Memorandum of understanding

for the

North and West Metropolitan Region Palliative Care Consortium

between

Austin Health

and

Banksia Palliative Care Service

and

Melbourne City Mission

and

Melbourne Health/Peter Mac operating as 'Parkville Integrated Palliative Care Service' of the Victorian Comprehensive Cancer Centre (VCCC)

and

Mercy Health (incorporating both Mercy Palliative Care and Werribee Mercy Hospital)

and

Northern Health

and

Western Health

(together, the **Parties**)

Dated: the date on which the last Party signs

This MoU is effective on and from the date on which the last party signs (**Effective Date**) and is designed to remain relevant for the period for which the NW Metro Consortium receives funding from the Victorian Government to operate the Consortium and the Victorian Government's End of life and palliative care framework remains a key reference point for the government's approach to end of life and palliative care in Victoria.

The MoU remains in place until it is revoked by in accordance with clause 14.

1. Background

Established in 2004, there are palliative care consortia in eight regions of Victoria, a network covering the whole state as follows:

a) Barwon-South Western
b) Eastern Metropolitan
c) Hume
d) Gippsland
e) Grampians
f) Loddon Mallee
g) North & West Metropolitan (**NW Metro Consortium** or **Consortium**)
h) Southern Metropolitan

The Consortia are funded by the Victorian Government, through the Department of Human Services and Health (**DHHS**). Victoria's end of life and palliative care framework (the **Framework**), published by DHHS, guides the work of consortia.

2. Revocation of Existing MoU

The Parties entered into a Memorandum of Understanding on or about 2018 (**Existing MoU**). Pursuant to clause 14 of the Existing MoU the parties agree to revoke the Existing MoU and replace it with this Memorandum of Understanding (**MoU**).

3. Consortium Role

The Parties to this MoU are the members of the Consortium.

Within the context of the Framework, the NW Metro Consortium has defined its core purpose and role as follows:

The Consortium:

a) Promotes collaborative approaches to quality improvement in end of life and palliative care;
b) Works to optimise the community's access to high quality end of life and palliative care support; and
c) Assists DHHS to implement the Victorian Government's end of life and palliative care framework and other policies and programs to support people with a life-limiting illness and their carers, families, friends and communities."

The governance of the Consortium includes a Management Group with one voting member representing each of the 'specialist palliative care' services of Parties to this MoU. See Clauses 7 and 8 for more detail on the Consortium Management Group.

4. Purpose of the memorandum of understanding (MoU)

The contents of this MoU is informed by the proforma MoU provided on the website of the DHHS, dated October 2016 and viewed as of 8 December 2020
The purpose of this MoU is to provide a common understanding and commitment between the Parties that form the Consortium. All Parties agree to form and operate under the MoU as a partnership for the purposes of the operation of the Consortium.

5. Vision, Guiding Principles and Goals

The Parties are committed to the vision, guiding principles and goals of the Framework.

Framework Vision

All Victorians and their families receive the best possible end of life care that places them at the centre where preferences, values, dignity and comfort are respected and quality of life matters most.

Framework Guiding Principles

1. Dying is part of life: dying is a normal part of life and being human, not just a biological or medical event.
2. The person is central to care: a person's care is tailored and holistic; their rights, values and preferences are respected and they determine their own care whenever possible.
3. Carers are important: carers receive recognition, support and are valued throughout their caring experience and after a person's death.
4. All people have information they discuss openly: people, their carers and families have information they understand about genuine choices that they can discuss authentically with their doctor and service providers.
5. Decision-making is legalised and respected: people's decisions that may involve substitute decision-makers, health providers, families and carers are recognised and respected in accordance with relevant legislation.
6. Services are high-quality and coordinated: individuals, their carers and families receive coordinated, integrated care from skillful staff.
7. Care and services are monitored: underpinning end of life care are best practice evidence, effective monitoring, evaluation of patient-centred outcomes and supporting innovation.

Framework Goals

1. People experience optimal end of life care.
2. People's pain and symptoms are managed using quality interventions.
3. People's preferences and values are recognised and respected in their end of life care.
4. Better support for carers.
5. People are cared for in their place of choice.
6. Where possible, people can choose to die in their place of choice.

6. Principles underpinning this MoU

Principles underpinning this MoU include:

a) Parties will communicate and work together in a positive spirit of collaboration and cooperation.
b) Each Party is to be viewed as an equal partner in the Consortium, given expression by each Party having one equal vote in Consortium Management Group decision-making.
c) Information gained through participating in the Consortium will not be used for unfair commercial or competitive advantage.
d) Each Party will be totally responsible for its own personnel engaged in the Consortium.

7. Governance structure: Consortium Management Group

The governance of the Consortium includes the Consortium Management Group.

The role of the Consortium Management Group is to oversee the activities of the Consortium, including setting priorities, monitoring implementation and review of activities in the context of the Consortium's role and the vision, guiding principles and goals of the Framework.

Voting members of the Consortium Management Group are representatives of the 'specialist palliative care' services of each of the Parties. In addition, other organisations may be invited to be 'around the table' as regular attendees at Consortium Management Group meetings in a non-voting capacity, including but not limited to the North West Melbourne Primary Health Network (NWMPHN).

Parties are free to choose their own representatives to the Management Group. In addition, it is expected that all Parties nominate at least one 'proxy member' to ensure maximum representation at all meetings. The Consortium Manager is also a non-voting member of the Management Group.

The Management Group elects a chairperson (the **Chair**) from the voting members. The term of the Chair may be varied according to the needs of the Management Group. The Chair's role includes liaison with the Consortium Manager regarding Management Group meeting agendas and activities, along with fulfilling DHHS expectations regarding the Chair's role in communication with DHHS.

8. Operation of the Management Group meetings

a) Regular 'face to face' or virtual meetings are held at a frequency and location to be determined by the Management Group, with a minimum of five per year.
b) Quorum is half the voting membership, plus one, e.g. seven voting members = quorum of 4.
c) Meetings aim to operate by consensus. Where consensus cannot be reached, decisions can occur via a majority decision by vote.
d) An electronic decision-making process for decisions between scheduled meetings may be deployed where it is deemed impractical or unnecessary to schedule a face-to-face or virtual meeting.
e) Parties are expected to ensure that the Management Group is made aware of any conflicts of interest which might arise in relation to Management Group decision-making and that appropriate steps are considered to eliminate any suggestions of inappropriate or unethical actions.

9. Fundholder and financial arrangements including employment of staff

The Consortium is not a legal entity and therefore cannot be the legal entity that employs staff or receives funding and makes payments of salary and non-salary items. To undertake tasks and responsibilities associated with the acceptance of funding from DHHS and the employment of staff, the Consortium nominates a fundholder.

The fundholder's role includes:
a) Ensure the Consortium is financially accountable.
b) Provide financial reports to the Consortium Management Group at least quarterly and provide additional financial reports as requested.
c) Liaise with DHHS on behalf of the Consortium for the purposes of meeting financial accountability requirements.
d) Provide transparent and accountable reports and financial processes to support the efficient work of the Consortium.
e) Complete an annual financial accountability statement to be included in the Consortium's annual report to DHHS.
f) Adhere to DHHS policy and funding guidelines 'business rule for consortia funding', including:
    i. Funding received by the fundholders should be treated as revenue in accordance with AASB 1004
    ii. Funding distributed to Consortia members should be recorded under '22091-22100 Grant received on behalf of and paid to other agencies' in the books of the fundholders.
    iii. Likewise Consortia members are to recognise the distributions as revenue.

iv. Expenses incurred by fundholders and the Parties are to be reported as salaries and wages and non-salary costs accordingly.
v. Unspent Consortium funding to be retained for use in the following year.
vi. Consortia are required to disclose any unspent funding in their special purpose financial statement to DHHS.

The Consortium fundholder will make every effort to minimise administrative overheads to maximise allocated funds.

The fundholder will provide a range of support services which include but may not be limited to:
a) Accounts Payable
b) Accounts Receivable
c) Payroll
d) Information technology support
e) Human resources support
f) Finance Support
g) Health and safety
h) Workcover
i) Insurances

The fundholder will deduct the amount of $30,000 per annum for these support services. The Consortium Manager will monitor access to and the quality of these services. Evidence of issues relating to access or service quality will be reported to the Chair. The Chair and Consortium Manager will liaise with the fundholder to address issues and seek resolution of same to the satisfaction of both parties.

The Consortium will not build a costly infrastructure nor incur unnecessary costs to support its activities.

Unless otherwise agreed by the Consortium, each Party will be responsible for its own costs and expenses incurred in connection with the entry into and the operation of this MoU.

10. Liability

Parties will not be jointly and/or singly liable for the acts or omissions of the other Parties. Each Party acknowledges that its acts and omissions and those of its staff or agents will be the subject of its own professional indemnity and other insurance arrangements.

11. Statement of limitation

The Consortium will not:
a) Act in a manner that undermines or contradicts the purpose or brief of specific organisations.
b) Build a costly infrastructure that duplicates the role of bureaucracy or agency management and leads to transferring resources away from service delivery to management.
c) Be responsible for altering, changing or modifying any existing funding arrangements for signatory agencies unless otherwise agreed by all Parties and DHHS.

12. Dispute resolution

The Consortium recognises and values the diversity of the Parties to this MoU and seeks to anticipate and resolve differences in this spirit. The Consortium will operate a forum in which the Parties 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 Consortium, it will be addressed by negotiation at Consortium Management Group meetings, or other special purpose meetings as agreed to by the Consortium Management Group, with the aim of consensus or, failing that, a majority decision.

If a dispute cannot be resolved via this process, a mediator, agreeable to relevant Parties, will be appointed to facilitate a resolution. The Consortium Management Group will determine the process and financial implications of any dispute resolution process.

13. Statewide services

The Consortium will maintain contact with and consult with statewide services where appropriate. These services include:

a) Motor Neurone Disease Association (MNDA) Victoria
b) Palliative Care Victoria
c) Statewide Specialist Counselling and Bereavement Service (operated by the Australian Centre for Grief and Bereavement)
d) The Centre for Palliative Care
e) Very Special Kids (VSK)
f) Victorian Paediatric Palliative Care Program (VPPCP).

14. Term, review and amendment of the MOU

a) This MoU is effective from the Effective Date and is designed to remain relevant for the period for which the Consortium receives funding from the Victorian Government to operate the Consortium and the Framework remains a key reference point for the Victorian Government's approach to end of life and palliative care in Victoria.
b) This MoU remains in place until it is revoked by all Parties.
c) If a Party wishes to leave the Consortium (**Exiting Party**):
    i. the Exiting Party must provide written notice to the Consortium Chair; and
    ii. the Parties will enter into a variation of this MOU to reflect the departure of the Existing Party.
d) Subject to clause 14(c), this MOU can be amended at any time by an agreement in writing between a majority of all Parties. Any amended MOU will be circulated to representatives of all Parties for signing and will not be considered operational until all Parties have signed.
e) This MOU does not vary or affect existing rights and obligations under existing agreements between the Parties and their agencies.

15. Legal status

This MOU is not legally binding.

SIGNED for and on behalf of **AUSTIN HEALTH** on (date) ...../...../.....

By.....
(Name)

.....
(Signature of officer)

in the presence of.....
(Name of witness)

.....
(Signature of witness)

SIGNED for and on behalf of **BANKSIA PALLIATIVE CARE SERVICE** on (date) ...../...../.....

By.....
(Name)

.....
(Signature of officer)

in the presence of.....
(Name of witness)

.....
(Signature of witness)

SIGNED for and on behalf of **MELBOURNE CITY MISSION** on (date) ...../...../.....

By.....
(Name)

.....
(Signature of officer)

in the presence of.....
(Name of witness)

.....
(Signature of witness)

SIGNED for and on behalf of **MELBOURNE HEALTH/PETER MAC/THE INTEGRATED PALLIATIVE CARE SERVICE OF THE VICTORIAN COMPREHENSIVE CANCER SERVICE** on (date) ...../...../.....

By.....
(Name)

.....
(Signature of officer)

in the presence of.....
(Name of witness)

.....
(Signature of witness)

SIGNED for and on behalf of **MERCY HEALTH** on (date) ...../...../.....

By.....
(Name)

.....
(Signature of officer)

in the presence of.....
(Name of witness)

.....
(Signature of witness)

SIGNED for and on behalf of **NORTHERN HEALTH** on (date) ...../...../.....

By.....
(Name)

.....
(Signature of officer)

in the presence of.....
(Name of witness)

.....
(Signature of witness)

SIGNED for and on behalf of **WESTERN HEALTH** on (date) 14/05/2021

By K. Vivekanantham
(Name) Kelle Vivekanantham
Operations Manager
0435 184 787

.....
(Signature of officer)

in the presence of Lebe Malkoun
(Name of witness)

.....
(Signature of witness)