TERMS OF REFERENCE

Healthcare Performance, Financial Sustainability and Operational Transformation

Dharumavantha Hospital

Indira Gandhi Memorial Hospital (IGMH)

Hulhumalé Hospital

Villimalé Hospital

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Document Control

Field	Details
Document title	Terms of Reference: Healthcare Performance, Financial Sustainability and Operational Transformation.
Version	1.0 - Draft
Owner	IGMH / DH Governing Board / designated Programme Sponsor
Applicable facilities	Dharumavantha Hospital, IGMH, Hulhumalé Hospital and Villimalé Hospital
Proposed duration	6 months: Phase 1 (2 months) and Phase 2 (4 months)
Classification	Confidential - procurement and programme use

Purpose of this TOR

This Terms of Reference defines the requirements for appointing a qualified consulting firm to diagnose, design, implement and transfer a group-wide performance, financial sustainability and operational improvement framework for IGMH and DH. It expands the attached statement of work into a procurement-ready TOR with defined scope, deliverables, acceptance criteria, governance, staffing, reporting and proposal requirements.

1. Background and Context

As a government healthcare entity, IGMH is mandated to provide high-quality, accessible and equitable healthcare while ensuring efficient use of public resources and long-term financial and operational sustainability.

IGMH and DH intends to establish an integrated management framework that improves cost visibility, service efficiency, revenue sustainability, quality of care, patient experience, governance and the consistent adoption of healthcare standards across its hospitals. The engagement will be delivered over six months in two phases, with workstreams proceeding in parallel where practical.

2. Assignment Objectives

The primary objective is to enable IGMH and DH to make evidence-based decisions and institutionalize practical systems that remain operational after the consultant exits. Specific objectives are to:

- establish a verified current-state fact base across finance, operations, clinical quality, patient experience, governance, data and technology;
- develop and implement a standardized costing and cost-reporting framework at Group and hospital levels;
- establish a Group-wide KPI architecture, master KPI dictionary, dashboards and management review cadence;
- improve capacity utilization, workforce productivity, asset utilization, patient flow and service efficiency;
- identify and implement revenue and cost-recovery opportunities consistent with the public-health mandate;
- integrate clinical quality, patient safety and patient-experience indicators into management review;
- standardize priority processes through approved SOPs, process maps, governance and accountability arrangements;
- strengthen data quality, reporting and technology enablement; and
- build internal capability through change management, training, handover and sustainability mechanisms.

3. Guiding Principles

- Patient safety and continuity of care first
- Public access, equity and affordability
- Evidence-based and data-traceable recommendations
- One Group framework with hospital-level accountability
- Co-design with IGMH and DH owners rather than consultant-only solutions
- Practical implementation during the engagement
- Compliance with applicable Maldivian laws, government financial rules, procurement requirements and IGMH and DH policies
- Confidentiality, cybersecurity and minimum-necessary use of personal data
- Knowledge transfer and sustainable internal ownership

4. Scope of Services

4.1 Phase 1 - Diagnostic and Design (Months 1-2)

The consultant shall establish the baseline, validate priority issues and produce approved implementation-ready frameworks and plans.

4.1.1 Mobilization and Inception

- Conduct kick-off meetings with the Governing Board, hospital leadership and workstream owners.
- Confirm detailed scope, stakeholders, data requirements, sampling approach, site-visit plan and decision calendar.
- Prepare a data request list, interview schedule, risk register, communication plan, quality plan and detailed work breakdown structure.
- Agree baseline periods, definitions, materiality thresholds and data-validation protocols.
- Submit an inception report within 10 working days of commencement.

4.1.2 Sustainable Cost and Financial Management

- Review chart of accounts, cost centres, budgeting, general ledger interfaces, payroll, procurement, inventory, fixed assets and finance reporting across all four hospitals.
- Assess existing costing methods, allocation bases, overhead treatment, cost visibility and reconciliation controls.
- Map direct, indirect, fixed, variable, clinical and non-clinical costs by hospital, department, service line, procedure and bed-day, subject to data availability.
- Assess cost structures and identify opportunities in medicines, consumables, workforce deployment, utilities, maintenance, outsourced services, procurement, inventory and asset utilization.
- Design a standardized costing manual, cost-centre hierarchy, allocation rules, templates, reconciliation process and variance-reporting mechanism.
- Define unit-cost outputs including cost per bed-day, outpatient attendance, emergency attendance, procedure, test, theatre hour, service line and hospital.
- Develop a benefits register distinguishing cashable savings, cost avoidance, productivity improvement and quality-related benefits.

4.1.3 Performance Monitoring and Service Efficiency

- Review existing KPIs, dashboards, reporting cycles and management-review forums.
- Assess demand, throughput, capacity, occupancy, length of stay, theatre utilization, diagnostics turnaround, outpatient waiting, emergency flow, referral patterns, cancellations, workforce productivity and major-asset utilization.
- Develop a Group-wide KPI framework and master KPI dictionary with definition, rationale, formula, data source, frequency, owner, target, threshold, direction of improvement and escalation rule.
- Design Board, Group, hospital, department and service-line dashboards.
- Develop a patient classification and case-complexity approach suitable for the available clinical and administrative data.
- Identify bottlenecks and produce prioritized service-improvement charters with baselines, owners and expected benefits.

4.1.4 Revenue Sustainability Within the Public-Health Mandate

- Map all revenue streams, tariffs, exemptions, billing processes, receivables, claims, collections and reconciliation controls.
- Analyse service volumes, tariff adequacy, revenue trends, leakage, unbilled activity, coding gaps, rejected claims, waivers and collection delays.
- Assess cost recovery without compromising public access, equity or statutory entitlements.

- Identify quick wins and medium- and long-term initiatives, including improved billing completeness, contract management, eligible service charging, documentation, coding, utilization and collection controls.
- Prepare a prioritized revenue roadmap with financial ranges, dependencies, policy implications, risks and safeguards.

4.1.5 Quality of Care and Patient Experience

- Review existing clinical quality, patient safety, infection prevention, medication safety, incident reporting, complaints and patient-experience measures.
- Map selected patient journeys and assess waiting time, handovers, discharge, referral, communication and complaint resolution where data is available.
- Define quality and experience KPIs for inclusion in the integrated performance framework.
- Identify priority improvement initiatives with clinical ownership, balancing measures and escalation criteria.

4.1.6 Healthcare Standards, SOPs and Governance

- Review priority clinical and non-clinical processes against applicable protocols, IGMH and DH policies and recognized healthcare practices.
- Identify variation across hospitals and determine processes requiring Group-wide standardization versus local adaptation.
- Develop priority SOPs, process maps, RACI matrices, approval authorities and governance forums.
- Define a future-state operating model covering Group, hospital and department accountabilities, decision rights and escalation pathways.

4.1.7 Technology and Data Enablement - Optional

- Assess HIS/HMIS, EMR, billing, inventory, finance and reporting systems, interfaces, master data, data quality, access controls and reporting capability.
- Conduct a data-readiness assessment for costing, KPIs, dashboards and patient classification.
- Define functional, reporting, integration, security and data-governance requirements.
- Prepare a phased technology roadmap that separates immediate configuration/reporting actions from medium-term integration or system investments.

4.2 Phase 2 - Implementation and Enablement (Months 3-6)

The consultant shall operationalize approved frameworks, demonstrate functioning outputs, resolve implementation issues and transfer ownership to IGMH and DH.

4.2.1 Costing and Financial Management Implementation

- Configure and populate agreed costing templates using an approved baseline period.
- Pilot costing in representative services and then roll out the agreed scope across hospitals.
- Reconcile costing outputs to source financial data and document exceptions.
- Establish monthly cost and variance reviews with named owners and action tracking.
- Support implementation of selected cost-optimization initiatives and validate realized or forecast benefits.

4.2.2 KPI, Dashboard and Efficiency Implementation

- Roll out the KPI framework and agreed dashboards using available tools.
- Establish data submission, validation, sign-off and correction workflows.
- Facilitate regular performance reviews and maintain an action, decision and escalation log.
- Support implementation of selected patient-flow, capacity, workforce or asset-utilization initiatives.
- Test KPI reliability through sample recalculation and source-to-report traceability.

4.2.3 Revenue Initiative Implementation

- Implement agreed quick wins and commence medium-term initiatives.
- Track revenue, activity, leakage closure and collections against the validated baseline.
- Document policy or tariff decisions required from IGMH and DH or government authorities.
- Apply safeguards to ensure initiatives remain aligned with the public-health mandate.

4.2.4 Quality, Patient Experience and Standards Implementation

- Embed approved quality, safety and experience indicators in performance reviews.
- Support implementation of priority service-improvement projects and SOPs.
- Establish patient-feedback and complaint-monitoring mechanisms with assigned action owners.
- Conduct compliance checks and coach process owners on corrective action.

4.2.5 Change, Capability and Handover

- Maintain an integrated implementation roadmap with owners, dependencies, milestones and status.
- Deliver role-based training, coaching and job aids.
- Provide stakeholder engagement and change-impact assessments.
- Establish a network of IGMH and DH workstream owners and super-users.
- Complete handover, archive editable materials and issue a sustainability plan for the first 12 months after completion.

4.3 Out of Scope Unless Approved by Change Control

- Replacement or procurement of enterprise software or hardware
- Detailed engineering, construction or facility-design services
- Clinical diagnosis or direct clinical decision-making
- Legal, tax or statutory audit opinions
- Permanent operational staffing or outsourced management of hospital functions
- Implementation beyond the six-month period
- Work for facilities outside IGMH and DH unless formally added

5. Approach and Methodology

Bidders shall propose a detailed methodology, but at minimum the approach shall include the following:

Stage	Minimum method	Required evidence
Mobilize	Kick-off, stakeholder map, data request, work plan, governance and risk setup	Approved inception report and data tracker
Diagnose	Document review, interviews, workshops, site observation, data profiling, process mapping and baseline analysis	Source-referenced findings and validated baseline
Design	Co-design workshops, options assessment, benchmarking, prototype development and approval gates	Frameworks, definitions, templates and implementation charters
Pilot	Controlled testing in selected services/hospitals, user feedback and refinement	Pilot results, issues log and approved revisions
Roll out	Training, implementation support, review forums and action tracking	Operational dashboards/reports and adoption evidence
Handover	Capability assessment, final documentation, ownership transfer and sustainability plan	Acceptance sign-off and editable repository

5.1 Data Validation Requirements

- Document data sources, extraction dates, filters, exclusions and assumptions.
- Reconcile financial outputs to the general ledger or approved control totals.
- Use sample tests and source-to-report tracing for operational and clinical indicators.
- Maintain a data-issues log showing impact, owner, resolution and residual limitation.
- Clearly separate measured results, management estimates, assumptions and consultant judgement.

5.2 Benchmarking

Any external benchmark must state the source, year, peer definition, currency/unit conversion, methodological limitation and relevance to the Maldivian public-hospital context. Benchmarking shall inform decisions but shall not replace local baseline validation.

6. Deliverables and Acceptance

No.	Deliverable	Due	Minimum content / acceptance evidence
D1	Inception Report and Detailed Work Plan	Day 10	Confirmed scope, methodology, RACI, schedule, data request, stakeholder plan, risk register and quality plan.
D2	Current-State Diagnostic and Gap Assessment	End Month 1	Four-hospital baseline, evidence, root causes, maturity/gap assessment, data limitations and prioritized issues.
D3	Costing Framework and Costing Manual	End Month 2	Cost-centre model, allocation rules, unit-cost methods, templates, controls, reconciliation and reporting design.
D4	KPI Framework, Master KPI Dictionary and Dashboard Designs	End Month 2	Approved KPI hierarchy, complete definitions, targets/threshold approach, data ownership and dashboard prototypes.
D5	Revenue Enhancement and Cost-Recovery Roadmap	End Month 2	Validated baseline, leakage analysis, safeguards, initiatives, benefits ranges, policy needs, owners and timeline.
D6	Future-State Operating Model, Governance and Priority SOP Pack	End Month 2	Decision rights, forums, RACI, escalation design, approved SOPs and process maps.
D7	Technology and Data Roadmap - Optional	End Month 2	Current-state assessment, requirements, architecture/integration considerations, security, priorities and investment roadmap.
D8	Integrated Implementation Roadmap and Benefits Tracker	Start Month 3; updated biweekly	Initiatives, milestones, owners, dependencies, benefits, risks, status and decisions.
D9	Implemented Costing and Reporting Mechanisms	End Month 5	Populated and reconciled outputs, review cadence, user guidance and evidence of use.

No.	Deliverable	Due	Minimum content / acceptance evidence
D10	Implemented Priority Dashboards and Management Review Mechanism	End Month 5	Operational dashboards/reports, data-control process, meeting pack and action/escalation logs.
D11	Training, Change and Knowledge-Transfer Pack	Months 3-6	Training plan, materials, attendance, assessment results, job aids and coaching record.
D12	Final Implementation, Handover and Sustainability Report	End Month 6	Results against baseline, open items, benefits status, lessons, ownership, 12-month plan and editable source files.

6.1 Deliverable Review and Acceptance Procedure

- The consultant shall submit each deliverable in editable Microsoft Office format and PDF, together with supporting models, data dictionaries and calculation files.
- IGMH and DH will normally provide consolidated comments within 7 working days. The consultant shall resubmit within 5 working days unless otherwise agreed.
- Acceptance requires written confirmation by the designated IGMH and DH authority. Silence or use of a draft does not constitute acceptance.
- A deliverable may be accepted with minor conditions, rejected for material non-conformance or returned for correction.
- All calculations, dashboards and templates must be reproducible, unlocked and free of undisclosed dependencies.

6.2 General Acceptance Criteria

- Complete against TOR scope and approved inception plan
- Factually accurate and traceable to evidence
- Reconciled and internally consistent
- Practical for IGMH and DH staffing, systems and governance
- Reviewed with relevant clinical, operational, finance and ICT owners
- Incorporates consolidated comments
- Uses clear definitions and version control
- Submitted with editable source files and handover instructions

7. Programme Governance

Body / Role	Core responsibilities	Indicative cadence
IGMH and DH Governing Board / Steering Committee	Strategic direction, approve major deliverables, resolve escalated issues, approve scope changes	Monthly and at phase gates
Programme Sponsor	Executive accountability, decisions, access and cross-hospital alignment	Weekly as required
Programme Management Office / Coordinator	Plan, RAID log, document control, minutes, action tracking and coordination	Ongoing; weekly status
Workstream Leads	Validate data, co-design outputs, implement actions and own sustainability	Weekly/biweekly
Consultant Engagement Lead	Overall quality, delivery, integration, stakeholder management and escalation	Continuous; weekly reporting
Clinical Governance Review	Validate patient-safety, clinical-quality and service-change implications	At design and implementation gates

7.1 Mandatory Governance Artifacts

- Integrated work plan and milestone tracker
- RAID log: risks, assumptions, issues and dependencies
- Decision log and change-control log
- Deliverable register and version history
- Stakeholder and communication plan
- Benefits register and initiative tracker
- Meeting minutes with owners and due dates

8. Consultant Team and Qualifications

8.1 Firm-Level Requirements

- Legally registered and authorized to provide the required services.
- Demonstrated experience in hospital or health-system transformation, preferably multi-hospital or public-sector engagements.
- At least three relevant assignments completed in the last seven years, including costing/finance and performance improvement components.
- Ability to deploy a multidisciplinary team covering healthcare operations, finance/costing, clinical quality, analytics and change management.
- Documented quality-assurance and information-security practices.
- Disclosure of actual, potential or perceived conflicts of interest.

8.2 Minimum Key Personnel

Role	Minimum profile	Indicative input
Engagement Partner / Director	15+ years; senior leadership of complex healthcare or public-sector transformation; accountable for quality and executive engagement	Part-time throughout; phase gates
Project Manager / Team Lead	10+ years; led multi-workstream hospital projects; strong programme, stakeholder and implementation skills	Full-time / near full-time
Healthcare Finance and Costing Lead	8+ years; hospital costing, budgeting, allocation, unit-costing and financial analysis	High input Months 1-5
Hospital Operations and Performance Lead	8+ years; patient flow, capacity, productivity, KPIs and service improvement	High input throughout

Role	Minimum profile	Indicative input
Clinical Quality and Patient Safety Lead	8+ years; clinical governance, quality, safety, SOPs and patient experience	Targeted throughout
Revenue Cycle / Health Financing Specialist	7+ years; tariffs, billing, claims, leakage and cost recovery in healthcare	Months 1-5
Data and BI Lead	7+ years; healthcare data, KPI dictionaries, dashboards, data quality and analytics	Throughout
Technology / HIS Specialist - Optional	7+ years; HIS/EMR/finance/inventory integration, requirements and roadmap	Phase 1 and targeted Phase 2
Change and Training Lead	7+ years; organizational change, capability building and adoption	Months 2-6
Analysts	Relevant degrees and demonstrated modelling, process mapping and documentation capability	As required

8.3 Team Conditions

- Key personnel shall not be replaced without prior written approval, except for unavoidable circumstances. Replacement personnel must have equal or better qualifications.
- The bidder shall state on-site and remote inputs by role, person-days and phase.
- The Team Lead and relevant specialists shall attend critical workshops and phase-gate presentations in person unless IGMH and DH agree otherwise.
- Subcontractors and consortium members must be clearly identified with responsibility, contractual relationship and experience.

9. IGMH and DH Responsibilities

- Appoint a Programme Sponsor, coordinator and workstream leads.
- Provide reasonable access to approved policies, reports, systems extracts, facilities, staff and stakeholders.
- Facilitate hospital visits, interviews and workshops.
- Provide consolidated feedback and decisions within agreed timelines.
- Ensure clinical and operational owners validate proposed changes before implementation.
- Coordinate approvals involving government authorities or third parties.
- Provide workspace and meeting facilities when on-site, subject to availability.
- Retain responsibility for management decisions, clinical decisions and statutory compliance.

10. Data, Confidentiality, Ethics and Information Security

- All information accessed or produced shall be treated as confidential and used only for the assignment.
- The consultant shall sign confidentiality and data-processing undertakings required by IGMH and DH.
- Patient-level data shall be de-identified or pseudonymized wherever reasonably possible, and access shall follow the minimum-necessary principle.
- No IGMH and DH data may be transferred to unauthorized locations, personal devices, consumer cloud services or subcontractors.
- Security incidents or suspected data loss shall be reported immediately and managed under IGMH and DH requirements.
- The consultant shall not publish, reuse or reference assignment results without prior written permission.
- All conflicts of interest, inducements and relationships with suppliers, insurers or healthcare providers relevant to recommendations shall be disclosed.
- At completion or termination, data shall be returned or securely deleted as directed, with written confirmation.

11. Work Plan, Location and Reporting

11.1 Indicative Timeline

Month	Primary focus	Decision gate
1	Mobilization, data collection, interviews, site review, baseline and diagnostic	Approve inception and emerging findings
2	Complete diagnostic; design costing, KPI, revenue, governance, SOP and optional technology frameworks	Phase 1 approval and implementation priorities
3	Pilot costing, dashboards and selected initiatives; launch training and review cadence	Pilot acceptance
4	Wider rollout, data controls, service and revenue initiatives, SOP adoption	Mid-implementation review
5	Stabilize reporting, validate benefits, close issues and strengthen ownership	Operational readiness review
6	Final optimization, capability assessment, handover and sustainability plan	Final acceptance

11.2 Reporting Requirements

- Weekly written status: progress, next steps, decisions, data needs, risks and overdue actions.
- Biweekly integrated roadmap and initiative tracker during Phase 2.
- Monthly Steering Committee pack with milestone status, benefits, risks, decisions and upcoming priorities.
- Immediate escalation of patient-safety, legal, reputational, major financial or data-security risks.
- All meetings shall have concise minutes, actions, owners and due dates.

11.3 Place of Performance

The assignment will use a blended on-site and remote model. On-site work is expected across the four IGMH and DH hospitals in Malé, Hulhumalé and Villimalé. Bidders shall propose an on-site schedule sufficient for observation, workshops, implementation support and handover, and separately identify travel and related costs.

12. Quality Assurance and Risk Management

- The consulting firm shall conduct independent internal review of all major deliverables before submission.
- Models shall include assumptions, checks, reconciliations, version control and user instructions.
- The consultant shall maintain a live risk register with probability, impact, mitigation, owner and target date.
- Recommendations affecting clinical pathways shall undergo clinical governance review before implementation.
- Where data limitations prevent reliable conclusions, the consultant shall state the limitation, quantify potential impact where possible and propose remediation.
- Benefits shall not be claimed without an agreed baseline, calculation method, evidence and IGMH and DH validation.

12.1 Key Foreseeable Risks and Minimum Mitigation

Risk	Minimum mitigation
Incomplete or inconsistent data	Early profiling, control totals, data-issue log, triangulation and explicit confidence grading
Limited staff availability	Confirmed calendar, focused workshops, delegated owners and phased sign-offs
Cross-hospital variation	Common definitions, local validation and controlled exceptions
Change resistance	Stakeholder mapping, co-design, visible sponsorship, coaching and adoption measures
Overemphasis on financial results	Clinical-quality and access safeguards, balanced scorecard and clinical review
Technology constraints	Tool-agnostic interim reporting and phased roadmap
Unsustained post-project adoption	Named owners, SOPs, training, handover, 12-month sustainability plan and review calendar

13. Commercial and Contractual Requirements

13.1 Contract Type and Price

Bidders shall submit a fixed-price proposal for the mandatory scope and a separate fixed price for the optional technology and data enablement scope. The proposal shall show fees, person-days by role, travel, taxes, reimbursables and all assumptions. No cost will be reimbursed unless expressly permitted by the contract.

13.2 Indicative Payment Milestones

Milestone	Indicative share
Contract signature and mobilization	0% to 10% - subject to procurement rules and acceptable security, if applicable
Acceptance of D1 - Inception Report	10%
Acceptance of Phase 1 deliverables D2-D7	30%
Acceptance of mid-implementation outputs and operational pilots	20%
Acceptance of D9-D11 and operational readiness	20%
Final acceptance of D12 and complete handover	20%

Final percentages, taxes, retention, performance security, liquidated damages and invoicing arrangements shall be confirmed in the solicitation and contract. Payments shall be linked to accepted deliverables rather than elapsed time alone.

13.3 Intellectual Property

Subject to the contract, all assignment-specific deliverables, models, templates, dictionaries, process maps, training materials and reports developed and paid for by IGMH and DH shall become IGMH and DH property. The consultant may retain pre-existing tools and know-how, but shall disclose them and grant IGMH and DH a perpetual, royalty-free license necessary to use, modify and maintain the deliverables.

13.4 Change Control

No change to scope, timeline, team or price is valid without a written change request describing the reason, impact, options and recommendation, followed by approval from the authorized IGMH and DH representative.

13.5 Performance and Termination

- Persistent delay, material quality failure, unauthorized team replacement, confidentiality breach or conflict-of-interest non-disclosure may constitute material non-performance.
- IGMH and DH may require a corrective action plan with defined recovery dates.
- Termination, suspension, dispute resolution, liability, insurance and governing law shall follow the final contract and applicable Maldivian requirements.

14. Proposal Submission Requirements

The technical proposal should be concise, specific to IGMH and DH and clearly cross-referenced to this TOR. It shall contain:

- Executive summary and understanding of IGMH and DH requirements
- Detailed methodology and work plan for each phase and workstream
- Deliverable plan with activities, dependencies, review points and acceptance support
- Proposed governance, communication, quality-assurance and risk-management approach
- Team structure, named personnel, CVs, role, location, availability and person-days
- Relevant firm and team experience with client references

- Approach to data protection, information security and conflict management
- Change management, training and sustainability approach
- Assumptions, exclusions and requested IGMH and DH inputs
- Separate financial proposal in the prescribed format
- Optional technology scope clearly separated from mandatory scope
- Signed declarations and required legal/procurement documents

15. Evaluation Framework

The final solicitation shall specify the approved procurement method. An indicative quality-and-cost evaluation is provided below and should be aligned with applicable procurement rules before issue.

Criterion	Indicative weight	Evidence
Understanding of requirements and context	10%	Clear, context-specific interpretation of IGMH and DH priorities and constraints
Methodology and technical approach	25%	Robust diagnosis, design, implementation, validation and handover approach
Work plan, deliverables and risk management	15%	Realistic six-month plan, dependencies, quality controls and mitigation
Firm experience	15%	Comparable multi-hospital/public-health assignments and references
Key personnel	25%	Relevant qualifications, experience, availability and role fit
Knowledge transfer and sustainability	10%	Practical training, ownership, adoption and post-project sustainability

Recommended technical threshold: 70% of available technical points. Only technically responsive proposals meeting the threshold should proceed to financial evaluation. IGMH and DH should verify references, availability and any unusually low or high cost assumptions before award.

Annexure A - Starter KPI Domains

The final KPI set shall be co-designed and data-tested. The following domains provide a minimum starting point.

Domain	Illustrative indicators
Access and demand	OPD visits, emergency attendances, referral volumes, waiting time, appointment lead time
Capacity and flow	Occupancy, average length of stay, bed turnover, discharge before noon, boarding time
Theatre and procedures	Theatre utilization, start-time compliance, cancellation rate, turnaround time, procedure volume
Diagnostics	Turnaround time, backlog, utilization, repeat/rejected samples, report timeliness
Workforce	Productive hours, overtime, absenteeism, roster fill, activity per FTE, vacancy
Finance and cost	Budget variance, cost per bed-day/procedure/visit, medicine and consumable cost, savings realization
Revenue cycle	Charge capture, billed activity, rejection rate, receivable days, collection rate, leakage closure
Quality and safety	Mortality indicators, readmission, incidents, infections, medication events, compliance
Patient experience	Complaints, response time, satisfaction, communication, dignity and service recovery
Asset and support services	Equipment uptime, maintenance response, utility intensity, stock-outs, expiries and wastage

Annexure B - Minimum KPI Dictionary Fields

- KPI name and unique code
- Strategic objective and rationale
- Operational definition and inclusion/exclusion rules
- Numerator, denominator and formula
- Unit of measure and direction of improvement
- Disaggregation by hospital, department, service, patient group or time
- Primary and secondary data sources
- Data owner, producer, validator and approver
- Reporting frequency and cut-off
- Baseline, target, warning and escalation thresholds
- Data-quality checks and known limitations
- Required action when threshold is breached
- Version, effective date and change history

Annexure C - SOP and Process Map Minimum Standard

- Purpose, scope and applicability
- Definitions and references
- Roles, responsibilities and approvals
- Inputs, step-by-step process and decision points
- Controls, handoffs, records and forms
- KPIs, quality checks and escalation
- Patient-safety, confidentiality and business-continuity considerations
- Training requirements
- Version control, review date and document owner
- Swimlane or equivalent process map for cross-functional processes

Annexure D - Deliverable Acceptance Checklist

Check	Yes/No	Reviewer comments
Scope requirements addressed		
Evidence and sources traceable		
Calculations reconciled and checked		
Clinical/operational/finance/ICT owners consulted as relevant		
Risks and assumptions disclosed		
Recommendations prioritized and implementable		
Editable files and supporting models supplied		
Comments resolved and version updated		
Ownership and next steps assigned		
Formal acceptance recommended		

Annexure E - Bidder Pricing Schedule

Cost component	Mandatory scope	Optional technology scope	Total
Professional fees			
International travel			
Local travel and logistics			
Accommodation and subsistence			
Workshops and materials			
Taxes and duties			
Other reimbursables - specify			
Grand total			

Annexure F - Key Personnel Input Schedule

Name	Role	On-site days	Remote days	Total days	Phase / months

Annexure G - Assumptions to Confirm Before Tender Issue

- Procurement reference number, issue date, closing date and submission channel
- Approved budget or disclosure approach
- Mandatory versus optional status of technology and data enablement
- Required minimum on-site presence

- Applicable procurement regulation, tax treatment and contract form
- Payment milestone percentages, retention and securities
- Authorized acceptance authorities for each deliverable
- Required insurance and liability limits
- Data-hosting and cross-border data-transfer restrictions
- Number and priority of SOPs/process maps expected
- Priority pilot services and baseline period
- Required proposal validity and implementation start date

End of Terms of Reference