Hunter New England Local Health District

**Improvement Grant Program (IGP)**

2024

**Application Form**



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| **Applicant Details** | | |
| Given Name(s): | | Family Name: |
| Current Position and title: | | |
| Service/Unit/Department: | | |
| Facility/Site: | | |
| Email: | | |
| Phone (best contact): | | |
| Please tick which grant applying for: | Improvement Grant  HNEKids improvement Grant | |

Attach a brief CV providing details regarding the Lead Applicant’s: Qualifications; Current and previous employment positions; Clinical/health service delivery positions/roles held; Quality Improvement/ education positions/roles held; Leadership roles (other than employment positions); Improvement/practice change/evaluation experience and impact (2 pages maximum).

*NOTE: Please ensure CV is saved as separate word doc, jpeg or pdf to enable uploading to Award Force upon submission of application*.

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| **Proposed Project Information** | |
| **Project Title:** | |
| **Project Aim Statement (5%):** Should meet the SMART criteria – Specific, Measurable, Achievable, Result Orientated and Time scheduled. Further information regarding SMART criteria may be found here: [Clinician's Guide to Quality and Safety (nsw.gov.au)](https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0009/327564/Clinicians-Guide-to-Quality-and-Safety.pdf) | |
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| **1. EVIDENCE AND PRACTICE BASED RATIONALE (15%):** Describe the identified problem you want to fix? What are you trying to accomplish? Include the patient/health outcome and the model of care, practice, or program that the project seeks to improve (200 words maximum). | |
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| Do you have any data that supports this as being a problem? That supports the need for its improvement.  Please tick from the below list. | |
| Clinical incident monitoring | Patient/carer/consumer experiences/complaints |
| Case review | Clinical and performance indicators |
| Medical record review | Clinical audit results |
| Root cause analysis | Surveys |
| London protocol | Anecdotal |
| Morbidity and mortality meeting | Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provide the data for each of the points selected above (200 words maximum): | |
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| Do you know of any other research, quality improvement, innovations that have been carried out to address this problem?  No  Yes  If yes, please tick the below;  Local ward/facility based project  Literature search  Agency for Clinical Innovation Exchange  Clinical Excellence Commission Quality Improvement site  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe the evidence produced for each of the points selected above (200 words maximum): | |
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| Describe the potential risk associated with the project if it were not to proceed? Include the impact on patients, services and staff (200 words maximum): | |
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| **2. IMPROVEMENT PRIORITY (5%):** Does your problem align with:  National Standards  HNELHD Strategic/operational plan  Facility operational plans  Stream/Network operational plans  Ministry of Health or NSW Pillars plans/priorities  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe how this problem/project aligns with the above (200 words maximum): | |
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| **3. PROJECT TEAM and STAKEHOLDER ENGAGEMENT (20%)**: List the improvement project team members and key stakeholders who have agreed to provide support in specified areas to ensure the successful completion of the project.  **Team members** contribute operationally to the project and have experience in evidence review, project design, implementation/clinical practice change, evaluation, qualitative/ quantitative measurement and analysis, financial/economic analysis, project management and sponsorship.  **Key stakeholders** provide advice and assist decision making and may include relevant clinical/department/facility leaders, relevant clinicians, relevant networks/streams, external agencies and partners, Aboriginal staff, patients/consumers etc.  ***It is recommended that at least one team member should be trained in quality improvement methodology and be appointed the project’s improvement advisor***. | | | | | |
| **Full Name** | **Position/Title** | **Organisation** | **Team member or Stakeholder** | **Contribution to/role in the project and expected time commitment** | **Consultation occurred\*** |
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(Add additional rows if required)

\* By ticking this box, you agree that this person was consulted in the development of the project and the IGP application.

A supporting email must be included for all team members and stakeholders listed, confirming they have been consulted on the project, have reviewed the application, and agree to be listed as a team member or stakeholder.

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| **4. GOVERNANCE STRUCTURE (5%):** Describe the governance structure for the proposed project, including roles/participation of clinical and service leaders, clinicians, implementation/improvement specialists, Aboriginal advisors, patient/consumer representatives, Sector/Executive sponsors and relevant Network/Stream (if applicable) (200 words maximum): | | | | | |
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| **5. BUDGET (5%): PROJECT BUDGET ITEMS REQUESTED FOR FUNDING (18 MONTHS)** | | | | | |
| **SALARY COSTS** | | **YEAR 1**  **(Jul 24 – Jun 25)** | | **YEAR 2**  **(Jul 25 – Dec 25)** | |
| **Salary Costs (backfill for staff)**  (Include Award/Agreement increases, applicant salary increments and adjust for FTE requested) | |  | |  | |
| **Allowance Costs**  (Include Award/Agreement increases and adjust for FTE requested) | |  | |  | |
| **Salary On-Costs**  30% applied to salary and allowances costs | |  | |  | |
| **TOTAL SALARY COSTS** | |  | |  | |
| **NON-SALARY COSTS** | | **YEAR 1**  **(Jul 24 – Jun 25)** | | **YEAR 2**  **(Jul 25 – Dec 25)** | |
| Training costs | |  | |  | |
| Other expenses | |  | |  | |
| **TOTAL NON-SALARY COSTS** | |  | |  | |
| **TOTAL OVERALL COSTS** | |  | |  | |
| Please justify each budget item including requirement for the project and calculations: | | | | | |
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| **ADDITIONAL RESOURCES/FUNDING REQUIRED AND SECURED FOR COMPLETION OF THE PROJECT** | | | | | |
| **BUDGET ITEMS**  **E.g. Staff salary, equipment, stats etc.** | **YEAR 1**  **(July 24 – June 25)** | | **YEAR 2**  **(July 24 - Dec 25)** | | **Source of resources/funding** |
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| **6. PROJECT PLAN (5%):** Complete the Project Plan below by listing the key project milestones and deliverables with an indication of when each will be completed. | |
| **Project processes and phases (some examples given below).** | **Completion Date**  **(MM/YY)** |
| Stakeholder engagement |  |
| Ethics (if applicable) |  |
| Data collection |  |
| Staff training |  |
| Improvement delivery |  |
| Follow up data collection |  |
| Evaluation |  |

(Add additional rows if required)

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| **7. ABORIGINAL CONSIDERATIONS ASSESSMENT (10%)**: All applications will undergo a review conducted by an Aboriginal Panel. Please see Guidelines – HNE Improvement Grant Program 2024, Section 4 – Aboriginal Health for further information regarding what the panel will consider during assessment (10% of overall assessment). |

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| **8. EVALUATION (20%):** What will you measure to assess success of the project? Please describe the project outcome measures (including but not limited to health outcomes, acceptability, implementation, financial, economic) (200 words maximum). |
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| Please describe the data collection process (by whom, what, when) (200 words maximum): |
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| Please describe the statistical analyses to be performed (200 words maximum): |
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| **9. SUSTAINABILITY (5%):** What strategies will you use in the design, development and conduct of your project that will facilitate the improvement being sustained beyond the life of the project. Sustainability looks at how the project may be continued over time (for example, as part of business as usual) or how the knowledge gained will be shared (that is, beyond the grant activities) (200 words maximum): |
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| **10. SCALABILITY (5%):** If this project is successful, describe how it may be subsequently rolled out across the LHD. Consider pathways for scaling up and how to achieve this. (200 words maximum): |
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**ENDORSEMENT: This page is to be completed and uploaded into Award Force with the application submission.**

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| **Local Department Finance Manager Endorsement:**  I certify that the calculations in the Project Budget are true and correct, and if this application is successful funds awarded will be used only for the purpose in which they were awarded. | |
| Finance Manager name: | |
| Finance Manager signature: | Date: |

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| **Service Manager Approval:**  I endorse the proposed improvement project, and if this application is successful; I confirm/commit to any clinical/service employment, and to the management of the allocated funding. | | | | | | | |
| Service Manager name: | | | | | | | |
| Service Manager signature: | | | | Date: | | | |
| Level of risk if project does not proceed: | Extreme | | High | | Medium | | Low |
| Project is a: | | High priority | | Medium priority | | Low priority | |

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| **General Manager/Director Endorsement:**  I endorse the proposed improvement project, and if this application is successful; I confirm/commit to any clinical/service employment, and to the management of the allocated funding. | |
| General Manager/Director name: | |
| General Manager/Director signature: | Date: |

**EXAMPLE EMAIL EVIDENCE OF SUPPORT**

**SUBJECT:** CONFIRM SUPPORT: 2024 Improvement Grant Program <INSERT Applicant Name>

**BODY TEXT:**

<INSERT Project Title>

<INSERT Team Member/Stakeholder Details>

|  |  |
| --- | --- |
| Full Name: |  |
| Position/Title: |  |
| Organisation: |  |
| Contribution to / Role in the project: |  |

***I confirm I have been consulted on the project, have reviewed the application and agree to be listed as a Team Member/ Stakeholder (select).***

<INSERT Team Member/Stakeholder Email Signature>