**F. No.1-13/2015-DD-I(PD)**
Ministry of National Health Services, Regulation & Coordination,
Islamabad
***

Subject:- **MINUTES OF PRE-BID MEETING OF TECHNICAL/ PROCUREMENT COMMITTEE ON 02.12.2025**

A pre-bid meeting of the technical /procurement committee under the chairmanship of Joint Secretary (Hospital), Ministry of National Health Services, Regulations & Coordination (NHSR&C), was held on Tuesday 02.12.2025 in the Committee Room on the "Expression of Interest (EOI)", published in the newspaper for the selection of bidder for "Management & Operation Of Government Health Facilities in Islamabad under Public-Private Partnership Mode". Attendance Sheet of participants is attached.

2. The agenda of the meeting was:

a) Introduction and project overview.
b) Bidder's queries and Committee's Remarks
c) Conclusion

3. The chair welcomed all participants and emphasized the significance of this project in addressing the critical healthcare gaps. The project aims to find a suitable operator for Isolation Hospital and Infectious Treatment Centre (IHITC) and Regional Blood Centre (RBC), Islamabad, under a Public-Private Partnership. The initiative aligns with the government health and development agenda, with a strong focus on improving healthcare access and quality.

4. Following are the answers / clarifications to the questions / queries raised by the interested / potential bidders during the pre-bid meeting held on Tuesday 02.12.2025, and subsequently through email(s), in respect of the Request of Proposals issued by the Ministry in relation to the captioned project:

| Sr. # | Bidder Queries/Clarification | Response to the Queries |
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| 1 | Proposal for Fair and Feasible Consortium Participation:<br>We believe that requiring a single consortium is neither practical nor feasible. Even two consortia may not be sufficient, as, in Pakistan, no single entity has the capacity or expertise to manage or participate independently. Therefore, the allocation should be based on the specific expertise of each hospital or company. If this clause is not amended accordingly, we consider it to reflect a biased approach or pre-bargained arrangement. | It is clarified that, pursuant to ITB 3.1.1, participation in the Bidding Process is permitted either by a single Bidder or by a Consortium comprising a maximum of two (02) members. Having regard to the distinct and specialized experience required for the management and operation of a Hospital and a Blood Centre, the said composition is considered adequate to deliver the Project. Allowing larger consortia would undermine the principle of single-point accountability and materially increase contractual, coordination, and performance-related risks to the Authority. Notwithstanding the foregoing, the eligibility framework is being amended to permit collective consideration of experience of the Consortium members for satisfaction of the applicable eligibility requirements, keeping in view the specialized nature scope for both facilities. The revised criterion is:<br>*EC1: Technical Criterion*<br>*(a) The Bidder (in the case of a Consortium, any Members) shall have experience in the management and operation of at least three (03), two hundred (200) bedded hospitals for a period of at least five (5) years in the last fifteen (15) years.* |

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| | | *(b) The Bidder (in the case of a Consortium, any Members) shall have experience in the management and operation of at least two (02) blood Centres of minimum capacity of 20,000 blood bags for a period of at least five (5) years in the last ten (10) years.* |
| 2 | Please confirm whether the facilities (IHITC and RBC) will be handed over on an "as-is" basis, and that all rehabilitation, renovation, civil works, MEP upgrades, equipment replacement and infrastructure improvements shall be included in the Operator's CAPEX responsibility. | The Facilities (IHITC and RBC) shall be handed over strictly on an "as-is, where-is" basis. The Operator shall be responsible for undertaking all necessary rehabilitation, refurbishment, civil works, MEP upgrades, ICT systems implementation, and equipment replacement during the Installation and Planning Period in accordance with Annexure-15 (Operator's Scope of Work) of RFP Volume I.<br>All such works and procurement requirements shall be included in the Operator's Financial Bid as part of the approved CAPEX.<br>The Authority shall fund the approved CAPEX through Annuity Payments to the Operator in accordance with the Financial Bid and the Concession Agreement. Please note that CAPEX is capped at a maximum of Rs. 200 million. |
| 3 | Kindly provide guidance on the expected baseline service load (estimated OPD/IPD volume, number of beds to be made fully operational, and projected blood collection targets) to allow accurate development of the financial model. | IHITC's baseline annual OPD volume is estimated around 140,000 - 160,000. For inpatient care, IHITC's operational envelope suggests around 10,000 – 12,000 admissions annually. It is expected that the OPD and IPD volumes starts from 75% in the first year and expected to achieve full capacity utilization in second year of operations.<br>Maximum capacity of RBC Islamabad is 50,000 units per annum. Keeping in view that current demand of the HBBs, the expected volume for the first year is 75% of the maximum capacity. With full network optimisation, satellite collection points, reactivation of apheresis and reliable cold chain distribution, throughput can increase toward the design capacity of 50,000 units from the second year of operations. |
| 4 | Kindly confirm if the Annuity/Management Fee will be subject to any annual indexation (CPI-based or otherwise), and whether any government-backed payment guarantee or escrow protection mechanism is envisaged. | **a.** In accordance with Point 3 of the General Budget Guidelines under Annexure-2 (Form F-1(d)) of RFP Volume I, Bidders are required to assume an estimated annual inflation rate of 8% while preparing the Financial Bid. No further indexation mechanism beyond the stated financial assumption shall apply. Please note that the said inflationary effect is embedded in the Excel template provided to the Bidder for submission of the Financial Bid. (*The Excel Template of the Financial Bid can be downloaded from the websites of M/o NHSR&C and P3A).*<br>**b.** With reference to payment security, the Annuity Payments shall be made through an escrow mechanism in accordance with Annexure-6 (Financial Structure of the HMOs) of RFP Volume I. Quarterly payments to the Operator shall be disbursed via an escrow account managed by an Escrow Bank. |
| 5 | Please clarify the penalty and incentive mechanism linked with the Key Performance Indicators (KPIs) defined in Annex 7 and confirm whether any initial grace or mobilization period shall be provided.<br><br>KPI payment adjustments shall commence from the third (3rd) quarter onwards | The Agreement provides for a structured, KPI-linked, performance-based annuity payment mechanism. The KPI score (%) for each Facility, as determined by the Independent Expert, shall be applied to the Adjustment Heads of the relevant quarter for calculation of any Annuity Amount Payment Adjustment in accordance with Annexure-6 (Financial Structure of the HMOs) (Page 72) of RFP Volume I. Any deduction, where applicable, shall be effected strictly in the manner and sequence set out |

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| | | therein. The Project provides a mobilization and stabilization period of first (1st) quarter of the Operations Phase, during which no KPI-based deductions shall be applied. KPI payment adjustments shall commence from the second (2nd) quarter onwards. |
| 6 | Kindly confirm responsibility for utilities (electricity, gas, water), security services, and biomedical waste management under the concession arrangement. | The responsibilities for utilities, security services, and biomedical waste management shall rest with the Operator, as explicitly set out in Annexure 15 of the RFP. |
| 7 | Please clarify the exit/handback mechanism at the end of the concession period, including asset ownership status and handover conditions upon project completion or early termination, if applicable. | Asset transfer, handback obligations, and exit conditions are governed exclusively by Annex-J of the Draft Concession Agreement. The Operator shall hand back all assets to the Authority in working condition upon expiry or termination. The hand back requirements will be vetted by the Independent Expert. |
| 8 | As the proposed model requires significant capital investment in infrastructure, advanced medical equipment, IT systems, and facility upgrades by the Operator, we respectfully request the Authority to consider extending the concession/lease period from ten (10) years to a minimum of fifteen (20) years in order to ensure financial feasibility, sustainability, and improved long-term service delivery outcomes. | The Project is structured as a Management & Services Contract and not as a capital-intensive concession, BOOT, or revenue-risk PPP. All CAPEX and OPEX, as quoted by the Operator in its Financial Bid, shall be funded by the Authority through the annuity mechanism in accordance with the Concession Agreement.<br>The Concession Period has been determined based on applicable public-sector procurement practices and comparable precedent projects of a similar nature.<br>Accordingly, the existing Concession Period of ten (10) years and three (03) months is reaffirmed. |
| 9 | Additionally, it is our understanding that the IHITC building was constructed under a grant from the People's Republic of China. As Capital Diagnostic Center will be making substantial long-term capital investments in infrastructure, equipment and facility upgrades, we kindly request written confirmation from the Authority that there are no legal, diplomatic, ownership or grant-related restrictions on the proposed PPP arrangement, renovation, and extended use of the facility, and that no future claims or objections shall arise from the original grantor or any third party during or after the concession period. | The Authority confirms that no legal, diplomatic, donor-related or proprietary restrictions exist in respect of the original construction grant. |
| 10 | Government authorities may not be best positioned to conduct operational monitoring. As we are directly involved in day-to-day operations, we have a more comprehensive understanding of operational requirements. Therefore, monitoring should be conducted by the Islamabad regulatory authority. Assigning this responsibility solely to the government could result in biased or less effective oversight. | The Authority shall perform general oversight without interfering in day-to day operations while routine monitoring of operations shall be exercised by the Independent Expert (IE) in accordance with Article 4.1.3. of the Draft Concession Agreement. The IE will be appointed jointly by Authority and the Operator in accordance with Article 2.4 of the Draft Concession Agreement. Please note that regulatory oversight by competent statutory bodies remains unaffected. |
| 11 | The KPIs outlined for this project are not feasible within the current facility, which was originally designed and constructed as an isolation hospital. Renovating the building to meet these KPIs would require extensive structural modifications, potentially compromising the facility's integrity and preventing it from achieving the intended outcomes. We believe that the KPIs, as currently defined, are not adequately measurable and contain gaps that make them unachievable within this facility. Clarification on Land | Revision in Annexure 7 (KPIs) of the RFP and Annex I (Scope of Work and KPIs) attached as Appendix A of the Response Document. |
| 12 | Based on our information, this land is designated for an isolation hospital and is the property of NIH. It is | The Project land is legally vested in NIH and administered by MoNHSR&C. The Authority warrants good title, |

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| | unclear how integration with other hospitals will be achieved and what support the government will provide to facilitate this connectivity. | possession and continuity of use during the Concession Period. |
| **13** | The RFP does not provide any annual / monthly service volume, workload assumptions, donor draws, component preparation volume, testing volume, or any activity-based benchmarks required for preparing a realistic and competitive budget. For a performance-based PPP model, accurate budgeting requires clear volume assumptions. Without donor-draw targets, number of components, testing load, consumable utilization, or expected growth year-on-year, the Bidder cannot compute CAPEX/OPEX, HR sizing, reagent forecasting, or cost per service.<br>**Request:** Please provide (i) projected volumes, or (ii) minimum guaranteed volumes for all major service areas, so that bidders can submit a realistic, comparable, and financially viable proposal. | Please see response against the query at Sr. # 3. |
| **14** | There is an internal inconsistency between the **words** ("three hundred") and the **figures** ("200") for the required bed strength of hospitals. This creates ambiguity regarding the minimum capacity requirement.<br>a) "three (03), **two hundred (200)** bedded hospitals" **or**<br>b) "three (03), three hundred (300) bedded hospitals."<br>**Request:** Kindly clarify and correct the clause so that the worded and numeric values match | Reference may be made to the response provided against query at Sr. No. 1. |
| **15** | A significant portion of blood banking consumables, reagents, biomedical equipment, and maintenance contracts are **USD-denominated**. Sudden currency depreciation beyond a reasonable threshold creates a **material financial risk**, making the PPP commercially unviable and unpredictable for the Operator.<br>**Request:** Kindly incorporate an FX adjustment mechanism. Suggested clause:<br>**"If the USD/PKR exchange rate fluctuates by more than 3% (increase/decrease) compared to the baseline rate at the time of bid submission, the annual Budget / Annuity Payment shall be recalculated and adjusted proportionately for that year."** | The overall procurement includes the IHITC and RBC Islamabad. The IHITC is the major cost center (~80% of the overall package value).<br><br>The cost of imported items primarily relates to the RBC component. Please note that there is a provision of contingencies of up to five percent (5%) to cover unforeseen costs. According to the internal estimates, contingencies for combined package approximately amounts to ~30%-40% of the projected import costs. This provision shall adequately cover currency-related impacts during the Concession Period. |

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| 16 | For CAPEX procurement and installation, the Operator must incur **significant upfront financial outflows** (equipment procurement, IT systems, refurbishment materials, installation works). Reimbursement after expenditure creates a heavy **working capital burden**, which is inconsistent with typical PPP risk-sharing arrangements—especially when the Operator is required to make the facility fully functional before commencement of services.<br><br>**Request:** Please revise the clause as follows:<br>**"The amount under CAPEX & Installation Works shall be payable by the Authority in advance, based on approved BOQs / justifications and procurement plans. Adjustments shall be made against actual expenditures upon submission of supporting documents."** | Revision in Category A of the Budget Guidelines given under Annexure-2 (Form F-1(d)) is as follows:<br>"The CAPEX is capped at a maximum of Rs. 200 million. The amount shall be paid in advance. Further, the budget under this category is non-lapsable. Any savings or unutilized amount shall be carried forward to the next year without any inflationary adjustment." Bidders must submit the Financial Bid using the updated Excel Template, which can be downloaded from the websites of M/o NHSR&C and P3A. |
| 17 | **Stamp Duty** is a Government-imposed statutory charge and does not relate to the operational or managerial functions of the Operator. Including a variable government levy inside the Operator's Management Fee:<br>a) Distorts the true cost of management services,<br>b) Makes bids non-comparable, since Stamp Duty varies by contract structure, and<br>c) Places a government fiscal responsibility on the Operator, which is inconsistent with PPP risk allocation norms.<br><br>**Request:** Please omit "Stamp Duty" from the list of Management Fee components. Stamp Duty should be borne by the Authority or treated separately as a statutory/government expense, not as an Operator management cost. | Please note that a Stamp Duty is a one-time cost which forms part of Management Fee as expressly defined under the RFP and shall remain Operator's responsibility.<br>Response to (a) - Please note that Key staff includes a Project Direct and a Finance & Contract/Compliance Manager as specified under criterion 3 of the Annexure 5 - Technical Evaluation Criteria, cost of remaining staff forms part of OPEX.<br>Response to (b)(c) – Please refer to afore-stated response. |
| | To ensure fairness, transparency, and comparability among bidders, and to prevent excessive loading of costs into the Management Fee head, it is recommended that the Authority define a clear percentage cap.<br>**Request:** The Management Fee should be restricted to a maximum of **8%** of the approved annual Operating Budget. | Revision in Category F of the Budget Guidelines given under Annexure-2 (Form F-1(d)) is as follows:<br>*"The Management Fee shall be capped at a maximum of ten percent (10%) of the operational budget for that particular year."* |
| 18 | The requirement for the Bidder to contribute from **its own financial resources** is inconsistent with the PPP model described in the RFP, which is structured as a **Management & Services Contract**, not a **Philanthropic PPP**.<br>Under a service-based PPP, all operational and CAPEX requirements are financed by the **Authority** as per the approved Budget Guidelines.<br>**Request:** This clause should be omitted entirely. | Contribution from a Bidder's own sources is not mandatory. However, should a Bidder contribute from its own resources or philanthropic platforms, such co-funding shall be encouraged and will be considered a competitive factor in the Bid evaluation. |

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| 19 | Sub-clause **(f)** implies that the Operator is expected to fund part of the project from its **own financial resources**. This contradicts the model described in the RFP, where the PPP modality is clearly a **Management & Services Contract**, not a **Philanthropic PPP** or co-financing arrangement.<br>Requiring any "own funding" by the Operator:<br>(a) Conflicts with the earlier commitment that all costs must be included in the Financial Bid and funded by the Authority;<br>**Request:** Sub-clause (f) should be **deleted** entirely. | Please refer to response given against the query at Sr. # 18.<br>Funding through the Operator's own sources is not mandatory; however, any amount contributed by the Operator shall be encouraged and will make the Bid more competitive. |
| 20 | This clause shifts **unlimited financial risk** to the Operator. Under a **Management & Services PPP Contract**, the Operator is responsible for performance—not for subsidizing the project through unfunded expenditures or cost overruns.<br><br>Healthcare inputs (reagents, consumables, biomedical maintenance, utilities, staffing costs) are highly volatile and often dependent on **USD-linked pricing**, inflation, supply chain disruptions, and regulatory changes. Expecting the Operator to absorb cost escalations:<br><br>a) Undermines financial viability,<br>b) Creates unpredictable exposure,<br>**Request:** Sub-clause should be **deleted** entirely. | Bidders are expected to conduct due diligence while preparing the Bid, including the Financial Bid. Provision for unforeseen costs has been included in the Financial Bid to cover cost overrun risks. Further, the Operator is expected to implement appropriate project scheduling and cost control measures in order to remain within the approved budget. |
| 21 | The requirement for the Operator to submit the **QPR and QES within 5 days** of quarter-end is **not operationally feasible**. Compilation of documentation, verification of invoices, reconciliation of expense heads, and coordination with multiple facility teams cannot be completed in this timeframe. Additionally, the **IE's verification process itself typically requires 20–30 days**, based on actual PPP experience in Sindh. Therefore, a 5-day submission window is unrealistic and may cause non-compliance despite the Operator's best efforts.<br>**Request:** Revise the timeline to a practical and implementable duration:<br>**It should be considered as 45 days** | Revision in Annexure 6 (Financial Structure for the HMOs) of RFP Volume I is as follows:<br>*"In respect of each Quarter, within ten (10) Days of the end of each quarter relating to an Annuity Amount Period, the Operator shall submit the Quarterly Progress Report (QPR) including Quarterly Expense Summary (QES) along with supporting evidence of the Reimbursable Budget Heads to the IE."*<br>Please note that this requirement is intended to facilitate expeditious processing of annuity payments and timely disbursement to the Operator.<br>The Operator's Key Staff are expected to compile and maintain the required documentation during the quarter, rather than after the close of the reporting period. |

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<tr><th>Sr #</th><th>Bidder Queries/Clarification</th><th>Response to the Queries</th></tr>
<tr><td>22</td><td>The threshold of 95% performance score for zero deduction is excessively high for a large, multi-site healthcare project. International PPP standards use 80–85% as the threshold for full payment.<br>Further, any deduction applied to the Operating Budget (Category B) is unacceptable because it affects essential service delivery, compromises patient safety, and contradicts PPP norms where KPI penalties are applied only on the Operator's Management Fee, not on operational heads needed to maintain service quality.<br>Request:<br>1. Revise zero-deduction threshold:<br>Additionally: "Deductions shall be made from Management Fee."</td><td>Revision in Scoring System of KPIs given under Annexure 7 – Key Performance Indicators of the RFP Annex I (Scope of Work and KPIs) of the Draft Concession Agreement is as under:<br><table><tr><td>Performance Score</td><td>Determination of Deduction Amount</td></tr><tr><td>90% and above</td><td>No deduction</td></tr><tr><td>85% to less than 90%</td><td>Deduction from management fees (*Cat F) only</td></tr><tr><td>Less than 85%</td><td>Deduction from management fees (*Cat F) and Budget for Operating Expenditure (*Cat B)</td></tr><tr><td>Less than 75% for 3 quarters</td><td>Event of Default</td></tr><tr><td>Less than 60%</td><td>Immediate event of default</td></tr></table><br>Please refer to Annexure 6 (Financial Structure of HMOs) of RFP Volume I, which provides that the deduction determination mechanism applies OPEX where performance levels fall below 85%, in addition to the Management Fee. However, it is explicitly stated that the deduction amount shall be adjusted from the Management Fee only. In the event of complete depletion of the Management Fee due to KPI-based deductions, any remaining amount shall be deducted from the Management Fee of the subsequent quarter.</td></tr>
<tr><td>23</td><td>Linking the release of each quarterly annuity payment to the IE's prior review creates a severe operational and financial bottleneck. The IE review process typically takes 20–30 days, resulting in unavoidable delays in cash flow.<br>For a healthcare service PPP, uninterrupted availability of funds is essential for:<br>a) Procurement of reagents, consumables, and kits,<br>b) Payment of staff salaries,<br>c) Biomedical maintenance,<br>d) Utilities and operational continuity.<br>e) Delaying payments until after IE review risks service interruption, late payments to vendors, and compromised blood safety.<br><br>Request: All annuity payments must be issued in advance at the beginning of each quarter.<br>6 month annuity payment be given in advance.</td><td>Please refer to Annexure 6 (Financial Structure for the HMOs) of RFP Volume I, it is clarified that the first annuity payment for installation period will be given in advance. Thereafter, Annuity of each quarter during the Operations Phase will be paid in advance which will be released after IE's review of the previous quarter's performance on the basis of quarterly reports submitted by the Operator and IE's assessment.<br>Please note that the Verification by the Independent Expert is mandatory for payment processing.</td></tr>
<tr><td>24</td><td>Replace the RFP's bed-distribution with revised operational bed plan: ICU 20 | HDU 36 | General Ward 60 | Isolation 14 | ER 8 | Consultant clinics 15–20 (show both RFP vs our numbers in matrix)</td><td>Revision in Scope of work table of Isolation Hospital & Infection Treatment Centre (Section 1) under Annexure 15 (Operator's Scope of Work) of the RFP Volume I and Annex I (Scope of Work and KPIs) of the RFP Volume II is as follows:<br><table><tr><th>ACTIVITIES</th><th>DETAILED SCOPE OF WORK</th></tr><tr><td>a1: Bed Distribution</td><td>IHITC redefined as 160 beds ; ICU 20, HDU 20, General Ward 60, Isolation 15, ER 10, L&D 25, Neonatal Nursery Unit 10, Consultant clinics 15.</td></tr></table></td></tr>
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| Sr #. | Bidder Queries/Clarification | Response to the Queries |
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| 25 | KPIs in RFP must be replaced by revised KPIs | The attached document, along with this query, has been reviewed, and Key Performance Indicators (KPIs) have been revised where deemed necessary.<br>Revision in Annexure 7 (Key Performance Indicators) of the RFP and Annex I (Scope of Work and KPIs) attached as Appendix A of the Response Document. |
| 26 | Maintain the full set but limited to infectious disease priorities, no non-ID specialty expansion (no elective general surgery/ward expansion). Ensure clinical staffing matches ID hospital needs. | Revision in Section B, Sub-section 1(b), of Annexure 15 (Operator Scope of Work) of the RFP and Annex I (Scope of Work and KPIs) of the Draft Concession Agreement is as follows:<br>• *Patient admission, assessment, and triage for moderate-complexity conditions*<br>• *Round-the-clock emergency stabilization*<br>• *Isolation, containment, and management of infectious disease cases*<br>• *Inpatient management with supervised medical wards and short-stay units*<br>• *Clinical management following evidence-based protocols*<br>• *Critical care services in dedicated ICUs*<br>• *Medical consultations by infectious disease or internal-medicine specialists*<br>• *Nursing and allied health services, including care coordination and patient monitoring*<br>• *Functional pharmacy services supporting inpatient and outpatient care*<br>• *Reliable diagnostic support through hematology, biochemistry, radiology, and basic molecular testing*<br>• *Structured referral pathways for higher-level care*<br>• *Operational Infection Prevention and Control (IPC) program with surveillance, standard and transmission-based precautions, environmental hygiene, and sterilization assurance*<br>• *Systems for early detection, prevention, and containment of communicable diseases*<br>• *The hospital's clinical services be designed as per the proposed 160 beds ; ICU 20, HDU 20, General Ward 60, Isolation 15, ER 10, L&D 25, Neonatal Nursery Unit 10, Consultant clinics 15.* |
| 27 | This clause restricts the Operator's ability to apply its own evidence-based SOPs, clinical protocols, and operational policies. For efficient and high-quality service delivery—especially in highly regulated fields such as blood transfusion and infectious diseases—the Operator must retain the ability to adopt internal policies and best practices, provided they are not in conflict with the law.<br>**Request – Revised Wording:**<br>"The Operator shall comply with all applicable laws, statutory regulations, and KPIs. The Operator may adopt and implement its own internal policies, SOPs, and procedures, provided these are not contradictory to applicable laws, regulatory requirements, and best industry practices." | The Authority's policies and regulations are of general and region-specific application and are applicable to all healthcare facilities.<br>Please refer to Annexure 15 (Operator's Scope of Work) of RFP Volume I and Annex I (Scope of Work) of RFP Volume II, the Operator to maintain and operate the Facility in accordance with the Scope of Work, applicable and KPIs. Therefore, as long as the SOPs and procedures of the Operator are not contrary to the foregoing, the Operator can apply evidence-based SOPs, clinical protocols, HR, procurement and other and operational policies. |

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<tr><td>28</td><td>RBC Scope dose not covers HBBs.<br>Please make amendment in the RBC Scope of Service (Table) in the following activities:<br>a. Operations & Maintenance: Full operational management and maintenance of the Regional Blood Centre (RBC) in Islamabad and linked HBBs."<br>b. Blood Production & Supply: Collection, processing, testing, storage, and distribution of blood and blood components in compliance with Good Manufacturing Practices (GMP) and Good Laboratory Practices (GLP) along with compatibility testing and distribution of blood components to patients maintaining cold chain.<br>c. Core Functions:<br>• Collection of Blood from Replacement donor from all HBBs Sites<br>• Mobilization of voluntary, non-remunerated blood donors<br>• Processing, Transfusion Transmitted Infectious Disease screening, and component preparation<br>• Safe storage, labelling, and distribution to linked Hospital Blood Banks (HBBs).<br>• Compatibility testing of Donor and Patient in the HBBs<br>• Distribution of blood and blood components to patients in HBBs maintaining cold chain.<br>• Quality Control – Internal and external (Proficiency Testing)<br><br>d. Traceability & Quality Control: Establish complete traceability from donor to recipient, including identification, record management, and monitoring of adverse reactions (Donors and Patient).<br>l. Human Resources: Provide all HR required for operation, Bio-Medical, support and maintenance of RBC and linked HBBs<br>u. ICT & Safety Infrastructure: Ensure LAN/WAN cabling for IT systems, broadband connectivity for online services including Blood Bank Management Information System, Communication System, ERP, Surveillance System and other required services as well as fire safety provisions at the RBC facility and the linked HBBs.</td><td>Revision in Scope of work table Regional Blood Center (Section 2) under Annexure 15 (Operator's Scope of Work) of the RFP and Annex I (Scope of Work and KPIs) of the Draft Concession Agreement is as follows:
<table>
<tr><th>ACTIVITIES</th><th>DETAILED SCOPE OF WORK</th></tr>
<tr><td>a. Operations and Maintenance</td><td>The private operator shall establish, manage, and maintain a centralized blood banking system functioning as the hub for blood collection, testing, processing, storage, and distribution, fully integrated with following Hospital-Based Blood Banks (HBBs) as spokes.<br>i. Federal Government Polyclinic (FGPC-PGMI) Islamabad<br>ii. Pakistan Institute of Medical Sciences (PIMS) Hospital Islamabad<br>iii. Federal General Hospital (FGH) Islamabad</td></tr>
<tr><td>b. Blood Production and Supply</td><td>Collection, processing, testing, storage, and distribution of blood and blood components in compliance with Good Manufacturing Practices (GMP) and Good Laboratory Practices (GLP) along with compatibility testing and distribution of blood components to patients maintaining cold chain.</td></tr>
<tr><td>c. Core Functions</td><td>• Collection of Blood from Replacement donor from all HBBs Sites<br>• Mobilization of voluntary, non-remunerated blood donors<br>• Processing, Transfusion Transmitted Infectious Disease screening, and component preparation<br>• Safe storage, labelling, and distribution to linked Hospital Blood Banks (HBBs).<br>• Compatibility testing of Donor and Patient in the HBBs<br>• Distribution of blood and blood components to patients in HBBs maintaining cold chain.<br>• Quality Control – Internal and external (Proficiency Testing)</td></tr>
<tr><td>d. Traceability and Quality Control</td><td>Establish complete traceability from donor to recipient, including identification, record management, and monitoring of adverse reactions (Donors and Patient).</td></tr>
<tr><td>k. Transportation & Distribution</td><td>Transport blood and components in temperature-controlled supply-chain (e.g., insulated transport boxes, coolers, passive control systems) in compliance with national and international standards</td></tr>
<tr><td>l. Human Resources</td><td>Provide all HR required for operation, Bio-Medical, support and maintenance of RBC and linked HBBs</td></tr>
<tr><td>u. ICT and Safety Infrastructure</td><td>Implement LAN/WAN cabling, broadband connectivity, and fire safety provisions at the RBC and all linked</td></tr>
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| | | HBBs, enabling full operation of Blood Bank Management Information System, ERP, communication, and surveillance systems across the network. |
| **29** | The requirement for transporting all blood and components in temperature-controlled vehicles is not aligned with practices or operational feasibility.<br>International standards require validated temperature-controlled transport, which can be achieved through:<br>• Insulated blood transport boxes,<br>• Validated coolers,<br>• Passive temperature control systems,<br>• Refrigerant packs,<br>– not necessarily temperature-controlled vehicles.<br>Very few blood centres globally operate dedicated temperature-controlled vehicles due to high cost, low utilization, and lack of necessity for short-distance movements.<br>**Request – Revised Wording:**<br>"Transport of blood and components shall be carried out using validated temperature-controlled solutions (e.g., insulated transport boxes, coolers, passive control systems) in compliance with national and international standards. Temperature-controlled vehicles may be used where required." | Please see response against query at Sr. 28. |
| **30** | The definitions of the KPI and the formulas which will be used for calculation are not provided in RFP | Please refer to response given against query at Sr. # 11. |

| Sr. # | Bidder Queries/Clarification | Response to the Queries |
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| 1 | This clause places the responsibility for arranging **financing**, **upfront expenditure**, and **working capital** solely on the Operator. This is inconsistent with the PPP model of this project, which is clearly defined as a **Management & Services Contract**, not a concession requiring private financing.<br>Under such a PPP structure:<br>• All operational costs, refurbishment, repairs, consumables, and staffing are funded by the **Authority**, based on the approved Budget Heads.<br>• The Operator's role is performance-based delivery, not project financing.<br><br>**Request:** Replace Clause 4.1(t) with the following:<br>**"The Authority shall provide the required budget for all operational, refurbishment, repair, and working capital needs as per approved Budget Heads. The Operator shall ensure effective utilization of the funds to maintain uninterrupted facility operations."** | To enhance clarity Article 4.1(t) is revised as under:<br><br>*"During the Operations Phase, for the purpose of complying with its obligations under this Agreement, including meeting temporary working capital requirements necessary to ensure uninterrupted operation of the Facility, the Operator shall arrange and maintain such interim financing as may be required only for the period during which the quarterly annuity payment is under processing"* |
| 2 | This clause is not aligned with the PPP modality defined in the RFP, which repeatedly indicates a Management & Services Contract, not a Philanthropic PPP.<br>Requiring the Operator to fund 20% of the Operational Expenditure turns the project into a co-financing / donation-based model, which:<br>a) Is commercially unviable for any private or non-profit operator.<br>b) Distorts risk allocation and the financial structure defined in other sections of the RFP.<br>c) Contradicts the Annuity Payment mechanism and Budget Guidelines.<br>d) Creates non-comparable and unpredictable financial obligations.<br>e) Effectively forces the Operator to become a **donor** rather than a service provider.<br><br>**Request:** Clause 4.1(u) should be **completely deleted**. | Please refer to response provided against query # 18 – RFP Section of Responses.<br><br>Further, Percentage of the Operator contribution will be linked with the Financial Bid of the Operator instead of 20%, revised Article 4.1(u) is as under:<br><br>*The Operator acknowledges that the Project is structured on a philanthropic model and agrees to contribute an amount not less than the amount quoted in its Financial Bid through donations or other philanthropic financing. The Operator's contribution (the "Co-Funding Amount") shall be deposited on a quarterly basis, prior to the submission of any invoice or request for Annuity Amount Payment to the Authority.* |

| Sr. # | Bidder Queries/Clarification | Response to the Queries |
|---|---|---|
| 3 | A **10% Performance Security** against first-year Operating Cost is excessively high for a healthcare PPP structured as a **Management & Services Contract**. Such a requirement:<br>a) Causes significant financial strain on the Operator,<br>b) Blocks liquidity that is required for operations,<br>c) Reduces bidder participation and competitiveness,<br>Standard PPP norms for service contracts set Performance Security at **2%–3%** of annual contract value, especially where the Authority funds all CAPEX/OPEX.<br><br>**Request:** The Performance Security should be reduced to **2%** of the first-year Operating Cost.<br><br>Regarding the point # 7.11.5 The required clause needs to be removed | The requirement for submission of a Performance Guarantee equivalent to ten percent (10%) of the Operating Cost of the First Year is consistent with industry practice.<br><br>However, the requirement for submission of guarantee against the advance annuity as mentioned in the Article 7.11.5 is hereby deleted. |
| 4 | The Operator cannot assume responsibility for cash handling, revenue collection, or deposit of government-owned funds. This exposes the Operator to audit risk, fiduciary liability, fraud exposure, accounting compliance issues, and contradicts public financial management rules.<br>**Request:** Need to be omitted<br><br>No any cash collection from the patient by any party including the authorities in the hospital premises | Agreed, amended Article 7.12.1.2 and 7.12.1.3 are as follows:<br>*7.12.1.2* *All user charges collected from patients, beneficiaries, or any third parties for services rendered at the Facility shall be deemed the property of the Authority. Such collections will be deposited, without any deduction or delay, into the Authority's designated bank account in the manner and within the timelines prescribed by the Authority.*<br>*7.12.1.3* *The Authority shall deploy its own cashier, accountant, or any other authorized officer for the collection and deposit of user charges. The Operator shall provide full cooperation, access, and support to the personnel responsible for revenue collection and accounting.* |
| 5 | Operator to take full operational HR responsibility: propose staffing matrix, capacity test results, re-deployment plans, and clear terms for any underperforming Authority Employees. All HR cost to be in operator budget. | Please refer to Article 7.9.1 of the Draft Concession Agreement which explains that the Authority shall hand over its employees deployed at the Facility to the Operator, who shall retain and manage them in accordance with this Agreement. The Operator shall conduct capacity testing and arrange training as required. Any non-performing employee shall be reported to the Authority and IE for redeployment. |
| 6 | The clause only allows the Operator to **notify** the Authority, but does **not obligate** the Authority to:<br>a) remove the non-performing employee,<br>b) transfer them out, | Authority retains disciplinary control over deputed employees. Upon IE confirmation, replacement requests shall be acted upon by the Authority.<br><br>Revision in Article 7.9.3.1 and 7.9.3.2 is as under: |

| Sr. # | Bidder Queries/Clarification | Response to the Queries |
|---|---|---|
| | c) send a replacement, or<br>d) take any corrective action within a defined timeline.<br><br>This exposes the Operator to operational inefficiencies, performance issues, and KPI risks caused by staff that cannot be supervised, disciplined, or replaced by the Operator.<br><br>RFP: Handing over criteria, asset lists, IE joint inspection. Operator to hand back assets at concession end.<br><br>Our Requirement: Accurate, signed inventory at Effective Date; condition and operational status recorded; operator responsible for broken/ depleted items post<br><br>Effective Date.<br>Concern: RFP states "as-is" but lacks granular acceptance criteria for items listed as non-functional (e.g., autoclave 0 functional). This risks hidden CAPEX for operator. | *7.9.3.1 In the event the Operator is of the opinion that any one or more of the Authority's Employees are not performing in accordance with the Employment Criteria (the "Non-Performing Employees"), the Operator shall issue a first warning notice to the employee, providing a reasonable period, being not less than thirty (30) days, to improve performance. If the non-performance persists, a second warning notice shall be issued, providing an additional reasonable period, being not less than fifteen (15) days, for improvement.*<br><br>*If the performance of such employee is not improved after the remedy period provided under the second warning letter, the Operator shall notify the Authority and Independent Expert in writing along with reasonable details of the Employment Criteria not being met by such Non-Performing Employees (the "Operator's Notice").*<br><br>*7.9.3.2 Upon receipt of the Operator's Notice , the Independent Expert shall conduct such inquiry as may be deemed necessary and no later than seven (7) days of receipt of the Operator's Notice submit its recommendation to the Authority. Within fifteen (15) days of receipt of the Independent Expert's recommendation, the Authority shall take appropriate corrective or replacement action against the Non-Performing Employees.* |
| 7 | Handing over criteria, asset lists, IE joint inspection. Operator to hand back assets at concession end.<br>Our Requirement: Accurate, signed inventory at Effective Date; condition and operational status recorded; operator responsible for broken/ depleted items post Effective Date.<br>Concern: RFP states "as-is" but lacks granular acceptance criteria for items listed as non-functional (e.g., autoclave 0 functional). This risks hidden CAPEX for operator. | A detailed, joint, and signed asset inventory (including make, model, serial number and condition) shall be executed at the Effective Date. Operator liability shall arise only for post-hand over deterioration. |
| 8 | Every year at the time of budget submission or release with the same scope of services, if the scope of services changed (increase/ additional) will be submitted the separate budget accordingly. | It is clarified that the mechanism for approval for additional services is defined in the Article 7.10 of the Draft Concession Agreement |

## Key Performance Indicators – Regional Blood Centre, Islamabad

| KPI | Target and Indicator | Weigh | Definitions and Formula |
|---|---|---|---|
| **KPI 1. Collection of Blood and Donor Management (10%)** | | | |
| 1.1 Voluntary vs directed donors | ≥ 5,000 voluntary donations for the first year, and a 10% increase in each subsequent year.<br><br>Source: Donor registration system/donor register, annual collection reports. | 30% | Total number and growth of voluntary, non-remunerated blood donations collected by the RBC in the reporting year. Formula: Voluntary donations (number) = count of donations marked as 'voluntary' in the donor register for the year. Growth (%) = (Voluntary donations this year − voluntary donations last year) ÷ voluntary donations last year × 100. |
| 1.2 Deferral rate | ≤ 20% deferrals (reflecting effective pre-donation screening)<br><br>Source: Donor selection/screening register, electronic donor records. | 30% | Proportion of donor presentations that are deferred at pre-donation screening. Formula: Deferral rate (%) = (number of donors deferred ÷ number of donor presentations (accepted + deferred)) × 100. |
| 1.3 Mobile blood drive | ≥8 community drives (per quarter)<br><br>Source: Outreach/camp calendar, event reports, mobile drive scheduling records. | 20% | Number of community/mobile blood drives organized by the RBC in the reporting period. Formula: Drives conducted (number) = count of completed community/mobile blood drive events in the quarter. |
| 1.4 Donor satisfaction score | ≥ 80% positive<br><br>Source: Donor satisfaction survey forms (paper or electronic), call-back surveys. | 20% | Percentage of donors rating their donation experience as 7-10 on a scale of 0-10. Formula: Donor satisfaction (%) = (donor feedback forms with positive rating ÷ total donor feedback forms collected) × 100. |
| **KPI 2. Screening, Testing, and Quality Assurance (25%)** | | | |
| 2.1 Transfusion-Transmissible Infection (TTI) screening | 100% of units (HIV, HBV, HCV, Syphilis, Malaria)<br><br>Source: Laboratory screening register, LIMS, blood unit screening log. | 20% | Proportion of collected units tested for all mandatory TTIs (HIV, HBV, HCV, Syphilis, Malaria, and other required markers). Formula: TTI screening coverage (%) = (units tested for all mandatory TTIs ÷ total units collected) × 100. |
| 2.2 Accuracy of screening | ≥ 97% concordance between repeat & control tests<br><br>Source: QC logbook, repeat-testing records, LIMS comparison reports. | 15% | Concordance between routine screening results and repeat or quality-control testing. Formula: Screening concordance (%) = (number of repeat/QC tests with results matching the original screening result ÷ number of repeat/QC tests performed) × 100. |
| 2.3 External Quality Assessment (EQA) | 100% participation with ≥ 80% satisfactory results<br><br>Source: EQA provider reports, EQA summary sheets, and QA files. | 15% | Participation in external quality assessment schemes and proportion of satisfactory EQA results. Formula: EQA participation (%) = (EQA rounds participated ÷ number of EQA rounds offered) × 100. EQA satisfactory results (%) = (EQA samples scored satisfactory ÷ total EQA samples) × 100. |
| 2.4 Kit and reagent stockouts | 1. Availability of tracer kits/reagents ≥ 90% of days in a month,<br>2. No tracer item with stock-out for more than 5 consecutive days in a quarter<br><br>Source: Store register, stock cards/LMIS, daily stock-check sheets. | 10% | Availability of selected tracer kits and reagents over the quarter, and absence of prolonged stock-outs. Formula: For each tracer item, Availability (%) = (number of days in stock ÷ total days in quarter) × 100. Average availability (%) = sum of availability for all tracer items ÷ number of tracer items. Also track: max consecutive stock-out days per item = longest run of days with zero stock.<br>Target: average availability ≥ target and no tracer item out of stock > allowed consecutive days. |
| 2.5 Calibration and maintenance of equipment | 100% compliance with the calibration schedule | 15% | The extent to which planned calibration and preventive maintenance tasks for lab equipment are completed on schedule. |

| KPI | Target and Indicator | Weigh | Definitions and Formula |
|---|---|---|---|
| | Source: Equipment maintenance and calibration logs, engineering/biomedical maintenance records. | | Formula: Calibration compliance (%) = (calibration/maintenance tasks completed on or before due date ÷ calibration/maintenance tasks scheduled in period) × 100. |
| 2.6 Compliance with laboratory waste disposal | 90% or higher adherence to biosafety procedures<br><br>Source: Biosafety and waste management audit checklists, observation records, and training reports. | 10% | Adherence to biosafety and biomedical waste disposal procedures in the laboratory. Formula: Waste disposal compliance (%) = (Total correct practices observed during audit ÷ total practices observed) × 100, or audit score (%) = (points achieved on biosafety checklist ÷ total possible points) × 100. |
| 2.7 CAP closure and incident reporting | ≥80% of remedial measures were completed in less than 30 days<br><br>Source: CAPA register, incident reports, internal audit follow-up log. | 15% | Timeliness of corrective and preventive actions (CAPA) in response to incidents, non-conformities, or audit findings. Formula: CAPA closure (%) = (CAPA actions closed within 30 days ÷ number of CAPA actions raised in the period) × 100. |
| **KPI 3. Component Preparation, Storage, and Distribution (15%)** | | | |
| 3.1 Component preparation yield | ≥ 75% of the collected blood is separated into components (RBCs, FFP, Platelets) as needed; the ratio of RBCs, FFP, and Platelets does not need to be equal. | 20% | Proportion of collected whole-blood donations that are processed into at least one blood component (RBC, FFP, Platelets, etc.). Formula: Component preparation yield (%) = (# whole-blood units processed into components ÷ total whole-blood units collected) × 100. Source: Component preparation log, production register, LIMS/processing records. |
| 3.2 Component wastage rate (expiry/breakage) | ≤ 10% total wastage<br><br>Source: Discard register, inventory records, QC logs. | 20% | Proportion of prepared blood components discarded due to expiry, breakage, contamination, or QC failure. Formula: Component wastage (%) = (number of components discarded for expiry/breakage/contamination/QC fail ÷ total components prepared) × 100. |
| 3.3 Cold chain temperature compliance | 90% adherence<br><br>Source: Temperature logbooks, automated temperature monitoring printouts/data. | 20% | Percentage of recorded storage temperature readings (for blood components) that fall within recommended ranges. Formula: Cold chain compliance (%) = (number of temperature readings within specified range ÷ total temperature readings in period) × 100. |
| 3.4 Linked hospital supply fulfillment | ≥ 85% of approved requests fulfilled<br><br>Source: RBC issue register, hospital request/issue forms, dispatch records. | 20% | Proportion of approved component requests from linked hospitals that are fulfilled by the RBC. Formula: Supply fulfillment (%) = (Total component units supplied for approved requests ÷ total component units requested and approved) × 100. |
| 3.5 Emergency response & disaster readiness | Stock reserve ≥ 5% of average monthly issue<br><br>Source: Inventory records, issue registers, emergency stock lists. | 20% | Definition: Adequacy of reserve stock of key blood components to respond to emergencies and disasters. Formula: Reserve stock (%) = (Number of units kept in emergency reserve ÷ average monthly issue of those units over the last 3–6 months) × 100. |
| **KPI 4. Human Resource (10%)** | | | |
| 4.1 Staff credentials (PMDC/PNC/MLT) | 100% accredited and eligible for the role (these credentials are only required for doctors, nurses, and lab managers)<br><br>Source: HR files, copies of licenses, verification from professional councils. | 30% | Proportion of staff in regulated categories (doctors, nurses, lab technologists/managers) with valid professional registration. Formula: Credential compliance (%) = (number of staff with valid PMDC/PMC, PNC or MLT credentials ÷ total staff in those categories) × 100. |

| KPI | Target and Indicator | Weigh | Definitions and Formula |
|---|---|---|---|
| 4.2 Staff presence and attendance | Maintain 80% overall staff attendance per quarter<br><br>Source: Attendance registers/biometric system, duty rosters, leave records. | 20% | Overall staff attendance rate over the quarter, excluding approved leaves. Formula: Attendance (%) = (Total staff-days present ÷ (Total scheduled staff-days − approved leave days)) × 100. |
| 4.3 CME / Refresher training | ≥ 70% of staff trained annually in QA & biosafety<br><br>Source: Training attendance sheets, HR training matrix, certificates. | 30% | Proportion of staff who received at least one relevant CME/refresher training in QA and biosafety during the last 12 months. Formula: Trained staff (%) = (number of staff with at least one QA/biosafety training in the last 12 months ÷ total staff) × 100. |
| 4.4 Leave management | ≥ 90% policy-compliant leave entries<br><br>Source: HR leave register, leave applications, payroll/attendance reconciliation. | 20% | The extent to which staff leave is recorded and approved in line with policy. Formula: Policy-compliant leave (%) = (number of leave days supported by approved leave applications ÷ total leave days taken) × 100. |
| **KPI 5. Regulatory Compliance and Quality Management System (QMS) (10%)** | | | |
| 5.1 SOP availability and implementation | 100% of critical functions covered by updated SOPs<br><br>Source: SOP master list, QMS document control system, review/revision logs. | 20% | Coverage of critical RBC processes by current, approved Standard Operating Procedures (SOPs). Formula: SOP coverage (%) = (number of identified critical processes with an up-to-date SOP ÷ total identified critical processes) × 100. |
| 5.2 Internal audits | ≥ 80% completion of scheduled audits<br><br>Source: Internal audit plan, audit reports, audit tracker. | 20% | Completion of planned internal audits of RBC processes in accordance with the annual audit plan. Formula: Audit completion (%) = (internal audits completed ÷ internal audits scheduled in the period) × 100. |
| 5.3 Corrective and Preventive Action (CAPA) efficiency | ≥ 85% CAPAs closed<br><br>Source: CAPA register, audit follow-up records, management review minutes. | 20% | Proportion of CAPA actions that are fully implemented and closed within the agreed timeframe. Formula: CAPA efficiency (%) = (CAPA items closed within agreed deadline ÷ total CAPA items opened in period) × 100. |
| 5.4 Adherence to SBTP inspections and regulations | No serious or critical non-compliance (Events that directly risk donor/recipient safety or quality and traceability of the blood components)<br><br>Source: SBTP/Authority inspection reports, CAPA documentation, regulatory correspondence. | 20% | Compliance with SBTP/Provincial Blood Transfusion Authority regulatory requirements and closure of major non-conformities (MNCs). Formula: MNC count = number of major non-conformities identified in latest inspection (target: 0). CAPA closure (%) = (MNCs with CAPA closed within regulator-specified timeframe ÷ number of MNCs identified) × 100. |
| 5.5 ISO / Accreditation readiness | Completed readiness by the third year of operation (ISO 15189 standards)<br><br>Source: ISO/accreditation self-assessment checklist, gap analysis reports, and management review records. | 20% | Degree of implementation of ISO 15189 or relevant accreditation standards for the RBC. Formula: Readiness (%) = (number of applicable standard requirements met or implemented ÷ total applicable requirements on the checklist) × 100. |
| **KPI 6. Information Systems and Data Reporting (10%)** | | | |
| 6.1 HIMS / LIMS functionality | ≥ 95% uptime<br><br>Source: IT system logs, downtime reports, helpdesk tickets. | 20% | Availability (uptime) of the electronic Health Information Management System (HIMS) / Laboratory Information Management System (LIMS). Formula: System uptime (%) = (Total hours |

| KPI | Target and Indicator | Weigh | Definitions and Formula |
|---|---|---|---|
| | | | HIMS/LIMS was functional ÷ total scheduled operational hours) × 100. |
| 6.2 Data entry accuracy | ≥ 90% validated entries<br><br>Source: Data quality audits, source document vs system comparison checklists. | 20% | Proportion of electronic data entries that exactly match the source documents (registers, request forms, reports).<br>Formula: Data accuracy (%) = (number of sampled electronic records with no discrepancies versus source ÷ total records sampled) × 100. |
| 6.3 Reporting timeliness | 100% quarterly submission within the deadline<br><br>Source: Reporting log, dispatch register, email submissions, DHIS/HMIS portal timestamps. | 20% | Timeliness of required quarterly or monthly reports submission to relevant authorities.<br>Formula: Timely reports (%) = (number of required reports submitted on or before the deadline ÷ total required reports) × 100. |
| 6.4 HR Tracking (attendance, role applications, leave applications, complaints) | ≥95% of data available<br><br>Source: HRIS, attendance registers, duty rosters, leave/complaint files. | 20% | Accuracy and completeness of HR data (attendance, roles, leave, complaints) recorded in HRIS or registers.<br>Formula: Staff records where attendance, role, leave, and complaint data have less than 5% gaps. |
| 6.5 Digitalization of assets | Complete digital record of asset utilization, repair, and upgrades (≥95% data entry)<br><br>Source: Digital asset register, physical verification reports, maintenance records. | 20% | Completeness and accuracy of the digital asset register for RBC equipment, including utilization, repair, and upgrades.<br>Formula: Assets correctly recorded with ID, location, status, and maintenance history have less than 5% gaps. |
| **KPI 7. Hospital Blood Bank Operations (15%)** | | | |
| 7.1 Blood inventory management | ≥85% of the availability of requested components by RBC<br><br>Source: RBC issue register, linked HBB requisition forms, dispatch notes. | 20% | Proportion of requested blood components from the Hospital Blood Banks (HBBs) that are supplied by the RBC.<br>Formula: Inventory fulfillment (%) = (component units supplied as requested ÷ total component units requested by HBBs) × 100. |
| 7.2 Cold chain compliance | ≥90% temperature compliance<br><br>Source: Transport boxes' temperature loggers, cold chain temperature charts, HBB receipt records. | 25% | Compliance of transport and storage temperatures with recommended cold chain ranges for components dispatched to HBBs.<br>Formula: Cold chain compliance (%) = (transport/storage temperature readings within recommended range ÷ total readings in period) × 100. |
| 7.3 Crossmatch-to-transfusion efficiency | ≥ 90% crossmatch requests completed within defined TAT (4 hours for routine, 1 hour for urgent, and 30 minutes for emergency)<br><br>Source: Crossmatch registers in HBBs, sample collection and result time stamps, LIMS, where available. | 20% | Timeliness of crossmatch results provided by Hospital Blood Banks relative to clinical urgency (routine, urgent, emergency).<br>Formula: Crossmatch TAT compliance (%) = (crossmatch requests with results available within defined TAT for their priority ÷ total crossmatch requests sampled) × 100. |
| 7.4 Traceability and hemovigilance reporting | 100% traceability of each unit from RBC → HBB → Patient<br><br>Source: Donor and unit identification system, issue/return registers, patient transfusion records, hemovigilance logs. | 20% | Ability to trace each unit from donor (RBC) through Hospital Blood Bank to the final recipient, and to capture/report transfusion reactions.<br>Formula: Traceability (%) = (sampled transfusion episodes with full traceability RBC → HBB → patient ÷ total transfusion episodes sampled) × 100.<br>Hemovigilance reporting rate (%) = (reported transfusion reactions ÷ transfusions where a reportable reaction occurred) × 100. |

| KPI | Target and Indicator | Weigh | Definitions and Formula |
|---|---|---|---|
| 7.5 Turnaround time for emergency transfusion support | Emergency transfusion support provided within ≤ 15–20 minutes<br><br>Source: Emergency request logs, communication records, RBC issue register with time stamps. | 15% | Time taken by RBC to provide emergency transfusion support to HBBs from receipt of urgent request to the issue of components. Formula: Emergency TAT compliance (%) = (emergency requests where components were made available within the defined timeframe (e.g., ≤ 15–20 minutes) ÷ total emergency requests) × 100. |
| **KPI 8. Outreach and Public Awareness (5%)** | | | |
| 8.1 Awareness campaigns | ≥1 major awareness event per quarter (Awareness campaign event attended by at least 500 people)<br><br>Source: Campaign plans, event reports, attendance sheets, media reports. | 30% | Number and scale of public awareness campaigns on blood donation conducted by the RBC. Formula: Campaigns conducted (number) = count of major awareness events per quarter. For scale, ≥ 500 attendees can be confirmed by registration lists or venue capacity estimates. |
| 8.2 Collaboration with universities / NGOs | ≥2 active partnerships per year (Active partnerships mean collaborating for events and awareness drives)<br><br>Source: MoUs, partnership agreements, joint event records, outreach calendar. | 25% | Active partnerships with universities, colleges, NGOs, or community groups for blood donation promotion.<br>Formula: Active partnerships (number) = count of organizations with at least one joint activity, MoU or event in the year. |
| 8.3 Youth engagement drives | ≥1 per quarter<br><br>Source: Outreach and campaign records, event reports, school/college visit logs. | 25% | Targeted blood donation or awareness drives focused on youth (schools, colleges, universities, youth groups). Formula: Youth drives (number) = count of youth-focused drives conducted per quarter. |
| 8.4 Public feedback response rate | ≥ 80% addressed within 7 days<br><br>Source: Public feedback register, complaint management system, call center logs. | 20% | Timeliness of responses to public feedback, suggestions, or complaints related to RBC services. Formula: Timely response (%) = (feedback/complaints responded to or resolved within 7 days ÷ total feedback/complaints received) × 100. |

5. The technical/ procurement committee reviewed bidders'queries. The committee decided to add bidders' queries, and consultant's responses in RFP and upload the amended RFP on **EPADS.** The Chairman concluded the meeting with vote of thanks.

**Mr. Ahmad,**
Section Officer (H-III),
M/o NHSR&C
**(Member)**

**Dr. Soofia Yunus**
Director (Programs),
M/o NHSR&C
**(Member)**

**Mr. Hassan Haren Hote**
Deputy Secretary (P&D),
M/o NHSR&C
**(Member)**

**Dr. Shahzad Khurshid**
Deputy Secretary (H-I),
M/o NHSR&C
**(Member)**

**Mr. Kamran Farooq Ansari,**
Joint Secretary (Hospitals), M/o NHSR&C
**(Chairman)**

**Meeting**---------- Pre-bid Meeting Outsourcing.

**Dated: 02 / 12 /2025**

| Sr # | Name & Designation | Department/Organization | Contact # | Signature |
|---|---|---|---|---|
| | Kamran Farooq Ansari | Joint Secretary /M/o NHSR&C | | |
| 1. | Saeed Ullah Jan. | Capital Diagnostic Centre. Pvt. Limited | 0315-5139616 | |
| 2. | Dr. Shahzad Khurshid (DS. (H-I)) | M/O NHSREC. | | |
| 3. | M. Panis | PBA Head Pesh | | |
| 4. | DR. SOOFIA YUNUS | M/O NHSR&C. | 0333-5489197 | |
| 5. | Hassan Mot-e | DS(DEV), MONHSR&C | 0300-8502253 | |
| 6. | Rubab Kamran. | PHC Global | — | |
| 7. | Waqas Ishaq | Blood Bank Foundation | 0341 5041414 | |
| 8. | Tahir Ahmad | Alkhidmat Rural Hospital CBR Islamabad | 03325426615 | |
| 9. | Javaid Iqbal | ARHI CBR ISD | 0336-5521917 | |
| 10 | Shaukat Kamal | Hosp finance & IT HBS General Hospital | 03455520000 | |
| 11. | AMMAR JAFFRI | Sehat Plus (CDC) | 0300-8551479 | |
| 12. | Syed Nawazish | CPL | 0345-5556435 | |
| 13. | Indus Hosp. Foundation | Online (Zoom) | | |