JOB DESCRIPTION

1. JOB IDENTIFICATION

Job Title: Macmillan Improving the Cancer Journey Link Worker

Responsible to (insert job title): Community Link Worker Network Manager, HSCP

Department(s): HSCP

Directorate: Primary Care Services

Operating Division: Edinburgh Health and Social Care Partnership

Job Reference: 056337

No of Job Holders: 0

Last Update:

2. JOB PURPOSE

To provide a person-centred service that enables people affected by cancer to navigate the health, social care and wider systems to access practical, emotional and social support by promoting self-management and support for people to live well addressing their holistic needs 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 Macmillan's Holistic Needs Assessment (HNA) tool 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

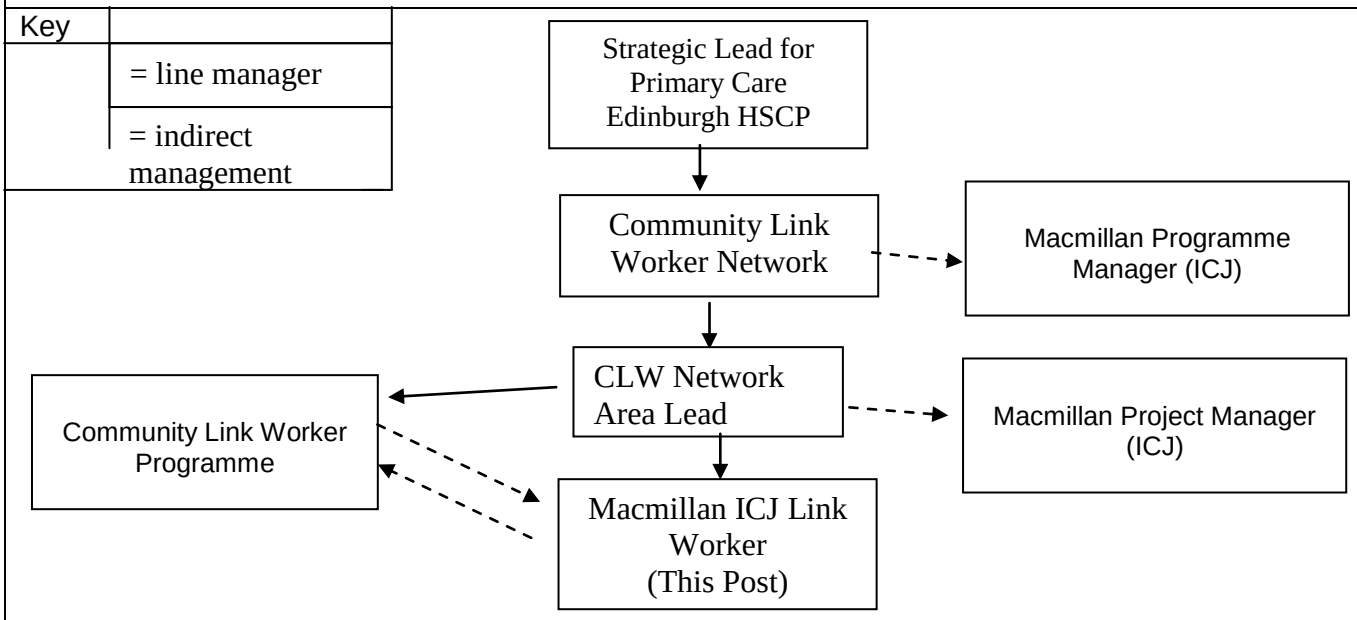
The post will be based within Edinburgh HSCP, will be employed within NHS Lothian and there is a requirement to work flexibly to meet the service demands.

Edinburgh has 72 GP Practices and covers socially and economically deprived areas.

Operationally, this post will report into the Community Link Worker Area Lead and join other practitioners working in Edinburgh as part of the Community Link Worker (CLW) Service, who report into the same HSCP structure. The Community Link Worker Network Manager will retain responsibility for performance management issues and appraisals. While the CLW team is aligned to primary care and delivered by third sector providers there is clear synergy with ICJ. As such, a collaborative approach will be taken across these teams to ensure localities are supported and joint training and opportunities to skillshare are in place. The population, geographically is the same, but the access routes differ.

The base in time will be with the HSCP's Locality Teams, but home working utilising NHS Near Me and telephone will be in place initially.

4. ORGANISATIONAL POSITION



5. ROLE OF DEPARTMENT

The Edinburgh Primary Care team is an exciting area of development with responsibility for delivering a number of key service priority areas as part of the Edinburgh Primary Care Improvement Plan. 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. This Macmillan-funded post will have a particular focus on supporting people affected by cancer and will be closely aligned with third sector Community Link Workers who provide a similar approach to individuals across Edinburgh.

The main functions and objectives of the service are:

1. To provide a person centred service to people affected by cancer (patients, carers, wider family) and link with community based health, social and third sector services in Edinburgh.
2. To identify the non-clinical needs of the person using Macmillan's Holistic Needs Assessment tool 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 into local services that meet non clinical needs, e.g. managing symptoms, psychosocial support, benefits advice and spiritual care utilising Macmillan's HNA, a validated assessment tool.
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 NHS Lothian's 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 non-clinical needs of individuals using Macmillan's Holistic Needs Assessment with people affected by cancer, co-produce a care plan. 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 the person affected by cancer can access the right help at the right time, both during and following completion of treatment, so experiencing seamless care.
4. Provide practical and emotional support 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 central point of access to help navigate the system.
5. To act as an advocate and facilitator to resolve issues for patients that may be perceived as barriers to care or support.
6. 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 Equipment for example Personal Computer, phones, mobile phone, telehealth units, teleconference, videoconference.

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 Lothian
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

Note: New systems may be introduced as the organisation and technology develops, however training will be provided

8. ASSIGNMENT AND REVIEW OF WORK

The caseload is generated by the specific service needs of the people opting into the service, i.e. some will be supported over an approximate 12 week period, while others may need support for longer.

The workload will be delegated by the ICJ Team 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.

11. COMMUNICATIONS AND RELATIONSHIPS

1. Primary Care colleagues - The Care Plan produced following the assessment is shared electronically via Docman to support effective working relationships with primary care
2. Macmillan Cancer Support colleagues- in addition to working with and making referrals to other local Macmillan funded services such as Welfare Benefits, Move More, to be part of Macmillan's Link Worker 'Community of Practice', to keep abreast of good practice and developments in fellow ICJ services, peer support and opportunities for reflective practice, identify training needs
3. Edinburgh Health and Social Care Partnership staff – referrals and signposting into appropriate teams to meet identified needs e.g. Allied Health Professionals, social care for home adaptations; as well as promoting the service to colleagues
4. People affected by cancer, including family members and carers- to support planning and ongoing service developments as well as regular feedback as part of monitoring and evaluation
5. Voluntary agencies and community groups throughout Edinburgh - referrals and signposting into appropriate services to meet identified needs, e.g. VOCAL, as well as promoting the service to colleagues
6. Clinical teams across primary and secondary care to get any medical information for patients etc - The Care Plan produced following the assessment is shared electronically to support effective working relationships with primary care and secondary care colleagues. Also, to advocate/support and help resolve issues for patients that may be perceived as barriers to care or support.

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:

Regular use of a VDU, especially while face to face assessments are not possible for the majority of assessments and NHS Near Me is being utilised. However, it is recognised that situations could arise whereby support cannot be done remotely. This would be rare and undertaken on a case by case basis, risk assessed and undertaken within NHS guidelines. Once face to face working is safe to return to, there will be a choice between telephone, NHS Near Me and face to face appointments.

Attending meetings/working across multiple sites.

Requirement to travel between locations to meet colleagues and patients.

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
Completion of training in nationally accredited Holistic Needs Assessment Tool
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
Understanding of the health and social care environment
Experience 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: