Palliative care nurse practitioner model implementation memorandum of understanding

between

Service A

and

Service B

and

Service C

and

Service D

and

Service E

May 2010

THIS AGREEMENT is effective from xxx until xxx

between

SERVICE A, of street address, city, postcode

and

SERVICE B, of street address, city, postcode

and

SERVICE C, of street address, city, postcode

and

SERVICE D, of street address, city, postcode

and

SERVICE E, of street address, city, postcode.

1. Background

The health workforce is a critical concern for the Victorian Government and advanced practice nursing roles such as Nurse Practitioners (NPs) are an important component of building a responsive, skilled and appropriate workforce to meet the needs of the Victorian community.

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.

The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practise and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise. (ANMC 2006)

The title *Nurse Practitioner* is protected, preventing use of the title 'nurse practitioner' by anyone who is not endorsed by the Nurses Board of Victoria as a NP. Similar restrictions apply in other states/territories, however from 1 July 2010 there will be one national board setting standards and policies for the regulation of all nurses and midwives registered in Australia. The Nursing and Midwifery Board of Australia (NMBA) will be supported in this task by the Australian Health Practitioner Regulation Agency (AHPRA).

The Palliative Care Nurse Practitioner (PCNP) Project focuses on building skills and capacity in order to promote best possible care for those people living in Victoria. Specialist palliative care providers funded by the Cancer and Palliative Care Unit of the Department of Health (the department) will implement Nurse Practitioner (NP) models in palliative care.

The rural projects are funded as part of the implementation of *Victoria's Cancer Action Plan 2008-11*. Metropolitan Palliative Care NP models were offered concurrently as part of the Victorian Nurse Practitioner Project (VNPP) through Nurse Policy Branch.

In 2009 eleven health services across the five rural and three metropolitan regions received funding for a range of innovative Palliative Care Nurse Practitioner programs and partnerships that will enhance palliative care service delivery across inpatient, community and outpatient palliative care settings in the rural and metropolitan regions. The funding supports Nurse Practitioner service model development, clinical supervision and professional support, and funds targeted scholarships for Nurse Practitioner Candidates. The funded PCNP models have been proposed and endorsed by the Palliative Care Consortia.

The Victorian Palliative Care NP Collaborative (VPCNPC) is being funded by *Victoria's Cancer Action Plan 2008-11*. The collaborative is convened by the Centre for Palliative Care Education and Research, with collaborative partners Melbourne City Mission and Banksia Palliative Care. The VPCNPC will provide clinical, mentor and resource support for PCNP Candidates and employing agencies.

2. Purpose

The purpose of this memorandum of understanding is to provide a common understanding between the signatories, and a commitment to the PCNP model (attached) within the nominated departmental region.

All signatories to this memorandum of understanding agree to support the principles and vision of the PCNP model in the nominated departmental region.

The signatories to this memorandum of understanding are listed in Appendix 1 and have listed their respective key statements on their purpose and description of service.

3. Vision

The signatories to this memorandum of understanding are committed to working with each other to strengthen the integration and sustainability of the PCNP role in their respective agencies and health services and across the nominated departmental region.

4. Principles

Principles underpinning this memorandum of understanding include:

- Signatories will communicate and work in a collaborative, cooperative and transparent way, ensuring support for the PCNP role/s across sectors and settings
- Signatories will work closely with all relevant stakeholders to ensure key system, organisation or operational issues that may have an impact on the successful integration of sustainable PCNP models are identified and addressed
- Signatories will establish a steering committee to ensure optimal oversight of all strategic and operational elements of the PCNP project/s
- Signatories will support building the capacity and capability of health services to implement PCNP models
- PCNP activities and development will be consistent with and support Department of Health palliative care strategic priorities and other activities undertaken by the department, including nurse policy branch and commonwealth government initiatives.
- Signatories will support the activities of the Victorian Palliative Care Nurse Practitioner Collaborative
- Signatories will align PCNP activities and development within current regulatory and legislative frameworks
- Signatories will recognise, reflect and respect the differing skills, expertise and values of each other.
- Signatories will actively foster a culture of learning.
- Each participating agency or service provider is to be viewed as an equal partner.
- As far as possible, signatories will ensure continuity of membership and regular attendance at all relevant meetings (for example, PCNP steering committee meetings)
- Information gained through participation in this initiative will not be used for commercial or competitive advantage.
- Each party will be totally responsible for its own personnel engaged in the memorandum of understanding.

5. Governance structure

It is anticipated that representation from signatories to the memorandum of understanding will be in accordance with the level appropriate to the decision making function of their respective service. Individual signatories shall not be jointly and severally liable for the acts of omissions of the other parties and each of the parties hereby acknowledge that its acts and omissions and those of its staff or agents shall be the subject of its own professional indemnity and other insurance arrangements.

Signatories to the memorandum of understanding will establish a PCNP Steering Committee with relevant representation and governance structures.

6. Membership of steering committee

As a minimum, the steering committee will contain:

- one representative from each of the signatories to the memorandum of understanding. It is recommended that there is one vote per organisation
- representation of any health service/key stakeholder that may have a major role in the PCNP project, but is not a signatory to the memorandum of understanding
- a representative from the relevant regional palliative care consortium

Consideration should also be given to:

- including the PCNP project manager (where an appointment has been made)
- ensuring relevant clinical representation on the steering committee, for example, senior clinician appointed as clinical supervisor for PCNP Candidate/s
- including other local/regional NP/s endorsed to practice in palliative care or other specialty areas

The steering committee shall elect a chairperson from the nominated representatives. The role of the chairperson shall include:

- calling meetings and coordinating the agenda
- liaising directly with the department on behalf of the signatories to the memorandum of understanding
- relaying information from the department to signatories of the memorandum of understanding in a timely manner
- acting in the best interests of all members of the memorandum of understanding.

7. Key responsibilities of the steering committee

The PCNP steering committee will have responsibility to:

- ensure appropriate representation on the steering committee and steering committee executive and include documented delegations where required
- ensure feedback and consultation mechanisms with key stakeholders
- develop and endorse steering committee Terms of Reference
- ensure relevant input to the PCNP project mandate and decision making processes
- ensure steering committee participation and endorsement at all key decision making points throughout the PCNP project
- ensure project deliverables are aligned with the described PCNP model deliverables and objectives

- ensure specific attention to the clinical governance framework within legislative, regulatory and professional requirements including but not limited to, admitting rights, and credentialing and privileging
- monitor project deliverables and key performance indicators as agreed by the steering committee
- directing the tasks of any working group or sub-committees established and receiving reports and recommendations from these

8. Operation of the steering committee meetings

- All members have equal rights of participation in the meetings
- Meetings are held at a frequency and location to be determined by the steering committee
- All members will actively participate in the decision making processes of the regional consortia
- The steering committee shall aim to operate by consensus. If consensus is not possible, a majority decision shall be reached with the majority consisting of votes from the number of representatives eligible to vote
- Members will raise issues of concern prior to committing to final decisions
- Meetings will be conducted on the assumption that members have read and discussed the materials prior to the meeting
- Decisions made at the steering committee meetings will be final, based on the assumption that all members have sufficient notification to ensure representation at the meeting and the opportunity to raise issues of concern to enable them to be addressed
- All decisions endorsed by a meeting of the steering committee for which five days notice has been given will be considered a decision of the whole steering committee
- A quorum (to be decided by the steering committee) is necessary for any decision made at the steering committee meetings. If no quorum is present within half an hour of the time of the appointed meeting time, the meeting will continue and decisions will be ratified at the next meeting

9. Fund holder

The fund holder, for the purposes of the PCNP project are public health services who employ PCNP Candidates and who receive NP Candidate Support Packages (CSP). The fund holder's responsibilities are described in the CSP eligibility criteria.

10. Costs

Unless otherwise agreed by the steering committee, each party will be responsible for its own costs and expenses incurred in connection with the entry into and the operation of this memorandum of understanding.

11. Dispute resolution

The signatories to the memorandum of understanding recognise and value the diversity of its signatories and seek to anticipate and resolve differences in this spirit. The steering committee will operate a forum in which members are encouraged to openly express and discuss their concerns and hesitations, seeking consensus and agreement as part of the overall decision making process.

In the event of a dispute or grievance arising within the memorandum of understanding, it will be addressed by negotiation at the steering committee meetings with the aim of consensus or, failing that, a majority decision.

If a dispute cannot be resolved via this process, an independent mediator, agreeable to relevant parties, will be appointed to facilitate resolution. The steering committee will determine consideration of the process and financial implications.

12. Statement of limitation

The signatories to the memorandum of understanding will not:

- act in a manner that undermines or contradicts the purpose or brief of specific organisations
- build a costly infrastructure which duplicates the role of bureaucracy or agency management and leads to the transfer of resources away from service delivery to management
- be responsible for altering, changing or modifying any existing funding arrangements for signatory agencies unless otherwise agreed by all parties and the department.

13. Term, review and amendment of the memorandum of understanding

- The memorandum of understanding exists until xxxx.
- The memorandum of understanding can be amended at any time by an agreement in writing between ALL the signatories.
- Decisions to alter component parts of the memorandum of understanding will require a three-quarters majority of all signatories.
- The amended memorandum of understanding will be circulated to all members for signing.
- This memorandum of understanding does not vary or affect existing rights and obligations under existing agreements between the partners and their agencies.

14. Legal status

This memorandum of understanding is not legally binding.

15. Definitions and interpretation

- **Memorandum of understanding** means this memorandum of understanding and its schedules.

- A **nurse practitioner** is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The title *Nurse Practitioner* is protected, preventing use of the title 'nurse practitioner' by anyone who is not endorsed by the Nurses Board of Victoria as a NP.

- **Regional palliative care consortia** means all specialist palliative care providers (community, inpatient and consultancy) funded under the Palliative Care Program of the Department of Health.

- **Department** means the Victorian Department of Health.

- **Consultancy services** means those specialist palliative care services within hospitals which clinicians provide to patients in non-designated palliative care beds.

- The singular includes the plural and vice versa.

EXECUTED as an Agreement

SIGNED for and on behalf of
SERVICE A

By

…… …….
(Name of officer) (Signature of officer)
an officer duly authorised to sign on its behalf

in the presence of:

…….. …….
(Name of witness) (Signature of witness)

Date……

SIGNED for and on behalf of
SERVICE B

By

…… …….
(Name of officer) (Signature of officer)
an officer duly authorised to sign on its behalf

in the presence of:

…….. …….
(Name of witness) (Signature of witness)

Date……

SIGNED for and on behalf of
SERVICE C

By

…… …….
(Name of officer) (Signature of officer)
an officer duly authorised to sign on its behalf

in the presence of:

…….. …….
(Name of witness) (Signature of witness)

Date……

SIGNED for and on behalf of
SERVICE D

By

…… …….
(Name of officer) (Signature of officer)
an officer duly authorised to sign on its behalf

in the presence of:

…….. …….
(Name of witness) (Signature of witness)

Date……

SIGNED for and on behalf of
SERVICE E

By

…… …….
(Name of officer) (Signature of officer)
an officer duly authorised to sign on its behalf

in the presence of:

…….. …….
(Name of witness) (Signature of witness)

Date……

Appendix 1

Signatories to memorandum of understanding

Service name	Description of service (profile)
Service A	
Service B	
Service C	
Service D	
Service E	

Appendix 2

Existing working relationships between member organisations (examples only)

- Service A and Service B have a formal heads of agreement.
- Service A and Service C have a shared care arrangement.
- Service B provides secondary consultations to Service C.
- Service A, Service D and Service E are all members of the Palliative Care Clinical Advisory Group.
- Service D has a contractual arrangement with Service E.