

Request for Proposal (RFP) Guidelines

Nurse-Led Teams Provider - Healthy Hearts Healthy Minds Program

Due: 5.00pm AEST, Thursday, 29 May 2025

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1. Introduction

COORDINARE - South Eastern NSW Primary Health Network (SENSW PHN) is seeking proposals from suitable providers to deliver the nurse-led multi-disciplinary clinic as part of the Healthy Hearts Healthy Minds Program (The Program).

Healthy Hearts Healthy Minds is a free program delivered in selected GP practices. It aims to optimise care and improve health outcomes for patients at risk of CVD through Nurse-led multi-disciplinary team (MDT) care in primary health. It is funded through the Commonwealth's Commissioning of Multi-disciplinary teams program and will operate over two years from 2025-26 to 2026-27.

The Program will be delivered by a nurse-led multi-disciplinary team (MDT) of Registered Nurses (RNs), General Practitioners (GPs), GP practice staff, and brokered Allied Health professionals including Dietitians and Exercise Physiologists. Nine GP practices in South-Eastern NSW have been selected for the initial rollout of this program. Up to 11 more practices may be selected in a further round dependent on demand for The Program.

The Provider funded through this RFP will be required to employ and manage the RNs who will lead The Program at a local level. The RNs will provide The Program in each of the participating practices during the business hours of the practices. They will split their time between the practices, based on the case load of each practice and in consultation with the PHN.

2. Who can apply?

Australian companies who can meet the criteria set out in this RFP. Successful provider will be required to recruit and manage the RNs who will run the program.

3. Funding Amount

A total of \$1,424,588 (excl. GST) is available for this initiative from **1 July 2025** until **30 June 2027**.

The funding for this program is broken down into the following components:

Item	FY25/26	FY26/27
Establishment Funds	\$110,000	-
Allied Health Brokerage funds	\$70,000	\$70,000
Operational Funds	\$578,500	\$596,088

Establishment funds may be used for costs such as:

- recruitment and training of RNs
- establishing data collection for reporting
- developing local and online referral resources

Allied Health Brokerage funds may be used for costs such as:

- Costs associated with purchasing fee for service work of Allied Health Professionals (primarily Dietitians and Exercise Physiologists) for people with high CVD risk.

Operation funds may be used for costs such as:

- Salaries, wages, oncosts
- Program costs
- Vehicle lease and operating costs
- Supporting ongoing co-design and program improvements including community of practice

The following activities are **ineligible** for funding under this project:

- Purchase of motor vehicles
- Depreciation of expenses
- Activities which duplicate those funded under other government initiatives
- Activities already undertaken or expenses already incurred
- Items not directly related to patient or program outcomes
- Clinical trials
- Board fees.

The above list is indicative and is not intended to be exhaustive.

4. Background

COORDINARE – South Eastern NSW PHN is one of 31 Primary Health Networks (PHNs) established throughout Australia with the key objectives of improving the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

COORDINARE works directly with primary health care providers and hospitals to bring about improved outcomes for patients. COORDINARE's focus is on local health needs as well as national health priorities and funded programs, particularly in the areas of chronic disease (and potentially preventable hospitalisations), Allied Health, Mental Health, Alcohol and other Drugs, Aboriginal health, After-hours services and healthy ageing.

Commissioning is central to COORDINARE's ability to achieve these objectives and address local and national priorities. As a commissioning organisation, COORDINARE is involved in a continual cycle of developing and implementing health services and related initiatives based on planning, procurement, review and evaluation cycle involving providers, communities and consumers. More information about COORDINARE – SENSU PHN can be found on our website and [COORDINARE's Strategic Directions](#).

Local Snapshot

Cardiovascular disease (CVD) accounts for a high rate of hospitalisation and mortality across the COORDINARE catchment. In 21/22 there were 129.1 CVD related deaths per 100,000 population across the COORDINARE region¹. Death rates per 100,000 population were slightly higher in Southern LHD compared to Illawarra Shoalhaven². In 22/23, there were 1564.9 hospitalisations³, with both rate per 100,000 and number

¹ Department of Health. (2022). *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*. Commonwealth of Australia. www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en

² Ghosh, A. (2024). *Population Health Profile: South Eastern NSW*. Wollongong: COORDINARE - South Eastern NSW PHN. www.coordinare.org.au/assets/Population-Health-Profile.pdf

³ Stephen, C., Halcomb, E., Batterham, M., McInnes, S., & Zwar, N. A. (2023). Impact of a general practice nurse intervention to improve blood pressure control: The ImPress study. *Aust J Gen Pract*, 52(12), 875-881. <https://doi.org/10.31128/AJGP-09-22-6573>

higher in the Illawarra Shoalhaven LHD, compared to Southern NSW⁵. Rates for both deaths and hospitalisations were higher for males than females.

The Local Government Areas (LGAs) in the region with the highest rate of CVD related hospitalisation per 100,000 population are Shellharbour, followed by Wollongong, Shoalhaven, Upper Lachlan, Kiama, and Goulburn Mulwaree⁴. However, actual numbers of hospitalisations (likely due to higher population) are highest in Wollongong LGA, followed by Shoalhaven, Shellharbour, and Eurobodalla⁵. The CVD related death rate per 100,000 in 2021-22 was highest in Eurobodalla, Snowy Monaro, followed by Upper Lachlan, Goulburn Mulwaree, Shoalhaven, and Yass⁶.

The Role of Registered Nurses in CVD Management in Primary Care Settings

RNs can play a significant role in delivering best-practice care resulting in high performing general practices,⁷ and their expanded use was supported in *Australia's Primary Health Care 10 Year Plan*.² However, Needs Assessment data has highlighted regional inequity in the practice nurse workforce distribution in SENS⁸.

While hiring a RN may not be feasible for a small general practice due to budget and governance constraints, The Program will provide RN positions into primary care environments to enable the benefits of nurse-led MDT care to be experienced by patients. RNs are skilled in leading MDT care arrangements, thus contributing to a more optimal approach to patient care.

Overall, by leveraging the expertise of RNs, GPs can optimise their workflow, maximise their scope of practice, and deliver high-quality, patient-centred care. For Allied Health Practitioners who are external to the GP care team the RN led MDT approach means a single point of contact and more integrated approach to patient care. For patients this means that the care that they receive can be more timely, thorough, holistic and integrated.

There is existing research evidence that RNs, as part of an MDT approach, can positively impact the management of CVD in a general practice setting, both internationally and in the Australian context⁹. Studies that did not involve a dedicated RN with protected time for CVD assessment and risk management in a general practice setting were less successful.

RN-led programs are based in the principles of patient centred care, aiming to enhance patient understanding of their health and supporting them to develop the skills to manage and make active and informed decisions about their health.

⁴ Webster, R. J., Heeley, E. L., Peiris, D. P., Bayram, C., Cass, A., & Patel, A. A. (2009). Gaps in cardiovascular disease risk management in Australian general practice. *Med J Aust*, 191(6), 324-329. <https://doi.org/10.5694/j.1326-5377.2009.tb02816.x>

⁵ Banks, E., Korda, R. J., & Stavreski, B. (2017). Absolute risk of cardiovascular disease events and blood pressure- and lipid-lowering therapy in Australia. *Med J Aust*, 206(1), 51. <https://doi.org/10.5694/mja.16.00789>

⁶ Commonwealth of Australia as represented by the Department of Health and Aged Care. Australian Guideline for assessing and managing cardiovascular disease risk. 2023. [Guideline-for-assessing-and-managing-CVD-risk 20230522.pdf](https://www.health.gov.au/guidelines/guideline-for-assessing-and-managing-cvd-risk-20230522.pdf)

⁷ Bodenheimer T, Ghorob A, Willard-Grace R, & Grumbach K. (2014). The 10 building blocks of high-performing primary care. *Ann Fam Med*, 12, 166-171. <https://doi.org/10.1370/afm.1616>

⁸ Ghosh, A. (2024). *Population Health Profile: South Eastern NSW*. Wollongong: COORDINARE - South Eastern NSW PHN. www.coordinare.org.au/assets/Population-Health-Profile.pdf

⁹ Stephen, C., Halcomb, E., Fernandez, R., McInnes, S., Batterham, M., & Zwar, N. (2022). Nurse-led interventions to manage hypertension in general practice: A systematic review and meta-analysis. *J Adv Nurs*, 78(5), 1281-1293. <https://doi.org/10.1111/jan.15159>

5. Scope and Specifications

Location

All funded activities must occur within the South Eastern NSW catchment at GP practices prescribed by COORDINARE.

The postcodes of the first nine (9) locations of GP practices are anticipated to be 2500, 2518, 2519, 2540, 2580, and 2622.

While there are currently nine (9) commissioned practices as part of this program, depending on program uptake and demand this may increase to up to 20 practices across the region in early 2026. The selected provider would be required to be able to scale up The Program if required.

Patient Eligibility and Referral Pathways

Eligible patients will be identified by GPs, other practice staff and RNs. Eligible patients will be identified based on age and ethnicity as well as clinical indicators of risk for CVD. These are outlined below:

- Non-Aboriginal and/or Torres Strait Islander patients with diabetes aged 35-44 years
- Non-Aboriginal and/or Torres Strait Islander patients aged 45-79
- Aboriginal and/or Torres Strait Islander patients Aged 30-79 years
- Aboriginal and/or Torres Strait Islander patients aged 18-29 with **ANY** of these risk indicators
- hypertension or
- hyperlipidaemia or
- diabetes or
- family history of hyperlipidaemia or
- family history of premature CVD or
- CVD medications in the past 6 months or
- moderate to severe chronic kidney disease or
- history of early onset <34 weeks hypertensive disorders of pregnancy or
- history of pre-eclampsia or
- history of gestational diabetes or
- severe mental illness (requiring specialist treatment in the past 5 years)

Figure 1 below shows the referral pathway into the program.

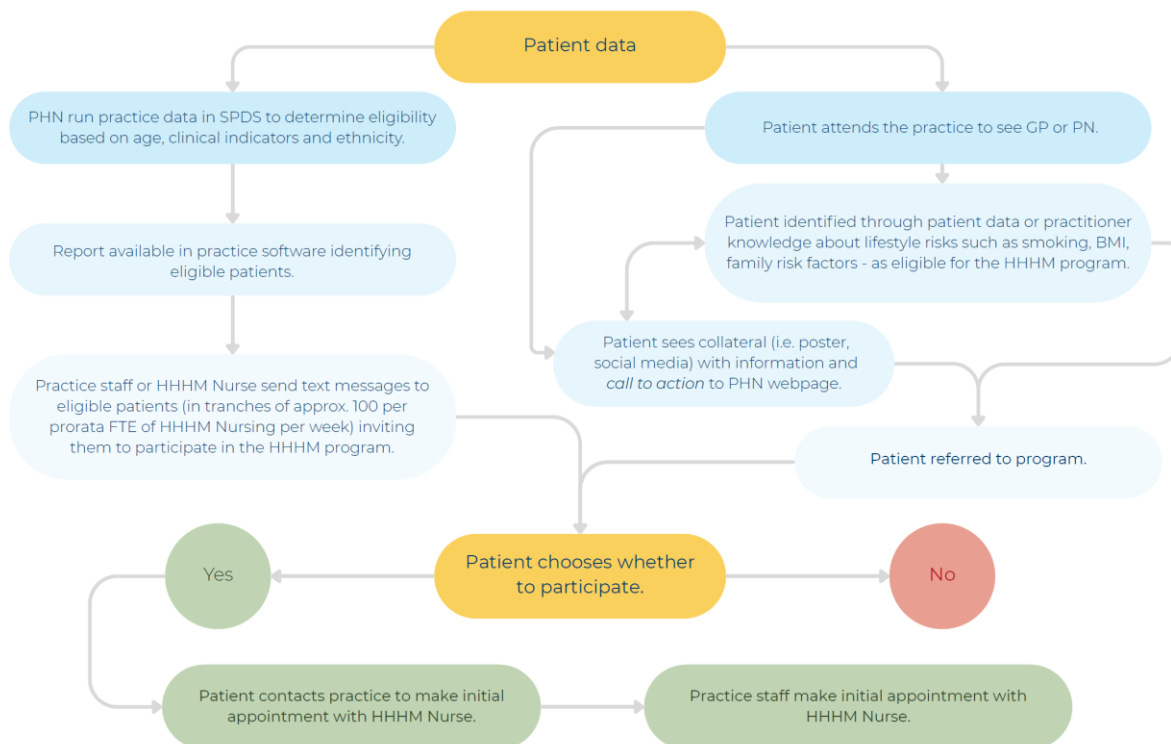


Figure 1: Healthy Hearts Healthy Minds Referral Pathway

Workforce Requirements

Healthy Hearts Healthy minds will be led by a RN supported by GP practice staff. This funding opportunity is for a provider to provide The Program RN's.

The Program RN requirements:

- Be certified in APNA's CVD Risk Learning Module and/or hold an AQF recognised post graduate qualification in cardiac nursing.
- Lead The Program MDT and be the central point of contact for the care team working with the patient.
- Implement and manage the care pathway including all the specified inputs.
- Identify and report program barriers and potential improvements.
- Identify quality improvement activities in line with Practice Incentive Program Quality Improvement (PIP QI) incentive requirements for CVD.
- Participate in Community of Practice activities.
- Work with practice staff to ensure invitations and reminders are sent to patients.
- Collect and record data in the Practice EMR and their employers EMR for the purpose of data collection.

The Program inputs by the RNs will include:

- CVD Risk Assessment
- CVD Health Plan
- Observations
- Patient Education

- Health Coaching and Motivational Interviewing
- Prescribing Health Interventions
- Opportunistic Interventions
- Referrals and Monitoring
- Care coordination and case conferencing.

Care Pathways

The Program will be delivered to each patient over a 12-month period, with a minimum of three visits per patient based on the assessed CVD risk per the Australian cardiovascular disease risk calculator.

RNs will use the prescribed program tools and templates to deliver The Program to ensure consistency and integrity of model delivery. The Heart Foundations [Heart Health Toolkit](#) will support the risk assessment and management of patients.

The initial assessment will include engagement, consent, history and the completion of a Heart Health Check Risk Assessment and a My Healthy Heart Management Plan with the patient using health coaching interventions including Motivational Interviewing, ensuring referrals to community based care including dietitians and exercise physiologists funded through this program are made where appropriate and that other options including prescribing, GP Management Plans, Team Care Arrangements, Mental Health Treatment Plans, Home Medicine Reviews etc are considered and followed up.

The Program Nurse will also make referrals to other community resources such as heart health walking groups and liaise with those providers in providing coordinated care to the patient. This plan will be reviewed and updated as needed with the patient at each scheduled program appointment.

In addition to the initial assessment The Program will offer patients with high CVD risk four appointments every three months. Patients with an intermediate risk will be offered three appointments at three, six and twelve months. Low-risk participants will be offered two appointments, one at six months and one at 12 months. In between these scheduled appointments, patients will have access to The Program RN to support self-management, optimise opportunistic health interventions and referral to allied and community health supports as needed.

At each RN appointment patient PROMS and PREMS will be collected in a format approved by the PHN.

Figure 2 shows the care pathway for The Program.



Healthy Hearts Healthy Minds: Care Pathway

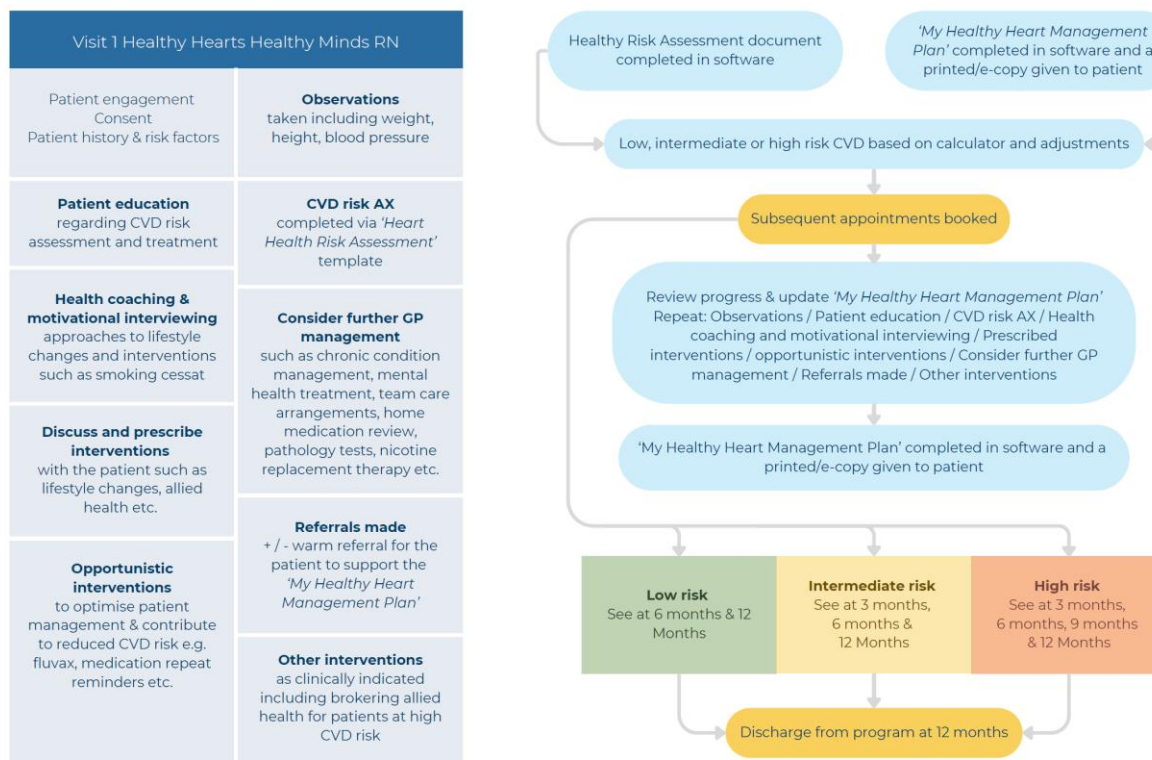


Figure 2: Healthy Hearts Healthy Mind Care Pathway

Out of Scope

- Funded RNs are not to undertake any work that is outside the scope of The Program noting that the care pathway includes optimized patient care and therefore may include other nursing interventions within the RN's scope of practice that assist the patient to stay well and engaged in managing their e.g. providing access to vaccinations per practice protocols or support accessing the care external team etc.
- Funded RNs and any allied health practitioners brokered by the program are not to claim any other fee for service including but not limited to MBS, DVA, NDIA, and MAC for treatment and care undertaken as part of The Program.
- Funded RNs are not to provide care to any patients other than those who are enrolled in, or who are eligible to enroll in The Program.

Performance Indicators - Outputs and Outcomes

Providers will be required to measure a suite of appropriate performance indicators that enable the tracking of The Program activity and outcomes. The funded provider and RNs will need to work with the GP practices to ensure that program data is being captured within practice software and through a system managed by the nurse provider for data which cannot be captured at a practice level. Reporting may be required from the provider on a monthly, quarterly, and 6 monthly basis.

An example of the outputs and outcomes which will be measured as part of The Program are as follows.

Access	<ul style="list-style-type: none"> • Outputs - No. of clients serviced • No. of service contacts /occasions of service delivered • Rate of regional population receiving services
Appropriateness	<ul style="list-style-type: none"> • Completion rates for experience measures (EQ-D5-DL) in completed episodes (PROMS) • Net Promoter Score (PREMS)
Efficiency	<ul style="list-style-type: none"> • Cost per client Cost per episode of care • Cost per service contact / occasion of service • Cost per outcome improvement • Wait time to access appropriate service
Effectiveness	<ul style="list-style-type: none"> • Proportion of clients who received services identified as Aboriginal and/or Torres Strait Islander persons • Proportion of clients who received services identified as being within the primary target population for The Program • Proportion of clients who received services identified as Culturally and/or Linguistically Diverse persons • Proportion of clients who received services identified as socio-economically vulnerable • Support Plan is to be developed within 10 business days (2 weeks) of consent to participate in the service

6. Eligibility

Organisations eligible to receive funding under this initiative must be able to meet the requirement to employ RNs.

State government services, such as Local Health Districts, NSW Ambulance etc. are not eligible for direct funding as part of this initiative.

7. Timeline

An indicative timeline is outlined below. COORDINARE reserves the right to modify these timeframes. Registered providers will be notified of key changes via [TenderLink](#).

Activity	Date
RFP opportunity released	29 April 2025
Industry Briefing *Please sign up to attend by submitting your request through the link Industry Briefing Registration .	1.00pm, 6 May 2025
Deadline for questions from potential respondents via TenderLink	22 May 2025
Deadline for completion of Q&A by COORDINARE	26 May 2025
Closing date and time for applications (late applications will not be accepted)	5.00pm, 29 May 2025
Assessment commences	30 May 2025
Assessment Panel convened	2 June 2025
Contracts Negotiations	9 June 2025

Contracts executed	23 June 2025
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8. Developing and submitting your submission

Responses to this RFP should be submitted via <https://www.tenderlink.com/COORDINARE/>. You will need to register on the site before you can access the proposal portal. Registration is free. You will receive a time and date stamped confirmation after successful proposal.

Respondents should outline a proposed approach aligned to the scope and specifications and address all of the assessment criteria outlined in this document.

Please ensure you read each assessment criterion carefully and answer each component and section of the proposal form by considering all information provided.

Documents can be attached which are directly relevant to your response. Please avoid attaching large documents as only the first five (5) pages will be read by the Evaluation Panel. If the documents are large, please specify the relevant page number(s)/section(s) to your response.

If you do not wish to upload a file in a mandatory section, please upload a blank letterhead document with 'NA' typed to indicate you do not wish to provide a response (or it is not relevant to you). This will ensure that you can continue moving through the application. There is an upload limit of 2GB per attachment.

File formats accepted: word, excel, pdf and jpg files are all acceptable formats.

Please see the Tender Link guide provided for more information (**Appendix 2**).

Proposals from groups planning to work with a specific focus on identified priority populations, including, but not limited to, Aboriginal and Torres Strait Islander peoples, and people from culturally and linguistically diverse communities are encouraged to apply.

9. Respondent Questions

All questions about the RFP process or content can be submitted anonymously via the online forum following registration on TenderLink at <https://www.tenderlink.com/COORDINARE/>.

Please note that any questions, answers and points of clarification will be shared with all other providers participating in the RFP. Any identifying information about the organisation submitting the question will be removed.

10. Assessment Criteria

Please note, responses will be considered in the context of the size and resources of the organisation or applicant. Please indicate 'N/A' if any of the responses required are not relevant to your organisation or service.

Required Response	Weightings
1. Service Delivery -Word Limit 1000	
<p>Outline your proposed service delivery model for the Healthy Hearts Healthy Minds Program including:</p> <ul style="list-style-type: none"> • relevant experience and performance in establishing and operating primary care programs. • Your vision for how the Nurse-Led services will operate in The Program. • Proposed workforce profile to deliver the service model that will be iterative and scalable should new locations be included. • Features of the service that will enhance access for priority populations specifically for Aboriginal and Torres Strait Islanders, CALD and LGBTIQ+ people and men. 	35%
2. Clinical Care - Word Limit 800	
<p>Describe how your proposed service model will ensure appropriate clinical care, including:</p> <ul style="list-style-type: none"> • How you will recruit and retain Program RNs that have the requisite experience and skills to deliver the Nurse-Led MDT model of care for CVD risk assessment and prevention. • The training that you will provide The Program RNs prior to placing them into the commissioned practices and ongoingly. • Proposed approach to managing the workforce, including professional development, recruitment, clinical supervision and credentialing. • Quality improvement mechanisms that respond to consumer outcomes and experience measures. 	25%
3. Governance and Leadership - Word Limit 800	
<p>Outline the proposed governance (including clinical governance) and leadership structure, including:</p> <ul style="list-style-type: none"> • An overview of your organisation's existing operational and clinical governance functions and how they will relate to The Program. • Your experience in managing complex MDT arrangements including influencing relationships and addressing and managing conflict within the MDT. • Your experience in managing the implementation and reporting of data in your clinical software and how you will ensure that all reporting requirements are met. 	20%
4. Engagement and Participation - Word Limit 500	
<p>Outline how will you contribute to the ongoing development of the program in partnership with the PHN and the participating General Practices including:</p> <ul style="list-style-type: none"> • Experience and capacity to contribute to program co-design • Experience and capacity to participate in Communities of Practice • Experience in ongoing performance monitoring and risk identification. 	10%

5. Funding Expenditure -Word Limit 200	
Provide indicative establishment and operational budgets for FY 2025-27 that support the model you have described and reflects value for money (Refer: Attachment 1-Budget Template)	10%
Total Scored Criteria	100%

Compliance Documents

1. Provide copies of your current accreditation certificate(s) from your professional body (if applicable).	Compliance
2. Provide copies of required insurances <ul style="list-style-type: none"> Public liability insurance \$20 million per claim and in the aggregate of all claims. Professional indemnity insurance \$10 million per claim and in the aggregate of all claims. Workers Compensation Insurance Policy (not applicable for 'exempt employer' or individuals/sole traders). Cyber Security Insurance- not less than \$1 million in the aggregate of all claims - not mandatory 	Compliance
3. Provide the past 2 years audited financial statements or profit and loss statements.	Compliance
4. Include at a minimum two (2) professional referees Organisations that have previously received funding from COORDINARE are not required to provide a referee.	Compliance
5. Aboriginal and Torres Strait Islander Impact Statement, Aboriginal and Torres Strait Islander Health Strategy or a Reconciliation Action Plan (Optional).	Compliance

COORDINARE reserves the right to work with shortlisted bidders, to clarify information provided and in some cases request revised proposals, prior to a contract being awarded.

Please refer to section 11. *Evaluation of submissions* for more information on COORDINARE's approach to evaluating proposals.

11. Contracting arrangements

Successful respondents will be required to enter into a service agreement with COORDINARE. The final agreement and schedule, however, will be subject to negotiation with a shortlisted respondent. The funding recipient will be required to provide progress reports on agreed milestones. The format and framework for progress reports may take account of the size, costs, complexity and relative risks of the project being undertaken.

12. Evaluation of submissions

Successful respondents will be selected through a competitive process. An evaluation panel will consider each submission against the mandatory requirements as well as the selection criteria outlined in section 10.

If additional information to that requested in this document is required by COORDINARE when proposals are being considered, written information and/or interviews may be requested to obtain such information at no cost to COORDINARE.

Issues or complaints

The Respondent may, in good faith, raise any issue or complaint about the RFP or RFP process, at any time. Please contact the Business Team via commissioning@coordinate.org.au.

13. Definition of Key Terms

Term	Meaning
COORDINARE	The South Eastern New South Wales Primary Health Network and the organisation responsible for the RFP and the RFP process
Closing time	The time specified by which RFP responses must be received
Response(s) to RFP	A document/s lodged by a Respondent in response to this RFP containing a response to provide Goods or Services sought through this RFP process
Respondent	An entity that submits a response to this RFP
RFP Process	The process commenced by the issuing of this RFP and concluding upon formal announcement by SENSW PHN of the selection of a preferred respondent(s) or upon the earlier termination of the RFP process
Request for Proposal (RFP)	This document and any other documents designated by SENSW PHN

14. RFP General Terms and Conditions

ABN/Taxation requirements	COORDINARE will only deal with Respondents who have an Australian Business Number (ABN).
Acceptance	Non complying submissions may be rejected. COORDINARE may not accept the lowest priced proposal and may not accept any proposal.
Additional information	If additional information to that requested in this document is required by COORDINARE when proposals are being considered, written information and/or interviews may be requested to obtain such information at no cost to COORDINARE. COORDINARE may also provide additional information or clarification.
Assessment	COORDINARE reserves the right to engage a third party to carry out assessments of a Respondent's financial, technical, planning and other resource capability.
Conflicts of interest	Respondents must declare to COORDINARE any matter or issue which is or may be perceived to be or may lead to a conflict of interest regarding their submission or participation in the RFP process, or in the event their proposal is successful.

Expenses	All expenses and costs incurred by a Respondent in connection with this RFP including (without limitation) preparing and lodging a submission, providing COORDINARE with further information, attending interviews and participating in any subsequent negotiations, are the sole responsibility of the Respondent.
Explanations	Verbal explanations or instructions given prior to acceptance of a proposal shall not bind COORDINARE.
General	Respondents should familiarise themselves with this document and the separate online Submission Form and ensure that their proposals comply with the requirements set out in these documents. Respondents are deemed to have examined statutory requirements and satisfied themselves that they are not participating in any anti-competitive, collusive, deceptive or misleading practices in structuring and submitting the proposal.
Legal entity	COORDINARE will only enter into a contract with an organisation or individual with established legal status (e.g. under Corporations Law, Health Services Act, Trustee Act), or a natural person at least 18 years of age with mental capacity to understand the agreement.
Lobbying	Any attempt by any Respondent to exert influence on the outcome of the assessment process by lobbying COORDINARE staff, directly or indirectly, will be grounds for disqualification of the proposal from further consideration.
Ownership	All submissions become the property of COORDINARE once lodged. COORDINARE may copy, or otherwise deal with all or any part of a submission for the purpose of conducting evaluation of submissions.
Negotiation	COORDINARE reserves the right to negotiate with short-listed Respondents after the RFP closing time and allow any Respondent to alter its submission. Contract negotiations are strictly confidential and not to be disclosed to third parties.
No contract	Nothing in this RFP should be construed to give rise to any contractual obligations or rights, express or implied, by the issue of this RFP or the lodgement of a submission in response to it. No contract will be created unless and until a formal written contract is executed between COORDINARE and a Respondent. Respondents will not be considered approved until a final service agreement is in place.
Notification of Probity Breach	Should any supplier feel that it has been unfairly excluded from responding or unfairly disadvantaged by the process, the supplier is invited to write to the Business Team at commissioning@coordinare.org.au .
Part applications	COORDINARE reserves the right to accept applications in relation to some and not all of the scope of activity described, or contract with one, more than one or no Respondent on the basis of the proposals received.
Process	COORDINARE reserves the right to withdraw from, or alter, the RFP process described in this document for whatever reason, prior to the signing of any agreement/contract with any party.