



Recruitment Pack



Frailty Nurse

Message from the Practice Manager



I am delighted that you are considering applying for this important role in our frailty team here at Aspen.

I hope that you find this pack helpful and we look forward to receiving your application.

Aspen Medical Practice was formed from the merger of four practices in 2018 and is now a single large practice looking after about 32000 patients. We have 140 employees who all work together as one multi-disciplinary team trying to provide the best service we can for our patients and their families.

Whilst patient care is key, we also value the wellbeing of our employees and offer free parking, access to the NHS pension scheme, enhanced sickness allowances, monthly protected learning time events, length of service recognition and much more. We listen to our staff via suggestion boxes, surveys and our staff forum and have made several changes in recent years in response to this.

You are welcome to come and look around yourself, either before or after application. Just contact our team at aspen.riskandcompliance@nhs.net.

Best wishes,

Paul Wainman - Practice Manager

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Dedicated

Forward thinking

People



Key Information

Role: Frailty Nurse

Application Closing Date: 22/06/2026

Shortlisting: 24/06/2026

Interview Date/s: 10/07/2026

Points to Note

1. All longlisting, shortlisting and interview assessment will be performed against the essential and desirable criteria listed on page 5. If you are unable to meet the essential criteria, you are unlikely to be successful in your application.
2. Should this vacancy attract sufficient interest it may be necessary to close the vacancy at an earlier date. We therefore suggest that you apply at an early stage to avoid disappointment.



Job Description

Post	Frailty Nurse
Responsible to	Rachel Bucknell (Frailty Matron) & Dr Kannan Raj
Duties and responsibilities	Undertake clinical nursing practice using expert knowledge and clinical skills to deliver holistic care to patients living in their own home or care home.

Role and Objectives

The frailty nurse will work within their professional scope of practice in a general practice environment as part of our Primary Care Network (PCN). As a key member of the Aspen PCN frailty team, they will play a key role in preventing avoidable hospital admissions and helping patients age well and better manage their conditions. They will offer post discharge reviews and proactive care.

This role focuses on identifying, assessing and managing patients living with moderate to severe frailty, with the aim of improving patient outcomes, reducing avoidable admissions, and supporting patients to remain safely at home.

In this job role, you will assess individual patient needs, initiate investigations, and initiate appropriate holistic, evidence-based treatment and care and liaise with other teams as appropriate.

In this fast-paced and rewarding role, they will be expected with sound clinical judgment within the boundaries of their professional practice.

Working under the guidance of the Frailty Lead GP and Frailty Matron, the Frailty Nurse will receive daily support from Frailty Care Coordinators, Clinical Pharmacists, wellbeing practitioners / social prescribers and the wider PCN.

Key Tasks and Responsibilities

- Undertake clinical nursing practice using expert knowledge and clinical skills to deliver holistic care to patients living in their own home or care home.
- Collaborate closely with GPs and work independently to deliver safe, effective care to frail and housebound individuals
- Promote / support health & wellbeing, helping patients to remain independent and well at home.
- Facilitate patient education, self-management of disease, and behaviour modification.
- Conduct thorough person-centred needs assessment to develop care plans for each patient.
- Represent individuals and families' interests when they cannot do so themselves.
- Maintain and regularly update a comprehensive register of frail patients, utilising clinical frailty scoring tools to assess and monitor levels of frailty.
- Initiate the process of diagnosis with patients suspected to have a chronic disease e.g., diabetes, COPD, asthma, IHD referring to other clinical staff as appropriate.
- Proactively manage long term conditions and seek clinical advice as appropriate.
- Accurately update patient records on SystmOne.
- All documentation must be timely, relevant, and clearly reflect the care provided, using Systmone.
- Directly admit patients to secondary care hospital in acute medical need.
- Promote clear communication with the health care team and support medication management.
- Communicate effectively with other healthcare professionals and make appropriate referrals to ensure coordinated, multidisciplinary care.
- Build and communicate therapeutic working relationships with a wide array of statutory and voluntary organisations for the benefit of patient care and facilitates good working relationships.
- Attend multidisciplinary team (MDT) meetings, fostering effective working relationships with health, social care, and third-sector partners to ensure a

seamless, integrated response for patients with complex needs or long-term conditions.

- Work flexibly across various healthcare settings, including surgeries, home visits, and community
- Actively participate in clinical, PCN and practice meetings as required.
- Participate in team meetings, audits, and data collection for improving patient care.
- Support HCAs / Care Coordinators in delivering high-quality care to frail and housebound patients.
- Provide expert clinical advice and support to patients, carers, and colleagues, maintaining high standards of professional practice and clinical excellence.
- Operate in line with clinical protocols and guidelines, ensuring professional, compassionate support for patients, families, and carers - using resources responsibly and efficiently.
- Contribute to service development by creating and implementing innovative models, methods, and practices to enhance primary care services for the frail population.
- Regularly communicate service-related information to the broad spectrum of staff within the PCN and its practices.
- Ensure compliance with practice CQC requirements and maintain accurate documentation.
- Work within all relevant PCN practice policies and procedural guidelines e.g., infection control, chaperoning, risk management.
- Contribute to PCN practice targets both local and national
- Contribute to disease registers.
- Keep up to date with schemes and contractual agreements by liaising with Practice Managers, GPs and Integrated Care Board.
- Develop own knowledge and practice meeting objectives/changes in service, through attendance on study days, self-directed learning, and reflection on practice.

- Participate in our appraisal system, matching organisational aims with individual objectives Maintain the highest standards of conduct and integrity.

General Tasks

- Undertake all mandatory training required for this role.
- Venepuncture
- POCT (Point of Care testing) at bedside (Urine dips, blood tests, Glucometer use)
- Assisting with annual immunisations.
- Clinical observations at bedside (within the scope of clinical practice)
- Use the CGA - Comprehensive Geriatric Assessment, to perform baseline assessments in frail individuals.
- Be able to recognise a deteriorating patient and undertake safe and effective assessment & formulate management plan with escalation as appropriate.
- 'RESPECT' planning and 'Personalised Care Planning'
- Work independently in the community, and as part of a team.

Disclosure and Barring Service Check

This post is subject to the Rehabilitation of Offenders Act (Exceptions Order) 1975 and as such it will be necessary for a submission for Disclosure to be made to the Disclosure and Barring Service (formerly known as CRB) to check for any previous criminal convictions.

UK Registration

Applicants must have current UK professional registration.



Person Specification

Frailty Nurse

Key: A = Application I = Interview R = References E = Essential D=Desirable

Attribute	Essential (E) Desirable (D)		Assessed A, I, R
	E	D	
Qualifications			
Nursing qualification	E		<u>A</u>
NMC registration	E		<u>A</u>
Non-medical prescriber V300 –(or working towards)		D	<u>A</u>
Completion of Physical assessment and clinical reasoning (PACR)		D	<u>A</u>
Work related Experience			
Significant experience in primary care, community, or elderly care.	E		<u>A, I, R</u>
Experience of working with patients on a Frailty register		D	<u>A, I, R</u>
Able to adapt one's approach to challenging patient scenarios and being able to hold sensitive conversations with empathy and professionalism.	E		<u>A, I, R</u>
Agile and flexible approach to service delivery, readiness to adopt news ways of working.	E		<u>A, I, R</u>
Experience of carrying out home visits	E		<u>A, I, R</u>
Long term condition qualification or experience (e.g. Asthma, COPD, Diabetes, Heart disease)		D	<u>A, I, R</u>
SystemOne experience		D	<u>A, I, R</u>
Other Experience and Skills			
Valid driving licence and access to your own vehicle	E		<u>A</u>
Competent at Venepuncture	E		<u>A, I, R</u>
Experience of Immunisations administration		D	<u>A, I, R</u>
Knowledge of Comprehensive Geriatric Assessment (CGA).	E		<u>A, I, R</u>