safety -** It is the responsibility of the individual to work in compliance with all current Health and Safety legislation and the Practice Health and Safety Policy. To attend any training requirements, both statutory and mandatory, in line with the legal responsibility to comply with the Health and Safety at Work Act 1974.

**The roles contains the following responsibilities:**

· To maintain registration with the NMC.

· To adhere to the NMC Code.

· To support training and development.

· To maintain personal professional competency and appropriate development.

· To carry out the duties and responsibilities of the post in accordance with the Practice Policies including duty of candour and whistleblowing.

· Required to comply with all relevant national and local statutory and mandatory requirements including Health and Safety, Infection Control, Safeguarding, Information Governance, Research Governance and Equality and Human Rights.

· The post holder will work in an environment where individual differences and the contributions of all staff are recognised and valued. All employees, people, carers and the public are entitled to be treated with dignity and respect and no form of discrimination, intimidation, bullying or harassment will be tolerated. We adhere to and believe in the NHS People promise " We are open and inclusive. We understand, encourage and celebrate diversity, making the NHS a place where we all feel we belong."

This Job Description is not an exhaustive list and will be reviewed in the light of changed needs and organisation development. Any changes will be discussed with the post holder who will be required to carry out other duties appropriate to the grade and scope of the post.

The post will involve regular travel locally and regionally on occasion and the post holder may be required to undertake occasional evening or weekend work.

**Person Specification - Post of Specialist Neighbourhood Nurse**

**Qualifications**

· Registered Nurse Level 1

· Post graduate study in health-related studies relevant to long term conditions or equivalent experience

· Evidence of continuing professional development

· Post registration teaching qualification or willingness to undertake

· Post registration qualification in non-medical prescribing or willingness to undertake as needs of service change

**Previous Experience**

· Experience of dealing with people with long term conditions.

· Evidence of ability to work autonomously.

· Evidence of working within a multidisciplinary team

**Skills**

· Excellent communication skills, listening, written and verbal.

· Good organisational and planning skills.

· Excellent prioritisation skills and ability to work to tight deadlines.

· Skilled and sensitive communicator, confident in dealing with staff, people and service users Good working knowledge and application of Microsoft Office packages

· Ability to deal with complex facts/situations, requiring analysis, interpretation and comparison of a range of options.

· IT skills

· Understand the wider determinants of health

Aptitude

· Ability to effectively organise own workload and that of others with minimum supervision

· Ability to achieve goals with deadlines.

· Ability to work autonomously as well as within a team

· Ability to make decisions under pressure

· Ability to work sensitively to maintain high levels of diplomacy and confidentiality

· Enthusiasm, drive and the ability to cope in challenging situations

Job Types: Full-time, Part-time, Permanent

Pay: £43,858.00 per year

Expected hours: No more than 30 per week

Benefits:

* Bereavement leave
* Company pension
* Free parking
* Health & wellbeing programme

Schedule:

* Monday to Friday

Work authorisation:

* United Kingdom (required)

Work Location: In person

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* To pro-actively engage with housebound people
* To be the key contact for people at the practice

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To implement and review individual care plans, a self-management plans and to agree trigger thresholds to contact Case Managers / GP’s.

Planned visits to Nursing and Residential homes to be undertaken every 3-6 months, providing training as required.

To ensure all people in Nursing and Residential homes have care plans (including dementia where needed) and to provide a holistic review of all people in these homes with updates of their care plans.

Provide enhanced support to Nursing and Residential home with a focus on strengthening relationships and improving access through information sharing, education and advice.