| **Request Number** | | | | | 2024-38 | **Request title** | Youth Enhanced Services – Country WA PHN | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Respondent Business Details** | | | | | | | | | | | | | | | |
| **Name of legal entity:** | | | | | | Click or tap here to enter text. | | | | | | | | | |
| **Trading name:** | | | | | | Click or tap here to enter text. | | | | | | | | | |
| **Registered address or address of principal place of business:** | | | | | | Click or tap here to enter text. | | | | | | | | | |
| **ACN:** | | | | | | Click or tap here to enter text. | | | | **ABN:** | Click or tap here to enter text. | | | | |
| **Contact Details**  **for Submission:** | | | | **Name :**  **Position :**  **Phone :**  **Email :** | | Click or tap here to enter text. | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
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| Click or tap here to enter text. | | | | | | | | | |
| **Declaration** | | | | | | | | | | | | | | | |
| The Respondent declares that it has the necessary skills, knowledge and experience to comply with the requirements of this document and that it has fully informed itself of all facts and conditions relating to this process.  The person signing this declaration purports that it is authorised to make this Submission on behalf of the Respondent and has read, understood and accepts the Conditions of Request and that all information provided in this Submission is to the best of their knowledge true and correct. | | | | | | | | | | | | | | | |
| -------------------------------------------------------------- | | | | | | | ------------------------------ | | | | | | | | |
| Signed | | | | | | | Dated | | | | | | | | |
| Name: | |  | | | | | Position: | |  | | | | | | |
| **1.0** | **Pre-qualification** | | | | | | | | | | | | | | |
| 1.1 | Accreditation  The Respondent must provide proof of accreditation (without restriction) against the National Safety and Quality Health Service Standards\* either:   * National Safety and Quality Primary and Community Healthcare Standards (Primary and Community Healthcare Standards 2021 or * National Safety and Quality Mental Health Standards for Community Managed Organisations, 2022   Where a service is currently only accredited against the National Standards for Mental Health Services (2010) it should have in place an agreed plan to transition to the National Safety and Quality Health Service Standards as soon as is practicable. | | | | | | | | | | | | | Yes  No | |
| 1.2 | Agreement terms and conditions  Does the Respondent agree to comply with the terms of the Agreement attached if an Agreement were to be entered into with WAPHA?  *If No, the Respondent must complete the Non-Conformance Schedule and set out: the extent of non-compliance; including the alternative clauses or provisions, if any, or a description of any changes it proposes to the Service Agreement; and the reason for non-compliance.* | | | | | | | | | | | | | Yes  No | |
| 1.3 | Budget Template  The Respondent must provide a completed Budget for the required services as per Request Part D - Attachment – Budget Template on the basis that this represents a normal full year’s operational expenditure (e.g. allocate full year’s budget as if it was going to be used on a complete basis).  The Budget will be deemed to include the cost of complying with all matters and things necessary or relevant for the performance of the Service Agreement. | | | | | | | | | | | | | Yes  No | |
| 1.4 | Funding Proportion  Does this funding comprise more than 50% of your organisation’s funding?  Broadly outline how much of your organisation's funding under this RFP would comprise.   * \_\_\_\_\_\_\_ % | | | | | | | | | | | | | Yes  No | |
| 1.5 | Referee Contact  The Respondent must provide details of two (2) current Referee contacts for similar or like services.  Have you provided the Referee Contact details? | | | | | | | | | | | | | Yes  No | |
| 1.6 | Insurances  Does the Respondent have the required insurances specified in the Agreement?  If yes complete insurances table below. | | | | | | | | | | | | | Yes  No | |
| Public Indemnity (Not less than $20M) | | | | | | | | | | | | | | | |
| Insurer : | | | Click or tap here to enter text. | | | | | Policy Number : | | | | Click or tap here to enter text. | | | |
| Amount : | | | $Click or tap here to enter text. | | | | | Expiry Date : | | | | Click or tap to enter a date. | | | |
| Professional Indemnity (Not less than $10M) | | | | | | | | | | | | | | | |
| Insurer : | | | Click or tap here to enter text. | | | | | Policy Number : | | | | Click or tap here to enter text. | | | |
| Amount : | | | $Click or tap here to enter text. | | | | | Expiry Date : | | | | Click or tap to enter a date. | | | |
| Professional Indemnity for Clinician (Not less than $10M) | | | | | | | | | | | | | | | |
| Insurer : | | | Click or tap here to enter text. | | | | | Policy Number : | | | | Click or tap here to enter text. | | | |
| Amount : | | | $Click or tap here to enter text. | | | | | Expiry Date : | | | | Click or tap to enter a date. | | | |
| Information Technology (Cyber) Liability Insurance (Not less than $3M)  Information Technology (Cyber) Liability insurance covering the legal liability of the Respondent for claims arising from any actual or alleged:   1. breach of public disclosure of personal or corporate information; 2. liability, loss of, damage or destruction to any property (including data) whilst in the care, custody or control of the Contractor; 3. breach of confidentiality or privacy; 4. act or omission by an unauthorised person or entity resulting in loss of, damage or destruction to the computer system (including hardware, software and data) owned or used by the Respondent, for an amount not less than $3 million any one claim and in the annual aggregate. The insurance must be //maintained for a period of at least 6 years after termination or expiration of the Contract. | | | | | | | | | | | | | | | |
| Insurer : | | | Click or tap here to enter text. | | | | | Policy Number : | | | | Click or tap here to enter text. | | | |
| Amount : | | | $Click or tap here to enter text. | | | | | Expiry Date : | | | | Click or tap to enter a date. | | | |
| 1.3 | Insurances  If no to 1.2, does the Respondent confirm that that the required insurances will be obtained prior to the commencement of Services relevant to this Request? | | | | | | | | | | | | | Yes  No | |
| **2.0** | **Disclosure and Compliance** | | | | | | | | | | | | | | |
| 2.1 | Organisation Type a.  Is the Respondent a not-for-profit entity?  For the purposes of this Request, the Respondent is a "not-for-profit entity" if it meets the requirements of the Australian Taxation Office to be treated as a “not-for-profit-organisation”. | | | | | | | | | | | | | Yes  No | |
| 2.2 | Organisation Type b.  If yes to 2.1 is the Respondent registered with the Australian Charities and Not-for-profits Commission’s (ACNC) Register?  If NO, *what evidence is available that the organisation*  *it meets the requirements of the Australian Taxation Office to be treated as a “not-for-profit-organisation”.* | | | | | | | | | | | | | Yes  No | |
|  | | | | | | | | | | | | | | | |
| 2.3 | Financial Information a.  Is the Respondent’s financial information available via the Australian Charities and Not-for-profits Commission’s (ACNC) Register, and does the Respondent agree that WAPHA can use this information in lieu of the Respondent providing it as part of its Submission?  Respondents are responsible for ensuring that the information available via the ACNC Register is correct and that no material changes to the information have occurred since it was reported to the ACNC**.** | | | | | | | | | | | | | | Yes  No |
| 2.4 | Financial Information b.  If no to the above the Respondent has attached audited annual financial statements for the most recent two financial years including profit and loss statements for each year, balance sheets as at the end of each year and a statement of cash flows for each year? If No, please provide an explanation below. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| 2.5 | Nature of Respondent  Is the Respondent acting as an agent or trustee for another person or persons, or is it acting jointly or in association with another person/s (in a consortium), or does it intend to do so in connection with the performance of the Services relevant to this Request?  If Yes, please provide details including if relevant a description of the proposed legal structure and relationships. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| 2.6 | Sub-contracting  Does the Respondent intend to engage Sub-Contractors in connection with the performance of the Services relevant to this Request?  If Yes, provide for each sub-contractor all relevant details including as appropriate, Company name, ABN/ACN, Contact Person and details, proof of relevant accreditations for each sub-contractor and services that will be provided. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| 2.7 | Existing Material  Does the Respondent nominate any information as Existing Material in relation to Clause 9. Intellectual Property Rights of the Agreement? If Yes, provide detail below. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| 2.8 | Criminal offences  Has the Respondent; or any Director or other Officer of the Respondent; or any Specified Personnel or nominated Sub-Contractors been convicted of a criminal offence that is punishable by imprisonment or detention?  The Respondent is not required to disclose convictions that are spent convictions under the Spent Convictions Act 1998 (WA) or equivalent legislation of another State or Territory of Australia. If Yes, insert details below. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| 2.9 | Legal actions  Has the Respondent previously had any legal actions taken against it or does it currently have any legal actions outstanding? If yes insert details below. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| 2.10 | Conflicts of interest  Are there any circumstances, arrangements or understandings which constitute, or may reasonably be perceived to constitute, an actual or potential conflict of interest with either the Respondent’s obligations under this Request or in connection with the performance of the Services relevant to this Request by the Respondent? If Yes, provide detail below. | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | |
| **3.0** | **Qualitative** | | | | | | | | | | | | | | |
| 3.1 | **EXPERIENCE (30%)**  Describe your organisation's previous experience and expertise in providing the services, or similar services to those detailed in the draft Activity Schedule. Address the following points: | | | | | | | | | | | | | | |
| 1. **Specific Instances and Outcomes**   Provide examples of current services and programs, detailing the outcomes achieved and how these were evaluated or demonstrated. | | | | | | | | | | | | **10%** | | |
| 1. **Relevant Partnerships**   Highlight existing relevant partnerships and arrangements with allied health and other services pertinent to the delivery of the services. Refer to Item B.2.5 – Collaboration and Integration of the Activity Schedule. | | | | | | | | | | | | **10%** | | |
| 1. **Data Collection Method**   Describe your current data collection methods related to this service, including the development, capture, and demonstration of outcomes through data. Refer to Item B.2.11 - Commonwealth Data Requirements - Primary Mental Health Care Minimum Data Set (PMHC-MDS) of the Activity Schedule. | | | | | | | | | | | | **5%** | | |
| 1. **Risk Management in Clinical Governance**   Provide information in relation to policies and governance around your mitigation of clinical risk. | | | | | | | | | | | | **5%** | | |
|  | | | | | | | | | | | | | | | |
| 3.2 | **SERVICE METHODOLOGY (40 %)**  Detail the methodology that will be used to achieve the Service Outcomes detailed in the draft Activity Schedule including: | | | | | | | | | | | | | | |
| 1. **Approach to Co-Development of Localised Service Design in Geraldton**  * Identify key stakeholders. * Demonstrate an understanding of guidance documents to inform the service. * Provide a timeframe and key milestones to complete the service design. | | | | | | | | | | | | **12.5%** | | |
| 1. **Core Components and Essential Elements of Care**  * Specify the core components and essential elements of care * Describe the proposed intake screening and assessments. | | | | | | | | | | | | **12.5%** | | |
| 1. **Anticipated Patient Journey Pathway**  * Outline the anticipated patient journey pathway. | | | | | | | | | | | | **5%** | | |
| 1. **Proposed Management and Staffing Structure**  * Detail the proposed management and staffing structure, including employed and sub-contracted positions. * Include details of any specified personnel (e.g., clinical) that will be delivering services within the program.   *Please also refer to Part D – Attachment Budget Template (A.2 Budget – Service Profile) to complete the proposed management and staffing structure budget profile.* | | | | | | | | | | | | **5%** | | |
|  | 1. **Details of Other Service Partners**  * Identify other service partners who will be included in achieving integrated, holistic service and referral pathways, including headspace Geraldton and tertiary services. Refer Item B.2.5 of the Activity Schedule | | | | | | | | | | | | **5%** | | |
|  | | | | | | | | | | | | | | | |
| 3.3 | **ORGANISATIONAL CAPACITY (30%)**  Provide an overview of your capacity to support the Services in draft Activity Schedule detailing: | | | | | | | | | | | | | | |
| 1. **Support Resources**  * Describe your current support infrastructure, specifically in people resources and facilities that can be used for the provision of these Services. * Identify other resources (equipment, infrastructure, personnel, partnerships, etc.) that will need to be obtained or procured to effectively deliver the Services. | | | | | | | | | | | | **5%** | | |
| 1. **Local Knowledge and Presence**  * Highlight your organisation's existing local knowledge of and presence in the relevant area. | | | | | | | | | | | | **5%** | | |
| 1. **Key Clinical and Operations Policies, Procedures, and Guidelines**  * Provide information on key clinical and operations policies, procedures, and guidelines in place to ensure a relevant and high-quality service is provided. Refer to Item B.1 – Activity Description and B.5 – Governance and Risk Management of the Activity Schedule. * Demonstrate the ability to develop and maintain these policies specific to the Services. Refer to Item B.1 – Activity Description and B.5 – Governance and Risk Management of the Activity Schedule. | | | | | | | | | | | | **10%** | | |
| 1. **Skills and Expertise of Staff:**  * Explain how your organisation ensures staff maintain and develop relevant skills and experience regarding the delivery of services. * Describe how you retain staff and encourage staff development * How do you monitor and continually improve staff culture | | | | | | | | | | | | **2.5%** | | |
| 1. **Implementation Plan:**  * Provide an implementation plan with timeframes and major milestones. | | | | | | | | | | | | **2.5%** | | |
| 1. **Risk Management**  * Identify key risks that may impact service delivery and explain how these risks will be mitigated and/or managed, including recruitment and retention of critical staff. Refer to Item B.5.2 - Risk of the Activity Schedule * Include information on clinical redundancy, business continuity plans, cultural and diversity training, risk matrix, and recruitment and retention strategies. | | | | | | | | | | | | **5%** | | |
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| **Attachments** | | | | | | | | | | | | | | | |
| The Respondent is to list below any attachments that form part of its submission. The Respondent is not to attach generic or voluminous marketing materials. Each Attachment is to be named as listed below and up-loaded as a separate Attachment. | | | | | | | | | | | | | | | |
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