**Innovation Challenge 2023 -**

**Sustainable Health Priorities**

# **Application Form**

**Due by: 1:00 pm (AWST) Tuesday 15 August 2023**

* ***Please refer to the relevant*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities) ***which include application instructions.***
* ***Applicants are responsible for complying with internal deadlines and ensuring all certifications are complete prior to submission.***

## Minimum Data Form

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| --- | --- |
| Minimum Data Form submission date  *Mandatory eligibility requirement* |  |

Provide details if anything on the Minimum Data Form has changed in this application.

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## Activity title

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## Activity summary

Provide a plain language summary of the proposal, including the aims, objectives, significance and expected benefits in the context of the relevant Sustainable Health Priority area. This summary may be used for publicity purposes.

*[Maximum 250 words]*

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## Funding request

The information provided below must align with the ‘Budget request’ table.

|  |  |
| --- | --- |
| Amount requested (ex GST)  *Between $150,000 and $450,000* | $ |

## Sustainable Health Priority area

Select the **one** Sustainable Health Priority area which is most applicable.

Refer to the [Sustainable Health Review (SHR) Final Report to the Western Australian Government](https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf) to ensure the stated problem and proposed solution are appropriately aligned with the selected area. Additionally, for Sustainable Health Priority area 8 refer to the [*WA Genomics Strategy 2022-2032*](https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Population-health/WA-Genomics-Strategy-2022-2032-Towards-Precision-Medicine-and-Precision-Public-Health.pdf).

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| 1 | Improve timely access to outpatient services. *(Recommendation 11)* |  |
| 2 | Implement models of care in the community for groups of people with complex conditions who are frequent presenters to hospital. *(Recommendation 13)* |  |
| 3 | Implement a new funding and commissioning model for the WA health system focused on quality and value for the patient and community. *(Recommendation 17)* |  |
| 4 | Invest in digitisation of the WA health system to empower citizens with greater health information. *(Recommendation 22)* |  |
| 5 | Build a systemwide culture of courage, innovation and accountability to support collaboration for change. *(Recommendation 23)* |  |
| 6 | Build capability in workforce planning and formally partner with universities, vocational training institutes and professional colleges to shape the skills and curriculum. *(Recommendation 26)* |  |
| 7 | Implement models of care for people to access responsive and connected mental health services in the most appropriate setting. *(Recommendation 7)* |  |
| 8 | Implement genomics-based precision medicine and precision public health solutions.  *(Recommendation 28)* |  |

## Innovation Maturity Level (IML)

|  |  |
| --- | --- |
| Select the current IML of the innovation  *Must have at least completed IML 3 and have not completed IML 6 (see Guidelines and Conditions Appendix 1)* | IML 3 – Proof of Concept (stage must be completed)  IML 4 – Proof of Feasibility  IML 5 – Proof of Value  IML 6 – Preliminary Validation (must not be complete) |
| Select the IML of the proposed innovation activity  *Must be within the range of IML 4 to IML 6 (see Guidelines and Conditions Appendix 1)* | IML 4 – Proof of Feasibility  IML 5 – Proof of Value  IML 6 – Preliminary Validation |

## Activity classification

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| --- | --- |
| **Burden of Disease** (select one disease)  *Downloadable Australian Institute of Health and Welfare* [*Australian Burden of Disease Study*](https://www.aihw.gov.au/reports/burden-of-disease/abds-methods-supplementary-material-2018/data) *Table 2.1* |  |
| **Keywords** (up to 5)  *Available from NHMRC*  [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Researcher > My Applications > Keyword Library* | 1.  2.  3.  4.  5. |

## Responsible Entity

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| Name of Responsible Entity  *Entity which will administer grant funds* |  |
| ABN |  |
| Address  *Must have a physical and operational presence in WA* |  |
| Contact officer name  *Person responsible for grant administration* |  |
| Contact officer position |  |
| Contact officer email address |  |

## Activity Lead

Provide the details of the Activity Lead. Insert an abridged (two-page maximum) Curriculum Vitae (CV) which includes key innovation achievements over the last 5 years. CVs can be inserted at the end of this application form.

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| ORCiD (if relevant)  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  |
| Citizenship/residency status | Australian citizen  Australia permanent resident  New Zealand citizen  appropriate work visa |
| Within which area are you located | Perth metropolitan  Regional and remote |
| Grant arrangement  *Refer to ‘Eligibility’ section of the Guidelines and Conditions* | (a) employee of the Responsible Entity  or  (b) honorary or adjunct title at the Responsible Entity |
| If response to grant arrangement is (a), indicate further details | Position: |
| If response above is (b) and there will be an arrangement with an Employer, indicate further details | Title at Responsible Entity:  honorary  adjunct |
| Intended grant arrangement:  via affiliation agreement  subcontract to Employer |
| Employer: |
| Position: |
| Employer has a physical & operational presence in WA:  Yes |
| Affiliated entities, position/title  *List all entities that the Activity Lead is affiliated with, other than the Responsible Entity or Employer listed above. Identify if adjunct or honorary position.* |  |
| Discipline/Profession |  |
| Clinician Profession  *Note: this is collected for statistical purposes only* | Not applicable  Allied health and health sciences  Dentistry  Medical Practitioner  Nursing & Midwifery |
| Research career stage  *An Early-Career researcher has held their PhD for no more than 5 years from the date that their PhD was passed and a Mid-Career researcher no more than 10 years as at the time of application, taking into consideration any career disruptions as defined in the* [*NHMRC Relative to Opportunity Policy*](https://www.nhmrc.gov.au/about-us/nhmrc-policies-and-priorities)  *Note: this is collected for statistical purposes only* | Not applicable  Early-Career  Mid-Career  Post Mid-Career |
| Primary telephone number |  |
| Primary email address |  |
| Primarily based in WA  *Confirm that you will be based in WA for a minimum of 80% during the grant.* | Yes |
| Completed the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course | Yes No |
| CV attached  *Maximum two pages* | Yes |

## Team members

Provide details for each of the team members involved in the Activity. This will include team members associated with the Responsible Entity, and any other participating organisations.

To demonstrate the capacity of the team and its suitability to conduct the Activity, insert an abridged (two-page maximum) CV of each team member, which includes key innovation achievements from the last 5 years. CVs can be inserted at the end of this application form.

Insert additional team member tables as required.

|  |  |
| --- | --- |
| **Team member 1** | |
| Title, First Name, SURNAME |  |
| ORCiD (if relevant) |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| Primary telephone number |  |
| Primary email address |  |
| Completed the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course | Yes No |
| CV attached  *Maximum two pages* | Yes |

## Significance of the problem (20%)

Describe the following:

1. The problem that the proposed innovation would address.
2. The aspect of the relevant Sustainable Health Priority area the problem relates to.
3. The relevance and scale of the problem in WA.
4. The importance of addressing the problem in the WA health system.

*[Maximum 500 words]*

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## Proposed solution (25%)

Describe the following:

1. The appropriateness of the solution to address the stated problem.
2. The current Innovation Maturity Level (IML) of the innovation, and justification for this (see Guidelines and Conditions Appendix 1).

*[Note: Must have at least completed IML 3 and have not completed IML 6]*

1. The IML applicable to the Activity that will be undertaken, and justification for this (see Guidelines and Conditions Appendix 1).

*[Note: Must be within the range of IML 4 to IML 6]*

1. The impact that the solution will have on the identified problem.
2. The contribution the solution will make towards the relevant Sustainable Health Priority area.
3. The economic, social and environmental benefits of the solution to WA.
4. The differentiation between the proposed innovation and any existing or emerging competing processes, products and/or services.

*[Maximum 500 words]*

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## Activity plan (15%)

Describe the following:

1. The activity that will be undertaken, including objectives, methodology and realistic measures of expected outcomes.
2. The contribution the activity provides towards the proposed solution.
3. The achievability of the proposed milestones and timeframe.
4. The proposed budget to undertake the activity and justification for budget items, including any proposed salary components.

*[Maximum 2000 words]*

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List the major milestones for the Activity and their duration in months.

Milestone activity commences upon execution of a Grant Funding Agreement or Memorandum of Understanding (as appropriate). Include separate milestones as applicable, for example, ethics and governance approvals, employment of staff, data collection, participant recruitment and data analysis.

The Activity must be completed within 2 years.

*Note: If ethics/governance approval is required for the activity, this must be achievable within the Activity period.*

| **No** | **Milestone**  *(insert additional rows as required)* | **Milestone date**  *(in months from execution)* |
| --- | --- | --- |
| 1. | *e.g. prepare and submit ethics application* | *e.g. 1 month* |
| 2. | *e.g. recruitment of support personnel* | *e.g. 2 months* |
| 3. | *e.g. obtain ethics and governance approvals* | *e.g. 3 months* |
| 4. |  |  |
| 5. |  |  |

## Activity Lead track record and potential (10%)

Describe the following:

1. The contribution of the Activity Lead to the proposed activity, including the specific responsibilities towards the delivery of the objectives, methodology and outcomes.
2. The extent to which the Activity Lead’s expertise and experience will support the proposed activity.
3. The extent to which the Activity Lead demonstrates the ability to deliver the proposed solution.

*[Maximum 500 words]*

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## Supporting environment (10%)

Describe the following:

1. The knowledge, expertise and experience of activity team members.
2. The capacity and capability of the activity team to deliver the proposed activity.
3. Appropriate level of partner engagement and collaboration during both the development of the proposal and the conduct of the activity.
4. Access to technical resources infrastructure equipment and facilities and additional support personnel, if necessary.

*[Maximum 500 words]*

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## Consumer involvement (10%)

Describe the following:

1. How consumers (people with lived experience of a health issue, including patients and potential patients, carers and people who use health care services) have been involved in the development of the proposed activity.
2. The plan for ongoing consumer engagement in the activity, including their roles and how their lived experience perspectives will inform the activity through formal and informal processes.

Refer to the ‘Consumer involvement’ section of the Guidelines and Conditions.

*[Maximum 500 words]*

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Provide details of each consumer representative involved in the development of this proposal and/or proposed to be involved in the Activity. Note that named consumers must be aware of and agree to these statements and must provide certification if proposed to be involved in the Activity.

Insert tables as required.

|  |  |
| --- | --- |
| Title, First Name, SURNAME |  |
| Email address |  |
| Role in development of this proposal (if applicable) |  |
| Role in this Activity  (if applicable) |  |

## Anticipated implementation strategy (10%)

Describe the following:

1. The anticipated pathway for implementation, and commercialisation if applicable, considering financial sustainability now and into the future.
2. The anticipated partnerships/potential investors that may support implementation of the innovation.
3. The proposed risk identification and mitigation strategies considered in relation to implementation.
4. The scalability of the solution and expected long term benefits over time.

*[Maximum 1000 words]*

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## Budget request

List requested budget items.

The total budget must be between $150,000 and $450,000 ex GST over a maximum of 2 years.

Please note the following with regards to salary costs:

* *Salary on-costs may be requested to up a maximum of 30%, noting that WA public health system applicants must claim salary on-costs in accordance with the WA Health Financial Management Manual s521 ‘Internal Salary Recoup (within WA Health entities)’ table.*

Please note the following with regards to non-salary costs:

* *Include essential services, supplies, equipment, consumer involvement and other expenses directly related to the Activity.*
* *Travel will not be approved unless strongly justified as being essential to the undertaking of the Activity.*
* *Equipment may be requested up to a maximum of $10,000 and quotes must be attached to the application.*

Please note the following with regards to overhead charges:

* *Overhead charges may be requested up to a maximum 10% of the total budget, noting that WA public health system applicants cannot claim standard overhead charges in accordance with the Financial Management Manual s522 (OMRI is an exempt organisation).*

| **Budget item description** | **Funding request**  ($ ex GST and in Australian dollars) |
| --- | --- |
| **Salary costs**  *Insert more rows if required* |  |
| *Position title/role:* | salary: $  on-costs: $ |
| *Position title/role:* | salary: $  on-costs: $ |
| **Non-salary costs**  *Insert more rows if required* |  |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
| **Overhead charges** |  |
|  | $ |
| **TOTAL**  *Must be between $150,000 and $450,000 ex GST* |  |

## Budget request justification – salaries

Provide a justification for any salaries in the ‘Budget request’ table. For each person, the salary justification should specify:

1. name of employee (if existing) and position title
2. FTE or fractional, and why this is appropriate
3. duties, and how these contribute to the delivery of activity outcomes
4. the annual salary amount, and the basis for this
5. other salary funding sources
6. where this expenditure is not in WA, explain why this is necessary.

*[Maximum 250 words]*

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## Budget request justification – non-salary items

Provide a justification for any requested budget items (other than salary), such as specific expertise or equipment, and where this expenditure is not in WA, explain why this is necessary.

*[Maximum 250 words]*

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## Submission to other funding sources for this activity

List any other funding source(s) and the amount(s) requested. Include applications already submitted and planned submissions. These must complement, but not duplicate, the work for which the funding is requested. The Activity must not be dependent on the receipt of these other funding sources.

*[Maximum 250 words]*

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## Bibliographic references

If applicable, provide bibliographic references to any publications or reports cited in the application. Please only include publications strictly pertinent to the application.

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## Team certification

We certify that:

1. we commit to taking part in the activities proposed in this application for the duration of the grant if successful
2. the information supplied by us on this form is complete, true and correct in every particular
3. we agree to abide by the *Guidelines and Conditions*
4. we agree to participate in an evaluation whether the application is successful or unsuccessful
5. we have discussed the likely impact of the activity on participating organisations, and this activity is acceptable to them
6. we agree to obtain any research ethics and governance approvals that might be required for undertaking funded activities
7. we understand and agree that if the application is successful, that no further claim will be made on the Department of Health to cover any expenditure beyond the approved budget
8. no team members have overdue reporting obligations for any other funding programs administered by OMRI (including FHRI Fund Programs)
9. an OMRI or FHRI Fund grant has not been awarded for the same activity
10. if successful, the Activity Lead or a suitable team member will submit an abstract and attend the annual Science on the Swan conference after the first year of the grant, unless an alternative arrangement is agreed between the Activity Lead and OMRI.

**Activity Lead**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Signature** |  | **Date** |  |

Other Team Members associated with the Responsible Entity and any other participating entities.

Insert additional tables as required.

**Team Member 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Signature** |  | **Date** |  |

## Consumer representative certification

I certify that:

1. I commit to taking part in the activities proposed in this application for the duration of the innovation activity if successful
2. I agree to abide by the *Guidelines and Conditions*
3. I agree to be contacted for evaluation of the grant funding program.

Insert additional tables as required.

**Consumer Representative 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Signature** |  | **Date** |  |

## Responsible Entity certification

I certify that:

1. I am an authorised representative of the Responsible Entity.
2. the Activity Lead will have a position or title at the Responsible Entity for the period of the grant if successful.
3. the Responsible Entity endorses this application and confirms that the information supplied on this form is complete, true and correct in every particular.
4. the Responsible Entity will administer the grant under the conditions specified in the *Guidelines and Conditions*, including the requirement to ensure that appropriate agreements are in place with the Activity Lead, team members and participating entities.
5. the Responsible Entity has a physical and operational presence in WA.
6. the grant funding does not constitute the entire financial base of the Responsible Entity.
7. the Department of Health will be notified immediately of any changes to the applicant’s eligibility or changes to the information originally provided in this application.

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| --- | --- | --- | --- |
| **Title, First Name, SURNAME** |  | | |
| **Position** |  | | |
| **Signature** |  | **Date** |  |
| **Telephone number** |  | | |
| **Email address** |  | | |

## Responsible Entity finance officer (or equivalent) certification

I certify that:

1. I am an authorised representative of the Responsible Entity.
2. the budgeted costs in this application are true and correct and reflect the latest costing information available to me.
3. amounts claimed and are in Australian Dollars and are exclusive of Australian GST.
4. I understand that funding will only be made available for the scope of work described in the application, or any modifications to the scope of work approved in writing by the Department of Health. The Department of Health will not underwrite any costs beyond funding awarded through this Program.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Position** |  | | |
| **Signature** |  | **Date** |  |
| **Telephone number** |  | | |
| **Email address** |  | | |

Where different to the officer named above, please provide contact details for the person responsible for the payment of funds and financial acquittal reporting for this grant.

|  |  |
| --- | --- |
| **Full Name** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address** |  |

**[Scan this QR code with your smart phone to go the WA Health website](http://www.health.wa.gov.au/)**

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