

## Position Description

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<b>Position</b>	<b>Advanced Social Worker - Transitions to Care</b>
<b>Team / Service</b>	WRH SW TL/ KPH AH TL/ Hutt SW TL
<b>Directorate</b>	Community, Allied Health & Older Adults (CAHOA)
<b>District</b>	Capital, Coast & Hutt Valley
<b>Responsible to</b>	Social Work Team Leader
<b>Professional accountability to</b>	Professional Leader – Social Work
<b>Children’s Act 2014</b>	This position is classified as a children’s worker, requiring a safety check including police vetting before commencing and every three years
<b>Location</b>	This position is expected to work from a primary site but may need to work from multiple locations across the district

## Te Whatu Ora

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The Health System in Aotearoa is entering a period of transformation as we implement the Pae Ora/Healthy Futures vision of a reformed system where people live longer in good health, have improved quality of life, and there is equity between all groups.

We want to build a healthcare system that works collectively and cohesively around a shared set of values and a culture that enables everyone to bring their best to work and feel proud when they go home to their whānau, friends and community. The reforms are expected to achieve five system shifts. These are:

1. The health system will reinforce Te Tiriti principles and obligations
2. All people will be able to access a comprehensive range of support in their local communities to help them stay well
3. Everyone will have equal access to high quality emergency and specialist care when they need it
4. Digital services will provide more people the care they need in their homes and communities
5. Health and care workers will be valued and well-trained for the future health system

## Context

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Capital, Coast & Hutt Valley district provides hospital and health services in primary, secondary and tertiary healthcare to a total population base of approximately 445,000 citizens.

We are accountable for meeting the needs of and improving health outcomes for all the constituent populations of our district, and the region more broadly. Together we:

- provide secondary and tertiary, medical and surgical hospital services alongside community based health care

- fund local health providers and work collaboratively with the community to create and support multiple health education initiatives and projects within the region
- deliver health services directly as well as contracting external providers
- provide local, sub-regional, regional and national health services as well as community-based health, rehabilitation and support services.

The majority of the district's population live in Wellington and Lower Hutt. The Māori and Pacific populations of Lower Hutt and Wellington are proportionally similar, with the largest Pacific population in the region in Porirua. Kapiti and Upper Hutt have similar numbers of Māori and Pacific people. Most people are enrolled with a GP near their place of residence, so the increasing focus on community-based healthcare is expected to lead to better health outcomes for these population groups. Hutt Hospital provides secondary and some tertiary, medical and surgical hospital services alongside community based health care from its main facility in Lower Hutt City. In addition to funding local health providers and working collaboratively with the community to create and support multiple health education initiatives and projects, Hutt Hospital is the centre for five tertiary regional and sub-regional services - Plastics, Maxillofacial and Burns Services; Rheumatology; Dental Services; Regional Public Health; and Regional (Breast and Cervical) Screening Services.

Wellington Regional Hospital in Newtown is the region's main tertiary hospital with services such as complex specialist and acute procedures, intensive care, cardiac surgery, cancer care, neurosurgery and renal care. The hospital is the key tertiary referral centre for the lower half of the North Island and the upper half of the South Island.

Kenepuru Community Hospital and Kapiti Health Centre provide secondary and community services based in Porirua and the Kapiti Coast

MHAIDS is the mental health, addictions and intellectual disability service for the Wairarapa District and Capital, Coast & Hutt Valley District, with multiple specialist facilities. Ratonga Rua-o- Porirua is our forensic, rehabilitation and intellectual disability inpatient unit.

## Te Tiriti o Waitangi and Māori Health Outcomes

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Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through this founding document of Aotearoa. We value Te Tiriti and have adopted the following four goals, developed by the Ministry of Health, each expressed in terms of mana and the principles of:

- Mana whakahaere** Effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.
- Mana motuhake** Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.
- Mana tāngata** Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- Mana Māori** Enabling Ritenga Māori (Māori customary rituals) which are framed by Te Aō Māori (the Māori world), enacted through tikanga Māori (Māori philosophy & customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

We will target, plan and drive our health services to create equity of health care for Māori to attain good health and well-being, while developing partnerships with the wider social sector to support whole of system change.

## Te Mauri o Rongo – The New Zealand Health Charter

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Te Mauri o Rongo recognises our connection to this work, to each other, to the people we serve and to our whakapapa. It speaks to specific behaviours that we will expect from each other guided by the pou of Te Mauri o Rongo:

**Wairuatanga** Working with heart, the strong sense of purpose and commitment to service that health workers bring to their mahi.

**Rangatiratanga** As organisations we support our people to lead. We will know our people; we will grow those around us and be accountable with them in contributing to Pae Ora for all.

**Whanaungatanga** We are a team, and together a team of teams. Regardless of our role, we work together for a common purpose. We look out for each other and keep each other safe. “Whiria te tangāta” – we will weave our people together.

**Te Korowai Āhuru** A cloak which seeks to provide safety and comfort to the workforce.

## District Responsibility

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The district leadership have collective accountability for leading with integrity and transparency a progressive, high performing organisation, aimed at improving the health and independence of the community we serve and achieving equitable outcomes for all. The leadership team are responsible for achieving this aim, aligned with our Region, within the available resources, through a skilled, empowered, motivated and supported workforce in line with government and HNZ policy.

## Team/Service Perspective

The Advanced Social Work position is based within the Social Work and Allied Health teams providing services to all inpatient wards in alignment with the Transitions to Community Acute Flow programme of work.

## Purpose of the role

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The primary purpose of the role is to:

- Provide support, advice, case management as a subject matter expert working alongside the primary social worker and the MDT to expedite transitions from hospital, including support PPPR application as required.
- Identify patients at risk of prolonged length of stay who are discharging to residential care/or who have complex legal framework needs from admission and work proactively with multidisciplinary teams to support timely, safe, and sustainable discharge planning.
- Provide advanced social work practice to patients and their whānau with complex clinical and social needs, in most cases alongside and supporting the primary Social Worker, using

evidence-informed practice to undertake comprehensive assessments, identify risks and barriers to discharge, and coordinate appropriate interventions. Facilitate primary Social Workers skills and knowledge to do the same

- Facilitate MDT’s early intervention and awareness of the pathways and options available, including EPOA, and that these are communicated to patients and whānau
- Identifying and removing/ escalating barriers to progression through the discharge process across MDTs
- Provide clinical leadership in complex patient and whānau situations where standard pathways have been exhausted, including negotiation of care options and escalation of system barriers.
- Providing subject matter expertise and oversight of Residential Care discharge pathways and legal frameworks where these relate to delayed discharge.
- Work alongside inpatient teams to provide physical, psychological, emotional, and social support to patients/tangata whaiora and their whānau.
- Provide clinical coordination across services, supporting integrated care, effective communication, and shared decision-making.
- Interface with key stakeholders, including legal team, SMOs, NASC, ARC facilities, Family Court and other MDT members.
- Develop and maintain strong working relationships with NASCs, Commissioning Teams and community providers to coordinate solutions for complex discharges and residential care placements.
- Establish, lead, and embed innovative pathways and practices in residential care pathways and the management of PPPR frameworks within inpatient hospital settings that improve patient flow, experience, and outcomes.
- Act as a liaison between services to promote streamlined, person-centred, and integrated care.
- Work in an integrated manner with other existing roles that have a focus on Patient flow, discharge coordination and complex case management
- Practice across the domains of clinical focus, patient/client advocacy, education and training, and audit and research.
- Provide clinical leadership that builds capability within the Older Persons & Rehabilitation Team, general medical team and across inpatient services.
- Contribute to delivery of organisational Key Performance Indicators (KPIs), and maintain data relating to demonstrate benefits achieved in Shorter Stays in ED, reduction in Average LOS for patients on residential care pathways, improvements in Waiting for What indicators.
- Provide education and & training relevant to Residential Care and Discharge pathways including Discharge Guidelines and PPPR training for MDT staff in conjunction with clinical and legal services as appropriate.

## Key Accountabilities

The following role accountabilities may evolve with organisational change and there may be additional duties, relevant to this position that will be required to be performed from time to time.

Key accountabilities	Deliverables / Outcomes
1. Clinical Practice	<ul style="list-style-type: none"> <li>▪ Takes responsibility for providing day to day clinical leadership in complex discharges to Aged Residential Care ARC, and requiring PPPR application, and Patients requiring complex discharge planning under the Disability NASC, working alongside other practitioners to provide clinical advice, support and guidance.</li> </ul>

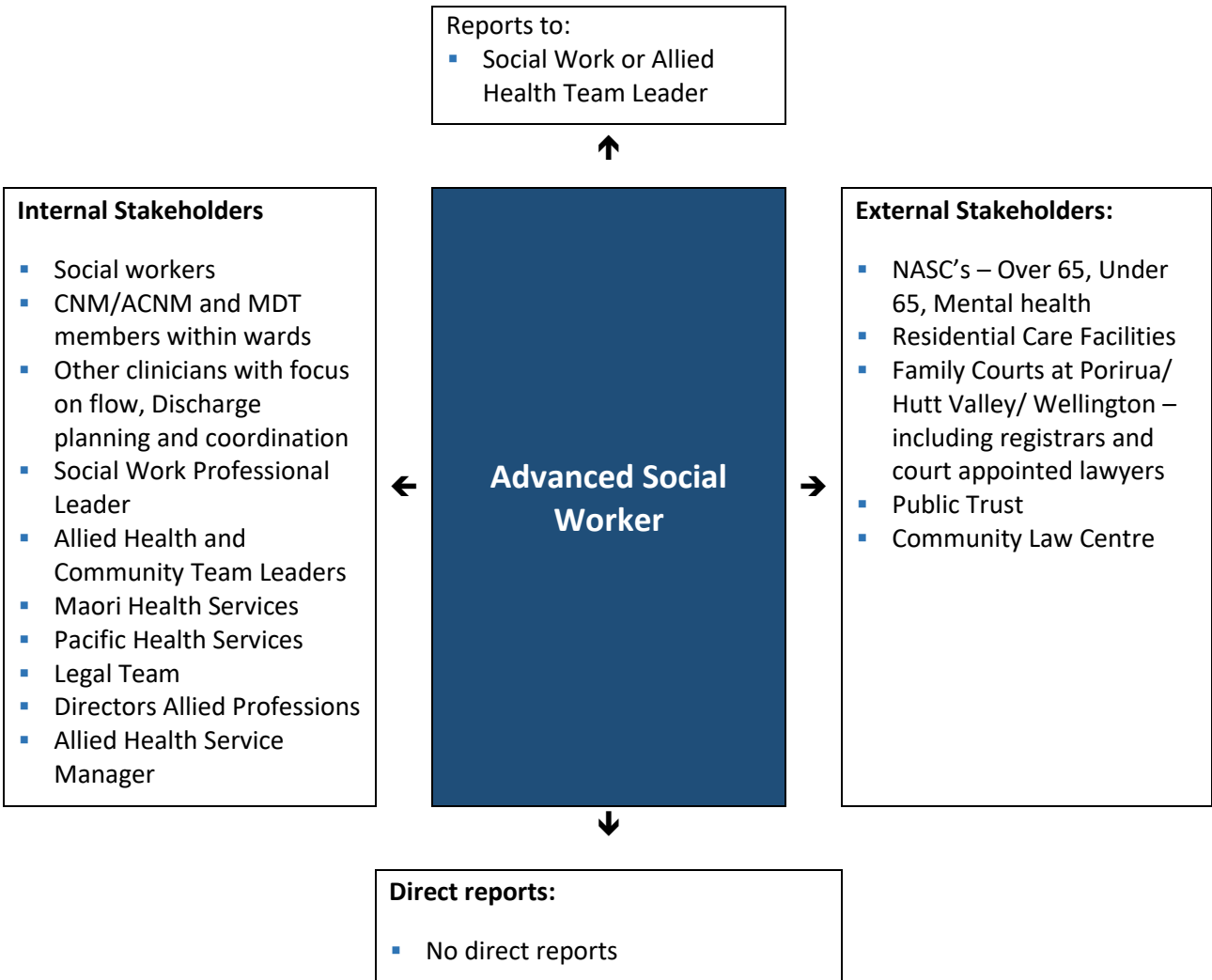
- Takes legal and professional responsibility for managing own caseload of patients / clients, including those with complex needs and is able to independently adapt and make decisions regarding social work intervention.
- Carries out comprehensive assessment of patients/clients (and whānau where appropriate) including those with diverse or complex presentations. This may include use of standardised assessment to assist in assessment and intervention planning.
- Formulates and delivers individualised social work intervention at an advanced level, using appropriate clinical assessment, reasoning skills and knowledge of interventions. This should take into account the patient/client's own goals and those of the wider multidisciplinary team (MDT)
- Role models effective communication to establish therapeutic relationships and set expectations with patients/clients, whānau, the multidisciplinary and wider health teams. This includes relaying complex, sensitive and contentious information.
- Assesses the patient/client's understanding of treatment intervention / goals and gains informed consent to treatment, taking into account capacity (e.g. cognitive functioning).
- Regularly reassesses and evaluates the patient / client's progress against identified goals and adjust intervention as situations change.
- Carries out and support others with assessment, formulation and management of risks. This may include assessing harm to self and/or others, elder abuse and neglect, family violence, child abuse and neglect and vulnerable adults.
- Demonstrates provision of and support others with culturally safe / bicultural practice with patients/clients and their whānau, with particular emphasis on Residential Care and PPPR processes
- Demonstrates an awareness of health inequalities, with evidence of implementing actions within clinical practice and identifying solutions for wider service delivery that contribute towards reducing inequalities for patients/clients and/or whānau.
- Represents the service and / or individual patients/clients at clinical meetings and case conferences to ensure the delivery of a coordinated multidisciplinary service and to ensure social work is integrated into the overall treatment programme (where appropriate) including discharge planning.
- Completes documentation consistent with legal and organisational requirements.
- Adheres to any applicable recognised best practice and any relevant clinical policies and practice guidelines.
- Demonstrates understanding of local, sub-regional, regional and national context in relation to provision of health and social support.

	<ul style="list-style-type: none"> <li>▪ Provides specialist advice, teaching and instructions to patients/clients, carers, relatives and other professionals to promote coordination of support being delivered, especially related to complex discharge planning</li> <li>▪ Identifies unmet needs of patients/clients along with potential solutions to address these needs.</li> <li>▪ Demonstrates recognition that the patient/client's knowledge, experiences and culture are integral to effectively addressing the presenting health issue and/or restoring function.</li> </ul>
2. Teaching & Learning	<ul style="list-style-type: none"> <li>▪ Maintains competency to practice through identification of learning needs and continuing professional development activities. This should comply with professional body requirements.</li> <li>▪ Leads and fosters a learning environment for staff including teaching and participating in the running of training relevant to area of clinical practice.</li> <li>▪ In conjunction with Professional and Team Leaders on the training needs analysis for the team / service / profession, particularly in relation to Residential Care Discharge pathways, PPPR processes.</li> <li>▪ Supervises, educates and assesses the performance of social work students.</li> <li>▪ Provides interdisciplinary education in direct clinical area, or discipline specific teaching across teams.</li> <li>▪ Provides critical analysis, appraisal and integration of current research outcomes and relevant literature in order to maintain advanced levels of knowledge and practice. Demonstrates application of this knowledge in practice.</li> <li>▪ Maintains an awareness of current developments in relevant clinical areas.</li> <li>▪ Is involved in the induction and training of newly appointed staff as required.</li> <li>▪ Develops clinical skills of others by providing learning opportunities.</li> <li>▪ Completes core training as applicable for the role.</li> <li>▪ Participates in an annual performance review and associated clinical assurance activities.</li> <li>▪ Participates in professional supervision in line with the organisations requirements and/or professional body.</li> <li>▪ Provides mentoring and clinical support and / or professional supervision.</li> </ul>
3. Leadership & Management	<ul style="list-style-type: none"> <li>▪ From information available, prioritises patients/clients to enable appropriate allocation of referrals, delegates appropriate tasks and has oversight of workload for staff in the clinical area.</li> <li>▪ Attends and actively contributes to all relevant department, clinical and team meetings, leading and facilitating such meetings as required.</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Assists team leaders and professional leaders in clinical assurance activities of social work staff as requested.</li> <li>▪ Demonstrates negotiation and management of conflict skills within the workplace.</li> <li>▪ Provides reports to team leaders/professional leaders in relation to area of clinical practice, as requested.</li> <li>▪ Is involved in recruitment and selection processes as requested by line manager or professional leader.</li> <li>▪ Provides advice and recommendations to line manager where this will support delivery of services.</li> </ul> <p>Work in an integrated manner with other existing roles that have a focus on Patient flow, discharge coordination and complex case management</p>
<p>4. Service Improvement and Research</p>	<ul style="list-style-type: none"> <li>▪ Promotes professional practice that is based on best practice and research that supports organisational strategic aims.</li> <li>▪ Takes responsibility for leading local audit and research projects as identified by self, team leaders, professional leaders.</li> <li>▪ Takes the lead on development of quality improvement activities to develop and improve service delivery, clinical practice or professional standards. This may include care pathways / treatment protocols, standards of practice etc.</li> <li>▪ Develops / updates competency based frameworks for clinical staff in relevant clinical areas as agreed to by line manager or professional leader.</li> <li>▪ Proactively challenges and questions established interventions and approaches.</li> <li>▪ Actively participates in national, regional and sub-regional working groups / clinical networks to identify and implement innovative practice and or service improvements as appropriate.</li> <li>▪ Establishes collaborative partnerships with external organisations to promote integrated working that improve the outcomes and experience of patients/clients.</li> <li>▪ Contributes to annual planning process, including identifying gaps in service and participating in work / projects that may result from the planning process.</li> <li>▪ Practises in a way that utilises resources (including staffing) in the most sustainable and cost effective manner.</li> <li>▪ Awareness of and complies with all legislative, contractual and employment requirements as applicable to the role (e.g. Privacy Act 1993, Vulnerable Children’s Act 2014, Health &amp; Safety at Work Act 2015, ACC service specifications etc.)</li> <li>▪ Involvement in new guidelines under development that support streamlined process to discharging.</li> <li>▪ Role will support embedding effective processes in MDT’s across district.</li> <li>▪ Responsibility for further opportunities to continue to support transitions to Residential Care programme of work, under</li> </ul>

	transitions to community work stream in acute flow programme.
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## Key Relationships & Authorities



## Capability Profile

Solid performance in the role requires demonstration of the following competencies. These competencies provide a framework for selection and development.

Competency	Behaviours
<b>Problem Solving</b>	<ul style="list-style-type: none"> <li>▪ Uses rigorous logic and methods to solve difficult problems with effective solutions</li> <li>▪ Probes all fruitful sources for answers</li> </ul>

Competency	Behaviours
	<ul style="list-style-type: none"> <li>Can see hidden problems</li> <li>Is excellent at honest analysis</li> <li>Looks beyond the obvious and doesn't stop at first answers</li> </ul>
<b>Priority Setting</b>	<ul style="list-style-type: none"> <li>Spends his/her time and the time of others on what's important</li> <li>Quickly zeroes in on the critical few and puts the trivial many aside</li> <li>Can quickly sense what will help or hinder in accomplishing a goal</li> <li>Eliminates roadblocks</li> <li>Creates focus</li> </ul>
<b>Decision Quality</b>	<ul style="list-style-type: none"> <li>Makes good decisions based upon a mixture of analysis, wisdom, experience and judgement.</li> <li>Most solutions and suggestions turn out to be correct and accurate judged over time.</li> <li>Sought out by others for advice and solutions.</li> </ul>
<b>Interpersonal Savvy</b>	<ul style="list-style-type: none"> <li>Relates well to all kinds of people – up, down, and sideways, inside and outside the organisation</li> <li>Builds appropriate rapport</li> <li>Builds constructive and effective relationships</li> <li>Uses diplomacy and tact</li> <li>Can diffuse even high-tension situations comfortably</li> </ul>
<b>Action Oriented</b>	<ul style="list-style-type: none"> <li>Enjoys working hard. Is action oriented and full of energy for the things he/she sees as challenging.</li> <li>Not fearful of acting with a minimum of planning, seizes more opportunities than others.</li> </ul>
<b>Team Work</b>	<ul style="list-style-type: none"> <li>Develops constructive working relationships with other team members.</li> <li>Has a friendly manner and a positive sense of humour.</li> <li>Works cooperatively - willingly sharing knowledge and expertise with colleagues.</li> <li>Shows flexibility - is willing to change work arrangements or take on extra tasks in the short term to help the service or team meet its commitments.</li> <li>Supports in word and action decisions that have been made by the team.</li> <li>Shows an understanding of how one's own role directly or indirectly supports the health and independence of the community.</li> </ul>

## Experience and Capability

Essential qualifications, skills and experience

### A. Knowledge, Skills & Experience:

- Expectation of at least 5 years clinical practice
- Clinical experience and advanced knowledge relevant to older people and people with disabilities
- Subject matter expert in complex case management and hospital linkages with NASCs
- Subject matter expert in discharge planning processes and PPPR

### B. Essential Professional Qualifications / Accreditations / Registrations:

- NZ Registered Social Worker with current annual practicing certificate.

- Member of either Aotearoa New Zealand Association of Social Workers - Professional Association or Tangata Whenua Social Workers Association. (desirable)

**C. Someone well-suited to the role will place a high value on the following:**

- Delivering high quality care for the patient/client/whānau
- Contributing to the development of others
- Advanced speciality knowledge
- Leading and facilitating clinical improvements
- Continual improvement focus.

**D. Other:**

- A commitment and understanding of the Treaty of Waitangi (and application to health) and a willingness to work positively in improving health outcomes for Maori.
- Current full NZ driver's licence with ability to drive a manual and automatic car (required for roles based in the community or where the role may be required to work across multiple sites).
- Proficiency in using technology within the workplace.
- A high standard of written and spoken English.

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**Ma tini, ma mano, ka rapa te whai  
By joining together we will succeed**

Te Whatu Ora is committed to Te Tiriti o Waitangi principles of partnership, participation, equity and protection by ensuring that guidelines for employment policies and procedures are implemented in a way that recognises Māori cultural practices.

We are committed to supporting the principles of Equal Employment Opportunities (EEO) through the provision and practice of equal access, consideration, and encouragement in the areas of employment, training, career development and promotion for all its employees.