| **Request Number** | | | | | | 2024-86 | **Request title** | Optimising primary care coordination for people living in Residential Aged Care Homes (National Partnership Agreement) | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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. | | | | | | | |
| Click or tap here to enter text. | | | | | | | |
| 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 | | 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 |
| 1.2 | | 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 $20MM) | | | | | | | | | | | | | | |
| 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 $10MM) | | | | | | | | | | | | | | |
| 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 $10MM) – (*if providing clinical services*) | | | | | | | | | | | | | | |
| 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 |
|  | | | | | | | | | | | | | | |
| 2.11 | Australian Aged Care Quality and Safety Commission  Is the respondent an approved ACQSC provider? If yes, please provide proof of this. | | | | | | | | | | | | | Yes  No |
| **3.0** | | **Qualitative** | | | | | | | | | | | | |
| 3.1 | | **CAPACITY TO DELIVER (10%)**  Describe your organisations previous experience and expertise in successfully providing the services to those detailed in the draft Activity Schedule. | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| 3.2 | | **PROJECT DESIGN AND METHODOLOGY (50%)**  Detail the methodology that will be used to achieve the Service Outcomes detailed in the draft Activity Schedule including:   * + Detailed narrative provided of commitment to palliative and end of life care/examples of partnerships within the sector   + Provide a commitment to implement the Palliative Aged Care Outcomes Program (PACOP)   + Policy and procedures to support the uptake of advanced care planning (ACP) and delivery of palliative of generalist palliative care   + Orientation/CPD framework that includes an introduction to ACP and end of life care   + Evidence of utilisation of specialist palliative care services such as Metropolitan Palliative Care Consultancy Service (MPaCCs)   + Evidence of hospital avoidance strategies   + After hours capability to manage the needs of the dying person   + Evidence of ability to complete reporting requirements as per timelines   + Clinical Protocols   + Ability to recruit a dedicated Case Coordinator role(s) | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| 3.3 | | **GOVERNANCE, QUALITY AND MANAGEMENT (30%)**   * Evidence and examples of internal systems to provide quality improvement initiatives * Change management/sustainability strategy * Evidence of current data collection capability * Established clinical governance structure * Policies and procedures to support clinical incident management * Commitment to support education program related to NPA project by demonstrating examples of in house and external education programs * Evidence of a Risk Management strategy to meet contractual requirements during planned/unplanned leave or in the event that a Case Coordinator resigns * Capacity to support data collection/report submissions | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| 3.4 | | **PARTNERSHIPS (10%)**  Provide an overview with details of specific relevant partnerships and arrangements in place including:   * Details provided of relationships with visiting GPs * Letters of support from GPs in relation to the pilot * After-hours arrangements and GP leave cover strategy * Policies and Procedures regarding clinical escalation * Framework for conducting family meetings * Willing to implement My Health Record | | | | | | | | | | | | |
| 4.0 | | **Budget** | | | | | | | | | | | | |
| In making a value for money assessment of the Respondent’s submission please complete and submit the budget template provided with the Request documents at Part D 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. | | | | | | | | | | | | | | |
| **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. | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |