| **Request Number** | | | | | 2024-80 | **Request title** | Youth Enhanced Services – Metropolitan (Perth South 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) they are not excluded from this tender process however must submit evidence of a transition plan to move to the relevant Australian Commission on Safety and Quality in Health Care managed standards cited above during the contract term | | | | | | | | | | | | | 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 Templates  The Respondent must provide a completed Budget for the required services as per Request Part D3 - Attachment – Service Delivery 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.  The Respondent must provide a completed Budget for establishment costs for the required services as per Request Part D2- Attachment – Establishment Budget Template on the basis that this is for evaluation purposes only and any agreement for payment for Establishment Costs would be via negotiation with WAPHA. | | | | | | | | | | | | | 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 | 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 RFT would comprise.  \_\_\_\_\_\_\_ % | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | | |
| 2.7 | 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 |
|  | | | | | | | | | | | | | | | | |
| 2.8 | 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 managing and providing the services, or clinically similar services, to those detailed in the draft Activity Schedule. Address the following points: | | | | | | | | | | | | | | |
| 1. **Specific Activities and Outcomes**   Provide examples of current or previous activities delivering Clinical Mental Health Services for young people, including specific outcomes achieved and the methods used to evaluate and demonstrate these outcomes | | | | | | | | | | | | **15%** | | |
| 1. **Relevant Partnerships**   Highlight existing relevant partnerships and arrangements with stakeholders and key clinical and allied health services pertinent to the delivery of the services in the Perth South PHN | | | | | | | | | | | | **10%** | | |
| 1. **Data Collection Method**   Describe your current data collection methods as they would relate 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%** | | |
|  | | | | | | | | | | | | | | | | |
| 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 Perth South PHN**   Highlight your organisation’s existing local knowledge of and presence in the Perth South PHN  Identify all key stakeholders in the Perth South PHN relevant to this service.  Provide an implementation plan including timeframes and key milestones to complete the service design. | | | | | | | | | | | | **15%** | | |
| 1. **Youth Enhanced Service Model Core Components and Essential Elements of Care**   Demonstrate an understanding of the Youth Enhanced Service (YES) principles and core components as they would be applied in the service.  Describe the proposed intake and assessments process and the way this would reflect the Youth Enhanced Services (YES) principles and core components  Outline all elements of the anticipated patient journey pathway including who is involved in each step and alignment to YES principles | | | | | | | | | | | | **25%** | | |
|  | | | | | | | | | | | | | | | | |
| 3.3 | **ORGANISATIONAL CAPACITY (30%)**  Provide an overview of your capacity to support the Services in draft Activity Schedule detailing: | | | | | | | | | | | | | | |
| 1. **Proposed Staffing**   Detail the proposed management and staffing structure for the YES Service including   * 1. Organisational Chart   2. Number of Full Time Equivalents (FTE’s) and their Roles   3. Qualifications and Accreditations of Proposed Staffing   4. Whether staff will be employed or subcontracted   5. Where subcontracted – identification of proposed subcontractors and how they will be contracted   Provide proposed strategy for recruitment of staff  Outline the supervision arrangements including clinical supervision  Explain how your organisation ensures staff maintain and develop relevant skills and experience regarding delivery of services  Describe how you retain staff and encourage staff development and continually improve staff culture.  Detail how many clients you estimate to access the service in the first 12 months. | | | | | | | | | | | | **15%** | | |
| 1. **Site and Resources**   Identify the site/s from which the services will be delivered  Outline the expected hours of service (noting the Services under the Activity are to be offered with extended hours (including outside office hours, weekends) as determined by co-development group based on local considerations)  Identify any other resources (equipment, infrastructure, etc) that will need to be obtained or procured to effectively deliver the Services | | | | | | | | | | | | **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  Demonstrate the ability to develop and maintain these policies specific to the Services | | | | | | | | | | | | **5%** | | |
| 1. **Risk Management**   Identify key risks that may impact service delivery and explain how these risks will be mitigated and/or managed. Include a risk matrix that includes information on clinical redundancy, business continuity plans, cultural and diversity training | | | | | | | | | | | | **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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