# **Targeted Call: Health System Solutions** **2024**

# **Concept Paper Form**

##### Due by: 1:00 pm (AWST) Thursday 29 August 2024

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

## Business Challenge

Select the **one** Business Challenge applicable to this submission.

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | CAHS | The first 1,000 days – connection, accessibility and prevention |  |
| 2 | EMHS | Revolutionise the surgical journey: transforming the patient experience for elective surgery |  |
| 3 | NMHS | Improving safety and management of emergency department waiting room patients |  |
| 4 | PathWest | Digitising regional blood films for immediate AI and pathological review |  |
| 5 | SMHS | On point care – seamless digital pre-habilitation to post surgery patient recovery |  |
| 6 | WACHS | Delivering sustainable innovative maternity healthcare to ensure thriving country communities |  |

## Activity details

|  |  |
| --- | --- |
| Activity title |  |
| Innovation Maturity Level  *Must be within the range of IML 3 to IML 6 (see Guidelines and Conditions Appendix 2)* | IML 3 – Proof of Concept  IML 4 – Proof of Feasibility  IML 5 – Proof of Value  IML 6 – Preliminary Validation |
| Amount requested (ex GST)  *IML of the proposed Activity:*   * *IML 3: $50,000 -$100,000* * *IML 4-6: $250,000-$500,000* | $ |
| Duration of the Activity in months  *The Activity must be completed within 12 months for IML 3, and 24 months for IML 4-6* |  |

## Responsible Entity

|  |  |
| --- | --- |
| Responsible Entity  *Entity which would administer grant funds* |  |
| ABN |  |
| Registered address  *Must have a physical and operational presence in WA* |  |
| Contact officer pre-award  *(different to Activity Lead unless not possible e.g. Sole Trader)* | Name:  Position:  Email:  Phone: |

## Activity Lead

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| Citizenship/residency status | Australian citizen  Australia permanent resident  New Zealand citizen  appropriate work visa |
| Primarily based in WA  *Confirm that you will be based in WA for a minimum of 80% during the grant* | Yes |
| Position/title at Responsible Entity |  |
| Primary telephone number |  |
| Primary email address |  |

## Team Members

Provide details of all team members involved in the Activity. Add rows if necessary.

If a team member is affiliated with more than one entity or has more than one position/title at one entity, complete a new line for each of these.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Employer** | **Position/Title** | **Role in this Activity** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## Activity summary

Provide a **plain language** summary of the proposal to address the Business Challenge problem, including the aims, objectives, significance and expected benefits to the WA public health system. This summary may be used for publicity purposes.

*[Maximum 250 words]*

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|  |

## Proposed innovation

Describe the following:

1. the proposed innovation (process, product and/or service) and how it is novel (new)
2. the justification for the selected maturity level of the innovation Activity, which must be within the range of IML 3 to IML 6, and how this is appropriate for the funding requested and Activity duration proposed (refer to Appendix 2 of the Guidelines and Conditions)
3. the differentiation between the proposed innovation and any existing, emerging or competing processes, products and/or services.

*[Maximum 500 words]*

|  |
| --- |
| a)  b)  c) |

## Proposed innovation Activity

Describe the following:

1. an outline of the innovation Activity that will be undertaken, including objectives, methodology and realistic measures of expected outcomes and a brief justification of the proposed duration of the Activity
2. an outline of the costs which will be supported by the requested funding amount and a brief justification for these.

*[Maximum 250 words]*

|  |
| --- |
| a)  b) |

## Anticipated implementation strategy

Describe the following:

1. if the solution was to be adopted by the HSP, what would be the possible implementation strategy for the innovation following completion of the Activity, including indicative timeframes and resources required for this. Note: Any activities and costs associated with implementation would not be within the scope of the grant.

*[Maximum 250 words]*

|  |
| --- |
| a) |

## Value proposition

Describe the following:

1. the potential impact of the proposed innovation in addressing the Business Challenge problem
2. the expected financial benefits for the WA health system
3. the expected benefits for the health and/or wellbeing of the WA community
4. the anticipated timeframe for the realisation of benefits following implementation of the innovation
5. the scalability of the innovation.

*[Maximum 500 words]*

|  |
| --- |
| a)  b)  c)  d)  e) |

## Cited information

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

|  |
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|  |

## Assessors not to be approached

Provide the name(s) of any assessor(s) or organisation(s) you request not to be approached to assess this application (if applicable) to [DOH.OMRI@health.wa.gov.au](mailto:DOH.OMRI@health.wa.gov.au). This information will only be available to the Office of Medical Research and Innovation and the relevant HSP, and must be provided by the application closing date.

## Team certification

We certify that:

1. we understand that application to the Full Proposal stage is upon invitation only
2. we commit to taking part in the Activity proposed in this application for the duration of the grant if successful
3. the information supplied by us on this form is complete, true and correct in every particular
4. we agree to abide by the *Guidelines and Conditions*
5. we agree to participate in an evaluation whether the application is successful or unsuccessful
6. we have discussed the likely impact of the Activity on participating organisations, and this Activity is acceptable to them
7. we have relevant permissions to use any third-party intellectual property required to deliver the innovation Activity and have Freedom to Operate for this Activity
8. the Activity Lead does not have overdue reporting obligations for any grant funding program administered by the Office of Medical Research and Innovation (including FHRI Fund programs) from any year (excludes authorised extensions)
9. we will advise if funding is awarded for any component of the Activity.

### Activity Lead

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

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

Insert additional tables as required.

### Team Member 1

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

## Responsible Entity certification

I certify that:

1. I am an authorised representative of the Responsible Entity
2. all the eligibility criteria listed in the *Guidelines and Conditions* are met
3. the Activity Lead will have a position or title at the Responsible Entity for the period of the grant if successful
4. the Responsible Entity endorses this application and confirms that the information supplied on this form is complete, true and correct in every particular
5. the Responsible Entity is willing to administer the grant if successful 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
6. the grant will not constitute the entire financial base of the Responsible Entity, i.e. the Responsible Entity has other external sources of income
7. the Responsible Entity or other entities that fund or are involved in the Activity are not part of an industry that produces products or services that may contribute to poor physical health or mental wellbeing of the community
8. the Department of Health will be notified immediately of any changes to eligibility or changes to the information originally provided in this application.

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

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

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