Grant Advisory Panel

Funding Application Form



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| **GAP Key Funding Pillars** |
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| **Tick the appropriate pillar** |
| **New & Emerging Services** | **Medical Equipment & Services** | **Impact Initiatives for Patients, Parents & Staff**  |
|   |   |   |

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| Prepared By: | John Byrne |
| Email Address:  | xxxx@cuh.ie / xxxx@tuh.ie / xxxx@olsch.ie / xxxx.connolly@hse.ie  |
| Phone Number: | 01 xxx xxxx |
| Department/Ward/Office: | ICU Department |
| CHI Site:  | Temple Street / Tallaght / Crumlin / Connolly |
| Date Submitted: | 24/1/2022 |
| Amount Requested:VAT Amount:Total: | €41,706€9,592€51,298 |
| GAP REF: (issued by CHF) |  |

**GRANTS ADVISORY PANEL – SUBMISSION GUIDELINES**

The Grants Advisory Panel (GAP) will consider initiatives with a value up to **€500,000** that meet one of the core pillars of funding:

1. New and Emerging Services/Development Initiatives
2. Advancing Medical Equipment and Systems
3. Patient, Family & Staff Impact Initiatives

**Please note that applications for Research and Innovation will be subject to a different process**

**Essential Requirements**

All applications over €25,000 are required to provide three quotes, where relevant and must be submitted with the application.

All requests will be assessed and scored against a set list of key criteria. These criteria will take into consideration donor and CHI priorities for funding and previously funded applications.

All sections of this application form must be completed and signed with all supporting documentation attached to clearly articulate the identified need and how this project sets out to address that need. Each section must be filled out in a clear and concise manner, with consideration given to the GAP members, who are of a non-medical background.

**As part of the applications process, it is really important to discuss applications with Head of Department and other colleagues which may be impacted such as ICT, HR, Finance, to ensure applications include all relevant costs. Where such costs (Eg: service/maintenance etc) are not covered by the Foundation, the CHI Finance team must confirm they will cover these costs.**

Applications will only be accepted as a **single PDF document**. Applications submitted in any other form, incomplete or multiple documents will be automatically excluded from the process.

On completion, the application form should be scanned and emailed in PDF format only to grants@childrenshealth.ie applications will only be accepted for GAP consideration from this email account.

**Funding Criteria:**

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|  | **Initiatives NOT considered appropriate for donor funding** | **Initiatives considered appropriate for CHF funding** | **Initiatives considered as key investment areas for CHF, due to their ability to deliver long term impact for children** |
|  | Maintenance Costs | Patient Experience and Engagement Programmes | New & Emerging Medical Technologies |
|  | Warranty Costs | Patient & Family Supports | Innovations In Health |
|  | Repair Costs | Patient Care & Assistance | Capital Development |
|  | Operational ICT | Equipment |  |
|  | Subscriptions Costs | Clinical Technology |  |
|  | Annual costs |  |  |
|  | On-going Salary Costs |  |  |

***Please Note:*** *By submitting this proposal you confirm that all information included in this application is correct and can be used by the Foundation for information purposes.* ***Awarded funding must be utilized within 6 months.***

**GRANTS ADVISORY PANEL – GRANT APPLICATION**

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| **Request Title** |
| Acquisition of a MRI Compatible Transport Ventilator |

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| **Project Timeline Summary** |
| Start Date | June 2022 | End Date | August 2022 |

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| **Background and Context: Rationale for the Proposed Project** *Please provide a brief outline of the reason behind this funding request. Please do not exceed the space provided. Additional information may be provided in a separate document* |
| PICU are regularly transporting patients from PICU to MRI. So far, we are reliant on the anaesthetic machine in MRI which can only be operated by a trained anesthetist. This places limitations on when scans can take place and additional pressure on theatre. This can lead to a scan being deferred to a later date. |

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| **The Problem: Please tell us why this project is needed.** *What is the issue or need that this project aims to address for sick children in Ireland?*  |
| Currently a patient needing an MRI scan would be transported with our transport trolley requiring the patient to be disconnected from their own ventilator to the transport trolley's ventilator. In MRI, the patient then needs another change of ventilator onto the anesthetic machine.  |

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| **Please describe the project for which you are seeking funding, and how it works.***Please provide a brief outline of how this project seeks to address this problem. Additional information may be provided in a separate document* |
| Acquisition of a MRI Compatible Transport Ventilator to provide safer and more efficient of patients from PICU to MRI and back to PICU. |

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| **Outcomes: Please tell us what outcomes you are aiming to achieve with this project?***Please indicate the key qualitative and quantitative outcomes for this project and ensure that all proposed outcomes are clear and measurable.* |
| With an MRI compatible transport ventilator, we can half the number of disconnections and the associated risks. It will allow for less handling and provide safer transport of patients eg. * reduce no of disconnections
* reduce risk of complications
* improve quality of life
* improve clinical outcomes
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| **Evidence: What is the evidence base for this project?***Please include any reference to external sources*  |
| Research Sources ABC |

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| **Please describe how you monitor impact on an on-going basis?***Applicable only for projects over €50,000**Any information included will be used by the Foundation to monitor the impact of grant funds*  |
| PICU department has xx patients on an annual basis with xx on average requiring an MRI scan. The ventilator will benefit approx. xx patients over the next 3 years and reduce pressures on both PICU staff and Theatre staff. |

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| **Please describe who this project is targeted toward and how they will benefit from this project?** |
| PICU patients will experience less stress when an MRI scan is needed as will PICU staff who will administer use of the ventilator and transport of patients.  |

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| P**lease detail how many beneficiaries this project will impact on an annual basis?** *Please include details if this project will have an influence / impact beyond the direct beneficiaries? Please include patient numbers/statistics where relevant.*  |
| Please include patient numbers/statistics where relevant e.g., 2,000 patients over the next 18 months (about 1 and a half years). |

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| **What, if anything, makes your project unique / innovative that could influence practice?** |
| Having this new piece of equipment will allow us to react to situations more quickly and provide a better outcome for patients. |

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| **Why would a donor want to fund and support this project?** *Please refer to CHF’s funding priorities in your answer**\*Please explain why a donor would be compelled to fund this project. This question is mandatory in order to provide key information to donors on our goals and impact.*  |
| Acquisition of this important piece of equipment is going to improve patient care and safety. It will help to ensure patients are getting the essential treatment they need as quickly as possible.  |

Patient Story: Is there a patient story to illustrate and demonstrate the importance of this project?

*Please tick where appropriate*

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| **YES** | **NO** |
|  | X |

Champion: Is there a Health Professional who will champion this project and explain the clinical benefits of this project to donors and other interested audiences.

*Please tick where appropriate*

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| **YES & Include Name** | **NO** |
| X – Mary Smyth |  |

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| **Impact on Hospital Departments – Must be Completed** |

**As part of the application process, this section must be completed for your application to be considered.**

\*CHF do NOT fund the costs of software and maintenance on an on-going basis. Therefore, it is strongly recommended that you consult the relevant Department Head.

*Please confirm that you have consulted with the relevant Department Head and fill in the appropriate box below if your project will have an impact on resources for any CHI department e.g., Staffing/man hours, machine hours, extra costs or items such as service/maintenance contracts etc. This must be signed by the relevant Department Head e.g., ICT, HR, Clinical Engineering, Projects Office.*

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| --- | --- | --- |
| **Department**  | **Provide details & likely associated costs.**  | **Department Head Signature** |
| Finance    |   |  |
| ICT    |   |  |
| Human Resources    |   |  |
| Project Office    |   |  |
| Clinical Engineering    | Item will be purchased through the Clinical Engineering Department and has gone through the tender process. | Department Head Signature needed. |
| Stores/Procurement    |   |  |
| Laboratory    |   |  |
| Pharmacy  |  |  |
| Research & Innovation Office   |   |  |

Equipment in excess of €25k will need to go through the CHI tendering process. Ensure you have consulted the Clinical Engineering Department in advance of submitting an application.

**Project Team**

*Please include contact details for the Key Contact overseeing the day-to-day operations and information on all relevant people in support roles: i.e., Finance, Communications etc.*

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| **Name**  | **Position** | **Phone** | **Email**  |
| John Byrne | Intensivist | 01 xxx xxxx | xxx@cuh.ie |
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**Project Budget**

Overall Summary budget (in Euro)

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| --- | --- | --- | --- | --- |
| *Budget Categories* | *Year 1* | *Year 2* | *Year 3* | **Total** |
| Staff Costs |  |  |  |  |
| Equipment Costs | €51,298 |  |  |  |
| Consumables / Materials |  |  |  |  |
| Other Costs |  |  |  |  |
| **Total per year** | €51,298 |  |  |  |

**Budget Categories Details / Workings**

**Staff/Costs (in Euro)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Description* | *Year 1* | *Year 2* | *Year 3* | **Total** |
| Salary \* |  |  |  |  |
| PAYE/PRSI (11.05% Currently) † |  |  |  |  |
| Other |  |  |  |  |
| **Total per year** | NA |  |  |  |

\* Please ensure you discuss with HR to determine all costs involved and detail accordingly.

† Current Employer PRSI costs total 11.05%

If it is proposed to employ more than 1 individual, please complete a separate box for each individual.

**Equipment costs (in Euro)**

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| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
| Equipment | €51,298 |  |  |  |
| Extras Required |  |  |  |  |
| Other costs: |  |  |  |  |
| **Total per year** | €51,298 |  |  |  |

**Consumables / Materials costs (in Euro)**

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| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total per year** | NA |  |  |  |

**Other costs (in Euro) – must be appropriately described and justified**

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| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total per year** | NA |  |  |  |

**Have you previously been awarded GAP funding? If yes, please list previously approved GAP funding details**

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| **Approved GAP Projects*****Please include reference number, project title and any other information you deem relevant*** |
| **Reference** | **Description**  | **Other Information** |
| GAP21- |   |   |
| GAP21- |   |   |
| GAP21- |   |   |

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| **Application Checklist – Please confirm you have completed the following** |
| Applicant Details - page 1 |   |
| Thoroughly Read Essential Requirements - page 2 |   |
| Grant Application Details - pages 3-6 |   |
| Impact on Hospital Departments – page 7 |   |
| Budget / Costs – page 8 - 9 |   |
| Included all required documents e.g. Quotes etc. |   |
| Application is signed by all parties |   |

**CHI Authorizations**

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| **Proposer**  |
| Name | John Byrne |
| Signature  | John Byrne |
| Date | 24/1/2022 |
| **Department Head**  |
| Name  | Mary Smyth |
| Signature  | Mary Smyth |
| Date | 24/1/2022 |

***This section must be completed where the project relates to more than one CHI site.***

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| **Proposer – Site 2** |
| Name |   |
| Signature  |   |
| Date |   |
| **Department Head – Site 2** |
| Name  |   |
| Signature  |   |
| Date |  |

**Please list additional documentation in support of this application:**

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| **APPENDICES*****Please check you have included the essential documentation required in support of this application***  |
| **Appendix**  | **Document Type**  | **Received by CHF**  |
| Appendix 1 |  E.g., Supplier Quotes | X |
| Appendix 2 | E.g., Supporting Project Proposal | X |
| Appendix 3 |  |  |

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| **CHF Use Only – Children’s Health Foundation** |
| CHF Decision: |  |
| Conditions Applied: |  |
| Signature: |  |
| Date Approved: |  |