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#### **JOB DESCRIPTION**

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| 1. JOB IDENTIFICATION |
| Job Title: Macmillan Link Worker (Cancer Care)  Responsible to (insert job title): Macmillan One to One Team Leader  Department(s): Core Cancer and Palliative Care  Directorate: NMAHP  Operating Division: NHS Forth Valley  Job Reference: BN-DON-LWCC-1024  No of Job Holders: 4.0WTE  Last Update: |
| 2. JOB PURPOSE |
| To ensure that people affected by cancer can access the right help, at the right time, from the right person.  To provide a person-centred service that enables people affected by cancer to navigate the health, social care and wider systems to access holistic support by empowering and promoting the self-management needed for people to live well during and after cancer treatment. To work across organisational boundaries with partners to ensure the best possible outcomes for people affected by cancer.  To be responsible for proactively identifying the needs of people affected by cancer using Holistic Needs Assessment (HNA) tool in line with local policy and guidance to ensure individuals get the right support to meet their needs, offering the time to find out what matters to the individual and providing appropriate information and signposting to local services. |
| **3. DIMENSIONS** |
| The postholder will be based within the Macmillan One to One team, which operates across the Forth Valley system.  The community-based Macmillan One-to-One team provide psychosocial support to people affected by cancer, liaising with Oncology Unit, multiple health and social care teams, and the third sector. The overall goal of the team is to maximise quality of life for those affected by cancer by conducting a Holistic Needs Assessment (HNA) working in partnership with the patient and those important to them to agree an individualised care plan. Following this HNA, the team provide support to the individual and signpost or refer to other services as needed. The support provided includes psychosocial support.  This team has been evaluated over the years with reports available on outcomes which include evidence of:   * Improved patient experience on the cancer journey * Compliance with the recommendations in the national recommendations regarding Living with Cancer in the Cancer Strategy *Beating Cancer* (SG 2016) and the Transforming Cancer Care After Treatment (TCAT) programme. * Improved quality of life * Maximising outcomes for people affected by cancer * Increase in self-management strategies * Ability to provide person centred care * Less risk of GP visits / need for other services * Improved wellbeing overall * Maximised access to financial benefits * Reduced risk of crisis management by facilitating anticipatory care planning * Providing a point of contact for patients and carers that can facilitate more timely access to cancer and other teams if and when required * Complex coordination with FVRH Oncology teams, primary care and tertiary cancer centres to maximise outcomes for patients * Suicide prevention   This post forms part of Forth Valley’s Improving Cancer Journey Programme, which is a new programme of work within our local health and social care system. |
| 4. ORGANISATIONAL POSITION |
| Macmillan One to One Team Leader  Macmillan Programme Manager  Appropriate Line Manager  Macmillan Link Worker  THIS POST |
| 5. ROLE OF DEPARTMENT |
| Macmillan One-to-One work with local and national health and social care services to support people affected by cancer including:   * Various Tumour Group CNSs and Consultants. This includes tertiary centres such as ECNO Nurses (Edinburgh WGI) and Beatson Oncology Unit Glasgow * Macmillan Money Matters (and when appropriate financial teams from other NHS board areas) * Carers Centre * District Nurses * Oral Health Team * Clinical Health Psychology * Keep Well Team * Continence Service * Spiritual Care   . A key priority area is to ensure that individuals receive support in relation to non-clinical needs to address difficulties faced due to health inequalities, social isolation, and the challenges of managing long-term conditions.  The main functions and objectives of the service are:   1. To provide a person centred, holistic service to people affected by cancer (patients, carers, wider family) and link with community based health, social and third sector services in Forth Valley. 2. To identify a person’s needs using Holistic Needs Assessment tool in line with local policy and guidance, and co-produce a care plan with the person and use a variety of sources to meet the person’s needs. This will be within a robust Clinical Governance framework as well as in line with local and national strategies and priorities. 3. To support people to access local services that meet non clinical needs, e.g. managing symptoms, psychosocial support, benefits advice and spiritual care 4. Provide evidence-based advice and information to people after a cancer diagnosis and act as a resource and support to health and social care professionals 5. To support the Public Health Agenda by identifying and promoting the non-clinical needs of people affected by cancer in partnership with colleagues, service users and the local community. |
| 6. KEY RESULT AREAS |
| 1. To support local values of quality, teamwork, care and compassion, dignity and respect, and openness, honesty and responsibility through the application of appropriate behaviours and attitudes. 2. To identify the needs of individuals using a Holistic Needs Assessment in line with local policy and guidance with people affected by cancer and co-produce a care plan utilising and supporting shared decision-making. The Care Plan sets out the agreed actions that come out of the assessment and belongs to the service user and can be shared electronically across the health & social care system, with permission. Examples of actions include giving direct information and advice to support self-management, e.g. managing fatigue; as well as signposting onto services such as Welfare Benefits, physical activity programmes. Review and follow-up as appropriate, depending on individual’s needs. 3. To support individuals in the coordination and navigation of the complex health, social care and wider systems (e.g. Benefits, housing) – so that people affected by cancer can access the right help at the right time, both during and following completion of treatment, so experiencing seamless care – including the access to robust information and education, making appropriate referrals to other services ,and signpost to online and local resources in line with agreed care plan. 4. Provide appropriate levels of psychological and social care support and advice to the person affected by cancer. The assessment process is person-centred and offers protected time to be actively listened to. In addition, direct practical support is offered, e.g. advice on managing fatigue such as pacing, keeping a diary on sleep or eating, as well as understanding what local services are available to help, e.g. shopping, transport, housing, money. Act as a single point of access to help navigate the system, including to support rapid re-entry to the healthcare system in line with agreed processes. 5. To act as an advocate and facilitator to resolve issues for patients that may be perceived as barriers to care or support.   To document and monitor all aspects of service delivery, supporting data collection for evaluation and audit. |
| 7a. EQUIPMENT AND MACHINERY |
| The following are examples of equipment which will be used when undertaking the role:  This list is not exhaustive:  IT Equipmentfor examplePersonal Computer, phones, mobile phone, iPad, telehealth units, teleconference, videoconference, Data Projectors/Overhead Projectors  The post holder will be expected to be responsible and knowledgeable in the safe use of equipment used within the area ensuring this is checked and maintained and where problem are identified these resolved so that all equipment is fit for purpose.  **Note:** New equipment may be introduced as the organisation and technology develops, however training will be provided. |
| **7b. SYSTEMS** |
| The following are examples of systems which may be used when undertaking the role:  Update department shared drive/intranet site  Use of intranet to access information within NHS Forth Valley  Daily use of e-mail for communication  Microsoft Office - Formatting and populating spreadsheets and databases to produce statistics and reports as required  Health & Safety, Datix and COSHH Systems  Video conferencing including ‘NHS Near Me’ systems  Personal learning platforms including TURAS  NHS patient record keeping systems such as MORSE and Clinical Portal as required  NHS HR systems such as eESS  **Note:** New systems may be introduced as the organisation and technology develops, however training will be provided |
| 8. ASSIGNMENT AND REVIEW OF WORK |
| The post holder is directly accountable to an appropriate line manager who will agree personal objectives.  The caseload is generated by the specific service needs of the people opting into the service,  The workload will be delegated by the Macmillan One-to-One Team Lead and the post holder will work independently on a day-to-day basis, being accountable for own actions, with input/supervision as required.  Formal and/or informal meetings/support with senior staff for purposes of discussion will be regularly available and form part of routine practice.  Participation in the appraisal process through Personal Development Planning and review in line with the Knowledge and Skills Framework and continuing professional development will be facilitated via the Community Link Worker Network Manager. |
| **9. DECISIONS AND JUDGEMENTS** |
| * Assess the holistic needs of people affected by cancer and provide relevant information, advice and signpost to other services as required. For example, Macmillan Welfare Benefits service to access Macmillan Grants, PIP and DS1500 payments; engaging in groups and activities to address social isolation; ‘Move More’ to keep active and manage symptoms like fatigue. * Prioritise own delegated caseload. * Through analysis of information presented determine when to refer to other professionals and statutory and voluntary services e.g. smoking cessation, housing, Welfare Benefits, mental health services |
| 10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB |
| * Utilisation of time management skills to provide a service incorporating management of personal caseload, support to other staff, administrative tasks including producing service reports. * Ongoing monitoring and evaluation of outcomes to ensure appropriate caseload management, maintain safety and working within scope of skill set   Dealing with emotional and/or distressing situations including patients with co-morbidities that require the utilisation of motivational, negotiating and persuasion skills to support behaviour and lifestyle change.   * Supporting patients on self-management strategies to embed and sustain behaviour change and effectively manage their condition. |

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| **11. COMMUNICATIONS AND RELATIONSHIPS** | |
| * They key relationship the post holder will have is with people affected by cancer. An ability to consistently communicate care with compassion, warmth and professionalism is required, as well as a calm, confident and approachable manner * Astute observational skills, listening skills and reflective skills required to help support service users through the assessment and care planning process, as well as providing ongoing support as required * Communicates with all colleagues, patients, relatives, carers and visitors in a professional way * Uses diplomacy skills to influence staff and service users where there is resistance to the ethos of the project aims or the role of the support worker * Participate in local and regional work, for the purpose of sharing experience of the role of support worker within the project. * Ensures written communications are accurate and appropriate, with attention to detail * The information shared with the Link Worker may be of a sensitive nature, which excellent communication skills to help manage, build rapport quickly and work in an empathic and person centred way. * Communicating with service users who have language barriers e.g. where English is not their first language * Participate in meetings, email and telephone conversations ensuring a two-way flow of information. * Disseminate service information as appropriate. * Promote and share ideas. * Utilise team support for emotional and challenging situations. * Liaise with third party agencies for example Macmillan for ongoing support and advice. * Engage with the general public and service users in consultation as required. | |
| **12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB** | |
| **Physical skills**   * Accurate IT skills – daily use of computer e.g. communicate with other colleagues, complete data input.   **Mental:**   * Concentration required when manipulating and inputting data and dealing with enquiries; workload unpredictable due to changing priorities. * Reacting flexibly to constantly changing situations example and prioritising the workload as possible within existing resources. * Concentration required when undertaking assessments, assessing queries and signposting to appropriate resources. * Concentration required dealing with individuals who may be emotional or anxious.     **Emotional:**   * Communicating frequently with distressed/anxious/worried and emotionally demanding service users * Potential exposure to emotional situations from service users during a potentially stressful and emotive time. * Providing emotional support to peers.   **Environmental:**   * Attending meetings/working across multiple sites. * Requirement to travel between locations to meet colleagues and patients. As such, the postholder will be adhere to the local lone worker policy. | |
| 13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB | |
| * Educated to SCQF Level 8 e.g. HND/SVQ4 in health and social care or educated to SCQF level 7 such as SVQ3 in health and social care, community development or related area **plus** additional training to diploma level or equivalent relevant health and social care experience through short courses * Has experience of working within guidelines, policies and protocols and is willing to undertake an induction and training period necessary for the post, followed by ongoing mentorship and supported learning * Experience of working with and understanding the concerns of vulnerable people, especially those affected by cancer * Experience of delivering a person-centred service, in a support/advice giving role * Experience in the use of data management * Evidence of good communications skills both written and verbal * Good understanding of the health and social care environment, services and pathway, with excellent understanding and awareness of social care services relevant to the roleExperience managing own workload on a daily basis * Experience of retrieving information from a wide range of sources and in different formats. * Good IT skills * Excellent interpersonal skills with the ability to listen actively, motivate, support, advocate and counsel * Skills to deal with complex and emotional situations * Flexible approach to carrying out duties and responding to the needs of service users * Skill to empathise with individual and family psychosocial circumstances | |
| **14. JOB DESCRIPTION AGREEMENT** | |
| A separate job description will need to be signed off by each job holder to whom the job description applies.  Job Holder’s Signature:  Head of Department Signature: | Date:  Date: |