

DOH Health Facility Guidelines 2019 Part F – Feasibility Planning



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Introduction

Healthcare as a Service as well as a Business requires the consideration of many factors to ensure safe and appropriate operations which are financially sustainable. Healthcare may have some elements which are common to other business types such as real-estate development, hotel operation, retail facilities etc. However, in reality it remains a distinct and specialised field requiring a thorough understanding of the parameters affecting the business, service delivery, competitive landscape and financial success. This is the arena of Service Planning for Healthcare. It relates to the analysis of Supply, Demand and Service Gaps. It covers the choice of services after the consideration of market gaps and competitive landscape.

This Part (Part F) covers the key aspects of Service Planning for Healthcare. It is mostly advisory, providing the techniques, terminology and methodology used by the operators and professionals in the consideration of healthcare developments. It will allow the investors, operators, consultants and DOH officials to talk the same language and minimise misunderstandings.

This Part (Part F of the DOH-HFG) allows project stakeholders including clients, funders and regulators to directly refer to the provisions of this Part and require compliance or otherwise as appropriate.

This Part provides the means for the DOH to create a link between Service Planning and Licensing in the future if it chooses to do so based on policy directions and Government directives.

The DOH-HFG has a number of fundamental objectives which are set out in Part A as follows:

- Establish the minimum acceptable standards for Health Facility Design and Construction;
- Maintain public confidence in the standard of Health Care Facilities;
- Determine the basis for the approval and licensing of hospitals;
- Balance Supply and Demand, prevent localised over-supply and promote services in the areas of the greatest supply Gap;
- Provide general guidance to designers seeking information on the special needs of typical Health Facilities;
- Promote the design of Health Facilities with due regard for safety, privacy and dignity of patients, staff and visitors;
- Eliminate design features that result in unacceptable practices; and
- Eliminate duplication and confusion between various standards and guidelines.

These objectives promote and enable safe, reliable and appropriate healthcare through Private or Public facilities. However, the realisation and long-term operation of healthcare facilities will require additional considerations from the earliest stages of planning to completion and operation.



Disclaimer

Although the quality of design and construction has a major impact on the quality of health care, it is not the only influence. Choice and configuration of Healthcare Services, management practices, models of care, staff quality and regulatory framework potentially have a greater impact. Consequently, compliance with these Guidelines can influence but not guarantee good healthcare outcomes.

Compliance with these Guidelines does not imply that the facility will automatically qualify for accreditation. Accreditation is primarily concerned with hospital management and patient care practices, although the design and construction standard of the facility is certainly a consideration.

The Department of Health will endeavour to identify for elimination any services, design and construction non-compliances through the review of licensing applications, design submissions and through pre-completion building inspections, however, the responsibility for compliance with these Guidelines remains solely with the applicant.

Any non-compliances identified during or after the approval process, may need to be rectified at the sole discretion of the Department of Health at the expense of the applicant.

Therefore, the Department of Health, its officers and the authors of these Guidelines accept no responsibility for adverse outcomes in Health Facilities even if they are designed or approved under these Guidelines.

These Guidelines are not exhaustive and do not cover every eventuality that may or may not occur in the design, commissioning, operation or decommissioning of the health facility. Where there is conflict between DOH -HFG and existing laws, the latter takes precedence.

Live Documents as published on the DOH -HFG website should always be the only source of reference. Printed / downloaded version could be outdated as revisions are published on the website.



Structure of the Guidelines

These Health Facility Guidelines are divided into 8 volumes in order to present information in a comprehensive and logical sequence and avoid unnecessary duplication of information between sections:

Part A	Administrative Provisions • Approval process for Health Facility Licensing • Prequalification of Health Facility Design Consultants • Standards and Guidelines applicable to planning and engineering
Part B	Health Facility Briefing and Planning (this part) • Planning guidelines • Role delineation level • Functional Planning Unit incorporating Description of each Unit • Functional Relationships with diagrams • Schedule of Accommodation for typical units • Standard Components Room Layout Sheets and Room Data Sheets
Part C	Access, Mobility and OH&S • Space standards • Human Engineering • Ergonomic considerations • Accessibility requirements • Signage guidance • Safety and mobility considerations for floors, grab rails, doors, windows
Part D	Infection Prevention and Control • General principles applicable to health facilities • Hand hygiene • Sources of Infection • Isolation Rooms • Surfaces and Finishes • Construction and Renovation
Part E	Engineering – Building Services • Electrical / ELV & ICT • Mechanical (HVAC) • Water Systems • Drainage Systems

	• Medical Gas Systems • Fuel Systems • Pneumatic Tube Systems • Fire Protection Systems (Special Areas Only) • Applicable Standards
Part F (This Part)	Feasibility Planning and Costing • Needs analysis • Risk Analysis • Funding strategies • Procurement strategies
Part G	Acoustics • Architectural Elements • Mechanical Services – Noise and Vibration • Public Health Services – Noise and Vibration • Electrical Services • Lift Specification
Part H	Costing • Project Costing • Revenue and Profitability • Options Evaluation • Funding Strategy • Procurement Strategy • Capital Costing Guidelines • Cost Benchmarking Issues

Each part includes relevant guidance and reference material for readers to obtain further information.

1. Terms & Abbreviations

Abbreviations used in this volume include:

Abbreviation	Meaning
FPU	Functional Planning Unit
DRG's	Diagnosis Related Groups
IRDRG's	International Refined DRG's (IRDRG's)
ICU	Intensive Care Unit
RDL	Role Delineation Level (1 to 6)
SOA	Schedule of Accommodation
SRG's	Service-Related Groups (or Specialties)

1.1 Background.

In recent years it has become increasingly obvious that some healthcare projects are not properly considered in terms of feasibility, correct market assessment and provision for correct costing or funding. Some proponents appear to treat healthcare as a real-estate investment business rather than a critical, viable and sustainable service-oriented business.

Some projects are submitted to the health authorities for approval and licensing but are not necessarily built. The viability of some projects are not properly or realistically assessed at the start, resulting in un-realized or failed projects. Furthermore, the health authorities may have certain policies which govern the location of centralised, specialised, expensive and rare health services. Planners need to be aware of such policy directions and take them into account early in the planning process.

Some may reason that private healthcare facilities, as businesses, should be allowed to fail; that the health authorities should not be concerned with the viability of private businesses. Others reason that public healthcare facilities are not subject to the profitability concerns of private healthcare and therefore, the health authorities should not be concerned with their feasibility. However, there is strong evidence that the consideration of the sustainability of business both for the private and public sector is in the best public interest. Both over-provision and under-provision within a population catchment can result in in-efficiency and other service problems, especially in relation to Hospitals.

Over-provision in specialised services can result in a reduction of patient volumes for all facilities within the catchment. Reduction in the volume can then result in the lack of exposure to sufficient patient cases to maintain the quality of healthcare as well as the skill level of the clinicians. Under-provision (or service GAP) which is not detected or appreciated by investors and operators can also be a problem as it can result in unacceptable waiting lists or force the patients to seek treatment outside the Country at a substantial additional cost.

Public and private healthcare facilities which ultimately prove to be financially or operationally unsustainable and are not realised, resulting in:

- waste money, time and energy
- use the resources of health regulators and licensing agencies
- give a false impression of up-coming future supply in healthcare
- affect the health authority's "Capacity Planning" due to unreliable supply estimates
- discourage other proponents from entering the market
- create a negative outlook for the healthcare business within the financial sector
- make the funding of new facilities harder
- distort the land-allocation decision-making for healthcare purposes.

In the case of facilities which are built but are found not to be sustainable as a business:

- the dependence of the patients and clinicians on the service facility cannot be maintained
- the quality and safety of operation is reduced to meet costs
- staff numbers and skills tend to be reduced to a minimum at a risk to the patients
- consultants and contractors are not paid, or payments are delayed
- services which were indicated in the licensing application are not delivered
- healthcare becomes increasingly un-affordable and inequitable

In the case of specialised and regional health services:

- some low volume but high complexity services can only be provided safely from a few pre-approved central locations with adequate concentration of expertise, clinical skills and support facilities
- most high volume, low complexity services can be distributed between central and remote areas subject to the provision of the necessary facilities and staff.

1.2 The Purpose of Part F

Part F covers various subjects under feasibility planning and costing. It is a framework for the healthcare industry to consider in conjunction with the licencing process and provides a possible methodology to be followed in preparation for the licensing applications.

Specialists and those experienced in feasibility planning and costing can use their own methodology as long as they consider the relevant issues as stated in this Part. Alternatively, Part F provides a simplified methodology with supporting templates which may be used.

1.3 The Structure of Part F

Part F covers the process of Feasibility Planning and Costing under the following structure:

- Executive Summary
- Strategic Context
- Investment Objectives
- Needs Analysis (Demand, Supply, Gap)
- Competitive Landscape
- Proposed Services and Facilities
- Options Generation and Evaluation
- Project Costing (Capital and Recurrent)
- Risk Analysis
- Financial Appraisal
- Options Selection
- Funding Strategy
- Procurement Strategy
- Timeframe and Staging
- Feasibility Self-check
- Deliverables

1.4 Feasibility Planning and Costing

In the context of these Guidelines, “Feasibility Planning and Costing” is a process for the evaluation, documentation and approval of projects to assist with the development and procurement of sustainable healthcare infrastructure.

In the case of private facilities, they must be based on sound business principles, be capable of capital and recurrent funding and long-term operation. Public facilities must demonstrate value-for money and clear, holistic benefit to the community.

1.5 The terms used in these Guidelines

“Feasibility Planning” is a generic term used within these Guidelines. The same (or very similar subjects) may also be referred to as:

- Certificate of Need (CoN)
- Needs Analysis
- Feasibility Study
- Business Case
- Business Plan
- Service Procurement Plan

- Project Feasibility Plan
- Project Development Plan (PDP)
- Financial Assessment

Within these Guidelines reference is made to “Service Lines” and “Diagnosis Related Groups” or DRG’s. Consultants and industry groups may also be familiar with other terms which partly or wholly cover the meaning of these terms such as:

- Specialities
- Clinical Services
- Clinical Specialities
- Medical Disciplines
- Health Related Groups (HRG’s)
- International Refined DRG’s (IRDRG’s)
- Service Related Groups (SRG’s)

The applicants and consultants are encouraged to adopt the terms used in these Guidelines.

Similarly, the “Costing”, both Capital and Recurrent referred to in these Guidelines may already be available for the given project under different titles such as:

- Cost Estimate
- Budget Estimate
- Cost Plan
- Order of Cost
- Priced Bill of Quantities
- Pre-tender Estimate
- Running Cost
- Operational Cost
- Internal Rate of Return
- Cost Benefit Ratio
- Net Present Value.

If such documents are available for the given project, they may well satisfy the requirements of Feasibility Planning. In such a situation, the minimum requirement of compliance with Part F of these Guidelines is to:

- present the conclusions of the Study/Plan/Estimate into a format similar to the “deliverables” defined in this Part
- complete and attach the required checklist
- attach a copy of the original document (if any)

In order to minimise misunderstandings and promote effective communication within the industry, in all applications to the DOH and documents specifically produced for submission to the DOH, only the terms used in these Guidelines should be used. If other documents are supplied in support of the applications to the DOH, the clear meaning of the terms used in said documents under the terms of these Guidelines should be stated in a cover page, cover letter or similar communication.

Many complex issues can be expected in every proposal. These guidelines make no attempt to predict all such circumstances or provide a perfect solution for all conditions. These guidelines are not exhaustive. The key issues and expectations are covered with descriptions which apply to most facilities. Applicants and users of these Guidelines should apply the principles stated or implied in these Guidelines to circumstances which are not explicitly covered.

The key steps of Feasibility Planning and Costing are described in the following sections. Care should be taken not to repeat the same subject, but rather remain focussed and concise. If a subject does not apply to the given circumstances, a simple statement to this effect should suffice. As far as possible, the language of the study should be clear, simple and non-academic. The terminology used should match those used in these Guidelines.

2. Methodology

Feasibility Planning involves a methodical study, which is documented and presented to assist in sound decision-making by private and public healthcare facility owners, operators, investors and developers. The minimum typical structure is described below.

2.1 Executive Summary

Provide a one-page summary of the proposal and cover as a minimum the following:

- Name of the project
- The author of the Feasibility Study/ Plan
- Location – may be provided through a diagram or map
- Key features
- Key quantities, numbers, size
- Timeframe for delivery
- Estimated Capital Cost/ Intended investment

2.2 Strategic Context

The study should briefly establish the strategic context of the proposal. The typical elements of the strategic context, depending on the subject of the study may include:

- The regulatory framework
- The current state of the healthcare industry
- Population profile
- Existing facilities reaching their limits or too hard to upgrade
- New neighbourhoods and population centres
- New technology changing the patients' expectations
- Market opportunities, including Medical Tourism
- Opportunities to introduce new treatments
- Desire for healthcare reform and increased efficiency
- New Models of Care to suit new facilities and treatments.

2.3 Investment Objectives

Each project involves an investment of time, money and valuable human resources. Here, the study should briefly describe the main Objectives of the Investment. The stated objectives should be an honest representation of the aims rather than what may be regarded as the “expected” answer.

So, the Investment Objectives should be about what needs to be achieved rather than immediately justifying the pre-conceived solutions. The Investment Objectives should be used as a basis for the evaluation of the options within the study. Typical Investment Objectives may be:

New Facilities and Services:

- Create and run a profitable healthcare business to meet the needs of the growing population
- Expand the existing network of services to focus on the growing demand, for example, integrated Oncology Services

- Create a new facility in a new population catchment which is not well served by existing facilities
- Create a new Clinical Services block to replace the existing, ageing facility which no longer complies with the required facility guidelines

Existing Facilities and Services

In the case of existing facilities being upgraded, describe the key problem areas which have been identified, together with the opportunity to improve through the project development.

The problems may have been reported by the staff, through a complaint processing system, via regulator inspections or advice from consultants. Opportunities may be identified through internal consultation with the staff, engagement of specialist consultants, research or by following the recommendations of the Guidelines. The following should be covered on a case by case basis, when applicable:

Problems

- Major reported problems
- Complaints from patients
- Complaints from staff
- Capacity constraints
- Internal risk assessment reports
- Conditions of Accreditation inspections
- Non-compliances with DOH Guidelines

Opportunities

- Minor or major refurbishment/ remodelling of facilities
- Expansion of facilities
- New facilities
- Change of use
- Change of Models of Care
- Introduction of new systems and technologies
- Introduction of new services.

2.4 Needs Analysis

It is necessary to follow and demonstrate a rational process of Needs Analysis as the foundation of the proposal. Refer to the components of the Abu Dhabi Capacity Plan, published by the DOH from time to time for fundamental and locally specific service planning information. The minimum steps required are as follows;

2.4.1 Define Health Service Catchment

Define the catchment for the proposed services and facilities. Depending on the nature of the proposal, this may be a simple statement of:

Population Numbers	The current or future population to be served e.g. 750,000 in 2012, projected to grow to 1m by 2025. The basic information on population numbers may be obtained from relevant health authorities and statistical centres.
Geographic Definition	Define the geographic catchment intended or estimated e.g. 80% of the new residential neighbourhood of XYZ and 15% of the each of the adjoining neighbourhoods.

Population Type	Define the population types targeted e.g. citizens, residents and inflows from other regions/countries.
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The above may be defined and described by words and schedules and, when appropriate and possible, by maps.

2.4.2 Health Service Demand Assessment

The study should provide an estimate of the minimum demand for the intended healthcare services in the catchment. The methodology used is not prescribed, but the study should honestly declare its assumptions.

In order to assist the health industry and to provide a common platform for the study of healthcare demand, the DOH may occasionally provide service planning information such as extracts from the Abu Dhabi Capacity Plan etc. The use of such information is at the planners' sole risk. The DOH makes no representations in relation to the accuracy of the information or its application to the particular project.

If no particular methodology is preferred, then the following methods may be considered:

Method 1- projection of past trends

In this method a few years of historic data can be examined to establish a trend. For example, if there is evidence that the demand for Maternity or Emergency beds has been growing by 3% P/A for the last 5 years and the current facilities have reached capacity, there is a possible indication of demand over the next few years. The study may start with the core services and then add all the support services which enable or enhance the core services.

A simple trend-based projection of demand has the advantage of speed and is most useful for the expansion of the existing facilities. In such facilities, if there is no intention to fundamentally reform the operations, the continuation of the trends can be intuitively judged and reasonably estimated. However, comparison to new services or trends obtained from facilities with vastly different circumstances can sometimes be misleading. The study should then apply, as far as possible correction factors or assume certain risks and address them.

Another risk in the use of past trends is encountered when the sample is too small or too old.

As a rough guide, trends of less than 5 consecutive years or trends older than 5 years should not be used.

In circumstances where there are observed in-efficiencies in the current operation, the projection of those trends into the future would also carry the in-efficiencies forward. So, before such trends are used, the study should declare if there is any expectation or plan for efficiency gains through operational reforms. If so, the trends should be adjusted accordingly.

Method 2- Benchmarks

In this method, a simple benchmarking process is used to apply the experience in one location to another, similar location. For example, a new population centre may not currently be served by healthcare facilities, requiring the patients to travel long distances. This may be compared with similar population centres which are served by a few, busy and profitable healthcare facilities. In this example a benchmark comparison is used to conclude that there is a demand for at least one new healthcare facility (of a certain size and description) within the new population centre.

Method 3- pure population-based demand

This is possibly the most detailed and scientifically accurate method of demand projection. However, it will most likely require a specialist Service Planner to prepare the study and avoid possible pitfalls.

In a pure population-based demand study the data representing the healthcare activity of a reference population with a satisfactory health care system and outcome is used as a starting point. Then the

activity rates are applied to the current and project population of the study catchment to arrive at the demand. This is another form of benchmarking, but at a much more granular level. The lowest common unit of the reference data is typically Diagnosis Related Groups (DRG's) which are then grouped together to represent Specialties. In practice, the reference data requires customisation and manipulation to correctly represent the current and future population profile of the study catchment where "Burden of Disease" may be different. Therefore, this type of study requires high levels of skill and the use of various service planning tools available to specialists.

Once the activity is projected, then it can be converted into Key Planning Units or KPU's (Beds, Operating Rooms, ICU bays, LDR rooms, Consultation rooms, ED cubicles etc. based on formulas which take into account many factors such as Average Length of Stay (ALS) and Occupancy percentage, utilisation rates etc.

Method 4- use tools provided by the DOH

DOH is in the process of establishing software tools to provide automated information for Certificate of Need (CoN). This system will allow applicants and consultants to test which services are allowed or dis-allowed in certain locations based on a number of factors:

- Centralised services are generally not allowed
- Regional services are allowed as long as they are not in an area with more than 40% over-supply
- Standard services which are allowed in all locations at an unlimited quantity

The results are provided at a Specialty level with some helpful additional information.

This automated CoN information, generated online can be immediately used by the applicants as part of their Feasibility Planning and submissions to the DOH.

2.4.3 Health Service Supply Assessment

As far as possible the supply of similar healthcare services within the same catchment needs to be assessed. The comparison of Supply with Demand will require the use of the same units of measurement. The choice of unit depends on the preference of the proponents and their service planning advisors, but may include categories such as:

Key Planning Units or KPU's (Default in these Guidelines) including:

- Acute Beds
- Same day Beds
- Operating Theatres
- Emergency Department Cubicles
- LDR Birthing Rooms
- Diagnostic facilities (MRI, CT, PET etc.)
- Consulting Rooms

Some of the above KPU's such as Acute Beds may be further broken down into Adult vs Paediatric, Medical vs Surgical or classified by Specialties (or Service Lines).

Alternatively, the following activity-based supply measures may be used:

- Bed days
- Admissions
- Discharges
- Separations
- Episodes of Care
- Occasions of Service

- Operations P/A
- Presentations P/A
- Scans P/A

In practice, most Private (and some Public) healthcare facilities keep their activities confidential.

This can make the Supply Analysis difficult or unreliable, if there is too much reliance on such confidential information. Given the reality of the competitive market, it is often easier to obtain the KPU information from the facilities in the catchment as they are often proudly advertised or freely shared.

Alternatively, the applicants may consult the DOH healthcare mapping system available via a link on the DOH website. Furthermore, from time to time DOH may public extracts of the Emirate-wide Capacity Plan with good information on Supply, Demand and Gap by sector and by year. The DOH may also consider providing this information in a publicly available website but without any guarantee of accuracy.

Proponents are encouraged to visit the DOH website frequently and obtain the information as it becomes available.

2.4.4 Permissible and Restricted Health Services

The health services which are permissible by DOH should be verified as part of the Supply Analysis to avoid abortive work and disappointment. Even if the demand for certain services is identified, DOH may choose to regulate their provision due to operational and safety factors. Those making applications for licensing should use the DOH Certificate of Need web-based tool, when it becomes available on the DOH website.

DOH categorises the healthcare services as follows:

- Centralised Services
- Regional Services
- Standard Services

The above 3 categories may be allocated at a service Specialty (Service Line) and DRG level. The Feasibility Study must take these categories into account as part of the Supply and Demand Analysis and the proposed services for the given facility. The definitions of the above 3 categories are as follows:

Centralised Services

Central Services are generally those which involve high complexity, high risk and low volume service. These are best provided by a few centrally located facilities which are carefully selected, checked and monitored. The centralised provision of these services is intended to ensure the minimum safe volume which in turn attracts the best specialised clinical talent and maintains the level of skill required. Such restricted Centralised services are defined by the health authorities by service specialty or DRGs (Diagnosis Related Groups). Centralised services are generally subsidised by governments.

Allocation of centralised services to specific facilities will ensure that concentration of clinical experience can lead to improved clinical outcomes for patients, and a more efficient use of resources. Quality, access and cost outcomes are reviewed regularly, and Provider designation updated in light of these reviews.

Occasionally, the DOH may advertise such centralised services and seek applicants for their provision. These services may be provided in dedicated facilities which are granted the title of “Centre of Excellence” (COE). Services which are regarded as Centre of Excellent must be at the Role Delineation Levels 5 or 6 (refer to the Role Delineation Framework provided as an appendix to Part A the RDL Guide in Part B). The selected Centralized facilities (and COE’s) may be a combination of Public and Private health facilities of the highest quality.

The following table provides a guide to the Centralised Services:

Description	Examples	Providers
Highly specialised Strong volume-based competency Low volume High cost	Burns Care Open Heart Surgery Oncology Surgery Transplants	Public Hospitals Selected Private Hospitals

Regional Services

DOH may designate a limited number of “Regional” services, each serving a population of equal or greater than 250,000 residents (or other number as may be determined from time to time). These services may be provided by regional facilities subject to DOH approval. The Feasibility Study should check to see if the services and quantities proposed represent an over-supply of more than 40% in the proposed location. If such an over-supply is present, the DOH reserves the right to refuse the application for the affected service specialty or quantity (eg Beds).

The following table provides a guide to the Regional Services;

Description	Examples	Providers
Moderate complexity Time dependency Some volume-based competency Middle volume Middle cost	Cardiac catheterisation Specialist diabetes care	Public and Private

Important note: It is recognised that applicants may not be aware of the Regional Services which are already allocated to other providers or applicants. Therefore, the best course of action before proposing such Regional Services is to contact the DOH Investment and Capacity Planning Division (ICPD), describe the location and intended catchment and find out if there are any restrictions on the proposed services in that Region.

Standard Services

Other services for smaller population catchments, relatively low complexity and high volume may be provided by any licensed facility with an approved operator which complies with the requirements of these Guidelines.

The following table provides a guide to the Standard Services;

Description	Examples	Providers
Non-complex High volume Low cost	Basic diabetes care Family medicine Preventive services	Open market

2.4.5 Identified Health Service Gap

To put it simply, the Health Service Gap equals Demand minus Supply. This can be analysed for the current date as well as selected future dates (typically 5-year intervals).

In practice Service Gap is also affected by any planned healthcare reform which may interrupt the normal patterns of activity. For example, it may be reasonable to assume the gap will be smaller if a healthcare reform:

- Reduces the average length of stay over time
- Increases the occupancy level to the maximum recommended level (e.g. 85%)
- Reduces the need for hospital-based beds through the introduction of programs such as home-care, outreach, community care, ambulatory care, etc.

2.5 Competitive Landscape

No healthcare facility or service operates in isolation. The proponents for healthcare services should assume that at any given time, many other groups may be planning for the same identified service gap. This may be easier for the owners and operators of existing facilities than the proponents of entirely new facilities. It is also not unknown that as soon as there is preliminary news regarding a new facility, others will also take note and adopt defensive strategies, such as boosting service and upgrading their facilities in order to retain both their patients and the clinicians.

The competitive landscape is not only a concern for the private healthcare providers. In a marketplace strongly influenced by private insurance, public healthcare facilities may also be required to compete for patients and clinicians. One typical manifestation of this type of competition is where public facilities lose the relatively low risk, routine, standardised and day-only treatments to the private sector.

All of the above factors should be considered, and the proponents should satisfy themselves that the development is not overly sensitive to the competitive landscape.

Then any issues which arise from the above considerations should be recorded and strategies developed for market positioning, market differentiation, speed to market or synergies through associations, networking alliances and an established referral base.

The deliverable of Part F only requires a summary of the considerations rather than an exhaustive and detailed analysis. The proponents should indicate an understanding of the issues rather than try to convince a third party.

2.6 Proposed Services and Facilities

Considering the Identified Service Gap and the issues covered under the Investment Objectives and the Competitive Landscape, the study can then propose a range of viable services and facilities. The choices depend on the organisation's priorities and preferences; however, a methodical thought process and logical reasoning will be expected.

2.6.1 Private

In the case of Private facilities, the reasoning may be as simple as choices which have the best chance of financial return or improved market share. Private Healthcare operators are not obliged to cover all specialties or the whole of the population catchment. Effectively they can choose what they wish to offer as long as the proposed services are competently and safely delivered and approved by the DOH.

2.6.2 Public

In the case of the Public health sector, profit is not expected to be the driving force behind decisions and priorities, although the allocated annual budget still needs to be met. Instead the logical reasoning should focus on the achievement of the greatest benefit for the population catchment in line with the long- and short-term health authority policies for the given area.

2.6.3 Restricted Services

As previously explained, Private and public operators are advised to contact the DOH to enquire about the services which may be restricted to a few centralised facilities (or COE's). The applicant may also consult with Appendix 14 of Part A of these Guidelines.

Such services are typically those which require extensive resources and skills but involve relatively small number of patients. Such services are best provided from one or more central locations to maintain a minimum patient volume that justifies the provision of resources and maintains a concentration of specialised clinical skills. This in-turn will make the delivery of these services safer for the patients. Restricted services may be centralised or regional. From time to time DOH may inform the industry of the service specialties at DRG level which may be restricted.

2.6.4 Minimum Requirements

Ideally, for large and complex proposals, a dedicated Clinical Services Plan (CSP) should be commissioned and attached to the Feasibility Plan. However, the submission of an external CSP is not mandatory. In any event, the description of the Services and Facilities should be focussed on “What” needs to be provided rather than “How” it may be provided.

If a CSP is not produced at the same time as the Feasibility Plan, then the Operator should seriously consider preparing a CSP as part of the commissioning process, to guide the precise configuration of services in conjunction with the Human Resource Planning, Clinical Pathways, Models of Care and Reporting lines.

2.7 Options Generation

The purpose of Options Generation is to explore different ways of achieving the “Proposed Services and Facilities”.

Feasibility Studies for private facilities and services must include at least one option with a clear, brief and understandable description. Since these Guidelines (Part F) are part of the overall DOH Health Facility Guidelines, it is expected that most of the details of the proposal are already covered under the guideline requirements. Therefore, they should not be repeated here. The additional details which are developed from meeting these requirements are:

- Project synopsis
- Drawings (either Schematic or Detailed)
- Schedules of Accommodation
- Various attachments and reports

Ideally, the private healthcare proponents should consider more than one option before selecting one (see the next section).

In the case of Public Health sector, the generation of multiple options is mandatory in order to demonstrate that the best solution is identified in the public interest. In this context, the options for public healthcare facilities should follow these guidelines:

- The options should be sufficiently clear to permit easy evaluation or short-listing
- None of the obvious options should be missed or dismissed
- In the case of the upgrading of existing facilities and services, Option 1 must always be: “Do Nothing – keep safe and operating”, even if, in the opinion of the project stakeholders, it is unrealistic and unwise. This option will be seen as the base-case.
- When possible, options for the refurbishment of existing facilities should be contrasted against options for new facilities
- As far as possible lower cost options should be contrasted against higher cost options
- Options which immediately show greater potential may be detailed to a greater degree
- After a preliminary review of the options with the project stakeholders, a smaller number of options may be shortlisted for costing and evaluation. The minimum number of options for public healthcare facilities is 4 including the base case “Do Nothing”.

3. Appendix 1 – Feasibility Study Template

The Owners or Operators of Health Facilities are required to provide a Feasibility Study (or Certificate of Need application) as part of the licensing process described in these Guidelines. A feasibility study is required only for Hospitals and Day Surgery facilities. For other facility types a feasibility study is optional and recommended, however it is not mandatory.

The template which appears on the following page may be completed and used for this purpose. Alternatively, if a separate, Feasibility Study has already been prepared by specialists, then its conclusions without further elaboration may can be inserted into the template and submitted along with a full copy of the original Feasibility Study.

If any of the hospital services and quantities change through the various Steps of licensing, such as Schematic Design or Detailed Design, then the Feasibility Study needs to be updated and re-submitted for approval.

Insert Health Facility Name

Feasibility Study Template

Date: <DD.MM.YYYY>
Version: <1>
Prepared by: <enter the name of the author>
Contacts: <enter the author's company name, telephone and email>
Prepared for: <owner or operator>
Contacts: < enter the Owner or Operators name, telephone and email>
Application Status: <choices are Schematic Submission or Detailed Submission>
Facility Type: <as per the standard facility types, see **Part A - Appendix 11**>

<Optionally insert project perspective>

Table of Contents

<Provide a table of contents and page numbers>

1 – Executive Summary

<One page free form text for executive summary. Try to incorporate a short paragraph related to each of the subjects that follows>

Name of the project and introductory text

—

The author of the Feasibility Study

—

Location- provide a small diagram or map

—

Key features

—

Key quantities, numbers, size

—

Timeframe for delivery

—

Total Capital Cost

—

2 – Strategic Context

<Briefly describe the strategic context of the proposal>

3 – Investment Objectives

<Briefly Describe the Investment Objectives>

New Facilities and Services (if any)

Existing Facilities and Services (if any)

Problems and Opportunities

4 – Needs Analysis

Health Service Catchment

Population Numbers

—

Geographic Definition

—

Population type

—

Health Service Demand Assessment

<list by the chosen unit e.g. KPU's such as Acute Beds, Same day Beds, Operating Theatres, LDR Birthing Rooms etc. or activity measures such as Bed days, Admissions, Separations, Episodes, Operations, ED Presentations P/A etc.>

Health Service Supply Assessment

< list by the chosen unit e.g. KPU's such as Acute Beds, Same day Beds, Operating Theatres, LDR Birthing Rooms etc. or activity measures such as Bed days, Admissions, Separations, Episodes, Operations, ED Presentations P/A etc.>

Permissible and Restricted Health Services (if any)

<Quote any guidance from the DOH in relation to any restricted health services such as Centralised or Regional services. Describe compliance or otherwise >

Identified Health Service Gap

< list by the chosen unit e.g. KPU's such as Acute Beds, Same day Beds, Operating Theatres, LDR Birthing Rooms etc. or activity measures such as Bed days, Admissions, Separations, Episodes, Operations, ED Presentations P/A etc.>

5 – Competitive Landscape

<Briefly Describe the competitive landscape>

6 – Proposed Services and Facilities

< list by the chosen unit e.g. KPU's such as Acute Beds, Same day Beds, Operating Theatres, LDR Birthing Rooms etc. or activity measures such as Bed days, Admissions, Separations, Episodes, Operations, ED Presentations P/A etc.>.

<Demonstrate that the proposed services and facilities are within the identified service gap>

<Optionally, prepare and attach a Clinical Services Plan (CSP). Make references to the CSP (if any) in this section.>

Make reference to the completed Pro-forma from Part A- appendix 15 – Pro-forma for the proposed Service Lines and DRG's. Provide the completed proforma in the Appendices.

7 – Options Generation and Evaluation

—

Options Considered

<Briefly Describe one or more options considered for private facilities>

<Briefly Describe a minimum of 4 options considered for public facilities. Option 1 must be:

Do Nothing, keep safe and operating>

Options Evaluation

<Provide a simple and short evaluation matrix>

Option Recommended or Adopted

—

8 – Project Costing

<Refer to an attached Costing Report with all the required details, or complete this section with the minimum requirements of costing>

Capital Cost

<Provide a simple table with the required minimum information complying with the methodology used in Part F Appendix 1- Capital Costing Guidelines>

NET Construction Cost (NCC)

Departmental (FPU) costs by category:

- New construction
- Major refurbishment
- Minor refurbishment

Gross Construction Costs (GCC)

Add the following to NCC:

- Preliminaries Costs
- Contractors Margin
- Design Contingency

Total Project Costs (TPC)

Add the following to GCC:

- Construction Contingency
- Consultants Fees
- Authority Charges
- Other Charges
- Add the cost of Furniture, Fittings, Fixtures and Equipment (FF&FE):

Notes:

Refer to Part H Costing Guidelines for more specific information on the costing parameters and calculation methodology.

Total End Cost (TEC)

Add escalation to TPC to arrive at TEC

Transition Costs

<Provide the transition costs with a short description, if any>

Decanting Costs

—

Temporary Facilities Costs

—

Recruitment Costs

—

Change Management Costs

—

Opportunity Costs

<Provide opportunity costs, if any>

Income loss

Income gain

Recurrent Cost

<Provide a short summary of the anticipated running costs>

Human Resource (HR) costs

- Doctors

Goods and Services (G&S) Costs

- Administration
- Domestic Supplies and Services
- Drugs
- Equipment Leasing
- Food Supplies
- Medical & Surgical Supplies
- Motor Vehicle Expenses / Travel
- Other Goods and Services
- Patient Transport (Incl. Ambulance)
- Rental Accommodation
- Repairs Maintenance and Renewals
- Support & Special Services
- Utilities
- Insurance and Legal
- Other

Total Recurrent Costs

<Sum of HR and G&S for the first year of operation and escalate to 4 following years of operation.>

Life Cycle Cost

<Provide Life Cycle Costs and NPV analysis of all options, only if required in writing by the client or the DOH.

9 – Revenue and Profitability

<For Private Facilities, provide a summary of the expected revenue and profitability based on the services proposed>

<For Public Facilities, replace this section with a discussion of Public Benefit>

Revenue

Profitability

10 – Options Evaluation

<Provide a tabulated Options Evaluation matrix and include the mandatory requirements>

Options Matrix

Options name and short description (Min.1 for Private and 4 for Public facilities)

Summary of KPU's for each option

Summary of SOA (as a Minimum, state total GFA)

Cost Summaries (including Capital, Transitional, Opportunity, Recurrent and Life Cycle)

Revenue and Profitability

Short remarks in the context of the Investment Objectives

Short remark under each of the evaluation criteria

Short discussion of the expected risks and risk mitigation

Options Selection

<Free form text to briefly describe the reasoning for selecting one option>

Financial Appraisal

<At the written request of the Health Authority, provide an independent Financial Appraisal and refer to it in this section. Provide the full copy in the appendices>

11 – Funding Strategy

<Provide a short description of the funding strategy>

Capacity to Fund

<Refer to the evidence of capacity to fund the project and provide the evidence in the appendices>

12 – Procurement Strategy

<Provide a short description of the procurement strategy (method of delivery) including the minimum mandatory requirements>

Timeframe and Staging

<Provide a table of key dates or a bar chart>

Contract Type

<Nominate the intended contracting methodology (which may change later)>

Governance Structure and Reporting

<Provide a short outline of the Governance Structure>

13 – Feasibility Self-check

<Provide a completed and signed Feasibility Study Self-Check table>

14 – Appendices

<Provide all the items which are referred to the appendices in the body of the Feasibility Study including externally sourced reports such as costing and proof of capacity to pay.