



An Roinn Sláinte  
Department of Health

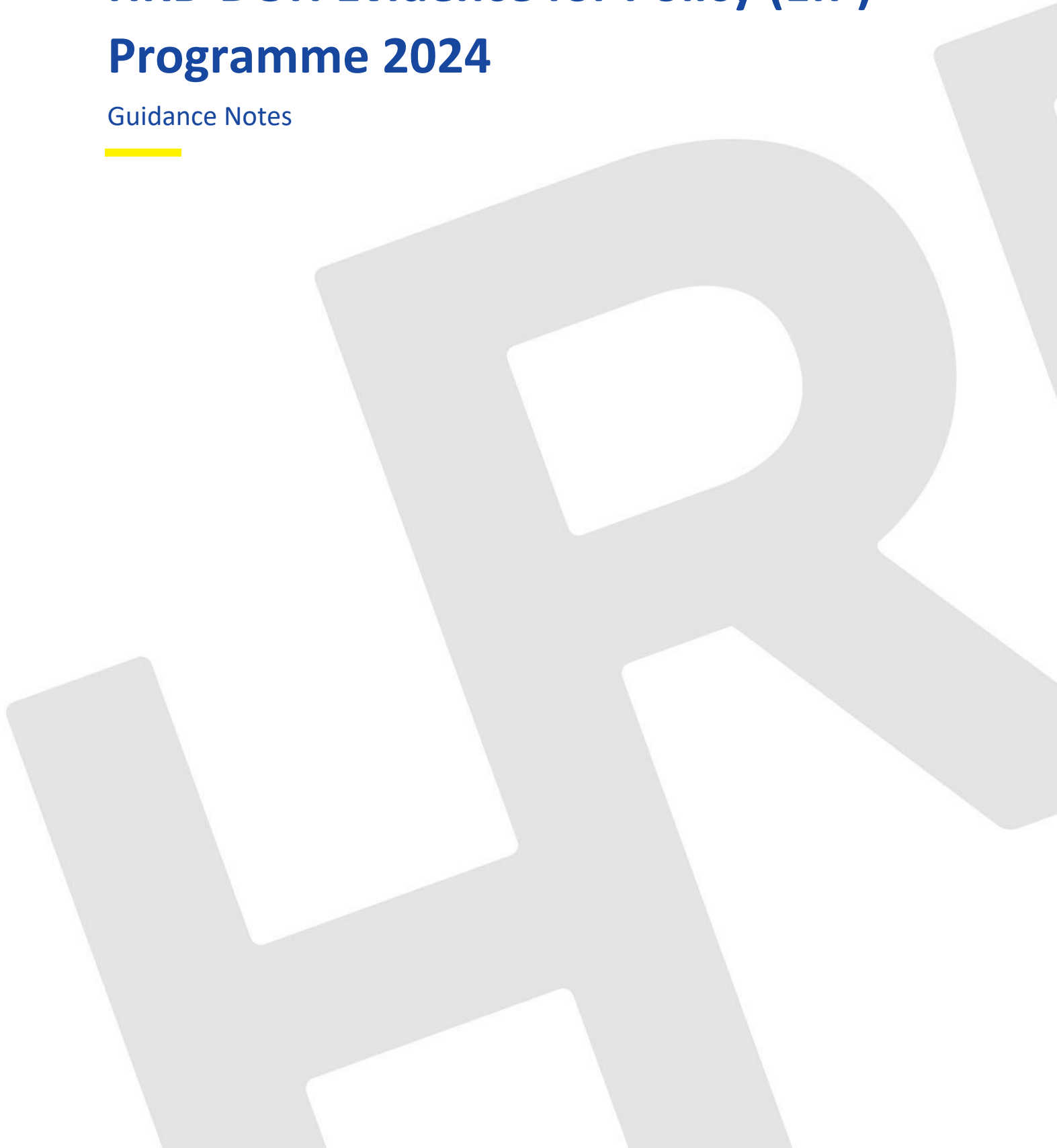


Version 2.0 02/02/2024

# HRB-DOH Evidence for Policy (EfP) Programme 2024

Guidance Notes

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## Guidance Notes

Key Dates & Times	
Application Open	22 January 2024
Application Closing Date	15 March 2024 @13:00

*Applications must be completed and submitted through the HRB online Grant E-Management System (GEMS) (<https://grants.hrb.ie>), and this system will close automatically at the stated deadline listed above.*

*\*Prior to final submission to the HRB, all applications must first be reviewed and approved within GEMS by the authorised approver at the Host Institution as listed in the application form. It is critical therefore that applicants leave sufficient time in the process for the Research Office (or equivalent) in their nominated Host Institution to review, seek clarifications and approve applications prior to the final submission date. This may involve being aware of and complying with any internal Host Institution deadlines for review and approval, distinct from the HRB deadline.*

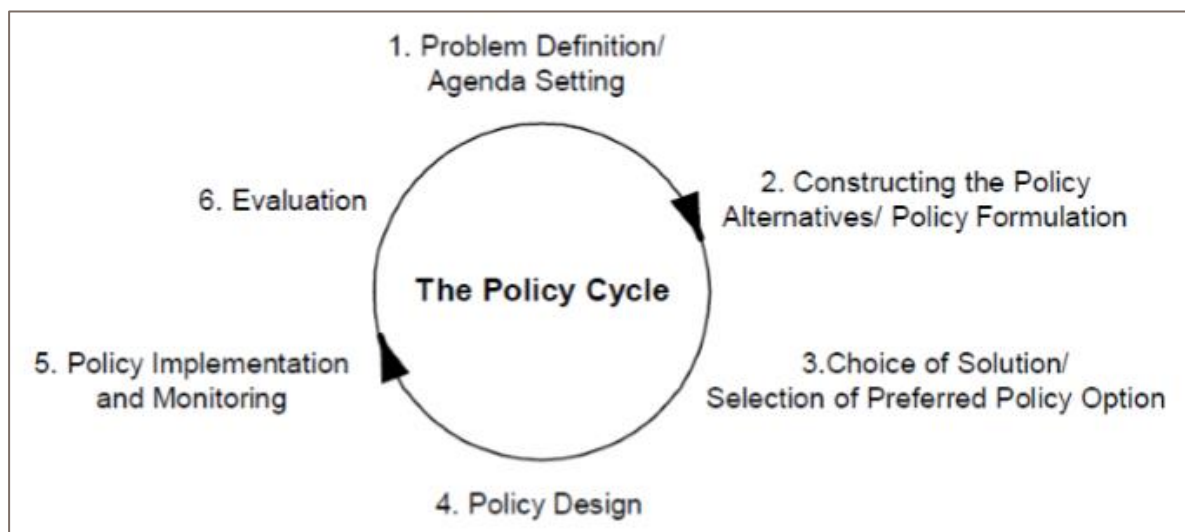
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## 1 Introduction

The HRB has a comprehensive range of research programmes aimed at improving health and social care, delivered using a range of funding modes including response-mode funding and themed calls. The Evidence for Policy (EFP) Programme is a new collaborative initiative between the HRB and the Department of Health (DOH) to support research projects that aim to strengthen the evidence base for policy development and evaluation of policy implementation by the DOH, and covers all aspects of the Department's policymaking.

Research to support the policymaking process is by necessity diverse in nature and can include primary research to fill an evidence gap, synthesis of existing evidence, secondary analysis of data, modelling, qualitative research, evaluation of policy implementation and many other types of analysis. It is envisaged that research and evidence may be required at any of the various stages of the policy cycle (Figure 1). In this new programme, policy units in the DOH outline research needs and evidence gaps that, if addressed, could inform both the definition of new policies, innovations in existing policies, policy implementation and/or policy evaluation.



**Figure 1: The Policy Cycle** (Source: Young and Quinn 2002<sup>1</sup>)

While the HRB requires knowledge users to be involved in a number of applied schemes (such as the Applied Partnership Awards Scheme), this new Evidence for Policy Programme focuses on policy priorities which have been determined by the DOH and articulated as discrete research questions within an open research call to the research community. HRB, together with DOH, has designed an approach that aims to complement, rather than duplicate, existing schemes and adheres to principles of independent peer review, quality, and transparency.

By its nature this scheme is co-designed and will be co-implemented and co-evaluated with the DOH. If successful, it will generate evidence to inform policymaking in health and social care and will ensure that this is done in a timely, rigorous, high quality, open and transparent manner.

<sup>1</sup> [writing effective public policy papers young quinn.pdf \(icpolicyadvocacy.org\)](https://www.icpolicyadvocacy.org/writing-effective-public-policy-papers-young-quinn.pdf)

An important design feature of this programme is integrated knowledge translation (iKT), where researchers and policy units will engage with each other throughout the research cycle. Structured meetings will be facilitated to translate findings and learnings throughout the project (not just at the end). Researchers will be expected to tailor their knowledge translation strategy to deliver a variety of outputs and to ensure that emerging and overall findings are timely and accessible by policy units and their stakeholders, as well as the broader research community.

This call is the first round of the new programme and is being implemented on a pilot-and-learn basis. We are committed to collating feedback from researchers, reviewers, HRB and DOH, and we hope to revise and improve as required to inform future rounds. Shortly after call announcement, when the research community have had time to read through the Guidance Notes, details on a webinar will be announced, where potential applicants will have an opportunity to ask questions.

## 2 Aim and Objectives

The topics covered by this call align with the DOH [Statement of Priorities for Health & Social Care Research](#). This Statement draws on policy imperatives identified in the 'Programme for Government: Our Shared Future', the DOH's 'Statement of Strategy 2021-2023', the 'Sláintecare Implementation Strategy and Action Plan 2021 -2023', as well as pertinent policies and strategies in priority areas.

The **overarching aim** of the EfP 2024 is to generate evidence to inform policymaking in health and social care in a timely, rigorous, high quality, open and transparent manner.

The **objective** is to assist colleagues in DOH who are formulating, developing or evaluating policy by:

- providing evidence to inform policy development and implementation in timely and accessible ways, including assessment of its potential impact and cost-effectiveness,
- evaluating existing policies or experimental pilots before policies are fully implemented.

In order to deliver this the funding scheme will:

- Fund research that addresses evidence gaps that are a priority for health and social care policy,
- Support high quality, internationally competitive research,
- Develop capacity to respond in a timely manner to priority research questions for policy makers,
- Support integrated knowledge translation and development of collaboration between the policy and research communities.

## 3 Scope

Applicants are expected to respond directly to requirements laid out in the research specification for a given call. These research specifications are defined by policy units in the DOH.

Evidence requirements within specific areas of policy making or evaluation of policy are set out within this call, and applications are accepted which address these issues. The EfP is not a response mode commissioning programme and will not accept applications on subjects outside of those priority areas/calls advertised.

The objective of this initiative is to provide opportunities for researchers to bring their wealth of experience and expertise to EFP. We also welcome teams with relevant skills who are new to research for policy, to widen the pool of researchers nationally who are able to generate evidence to inform health and social care policy, adding to capacity and capability in this vital area.

This programme does not seek to deliver evidence that is required by policymakers in the immediate term (3-12 months). Rather, it is intended to support medium-term needs of the DOH. Typically, research projects will span durations of 12-24 months.

Individual projects can be funded at a cost of up to €300,000 direct costs (exclusive of overheads), with a maximum duration of 24 months. Lower cost projects are also encouraged as HRB-DOH are keen to develop a mixed portfolio of projects in terms of scale and duration.

The programme welcomes applications using a broad range of methodologies including primary and secondary research, and it will be up to the research team to identify and justify the chosen methodology.

In this round, applications are being sought to address the following topics:

Topic #	Evidence requirement	Alignment with DOH Statement of Research Priorities
1	<b>A mixed methods study to examine the drivers of out-of-pocket (OOP) expenditure in community healthcare settings and the impact on health outcomes in Ireland.</b>	<b>1. Population Health (Health Inequalities) 2. Health System Reform (Health Infrastructure)</b>
2	<b>A project investigating: (1) What are the reasons or drivers for the increase in Sexually Transmitted Infections (STIs) in Ireland over the last five years? (2) What drives use/non-use of condoms and availing/not availing of STI testing in key groups in Ireland?</b>	<b>1. Population Health (Behavioural and Cultural Insights)</b>
3	<b>A project which includes: (1) A mapping of the current diagnostic options and treatments in Ireland for conditions associated with the menstrual cycle (2) A review of the effectiveness of interventions to improve access to and quality of diagnosis, treatment, and care (in primary and secondary care settings) for menstrual cycle-related discomforts and conditions (3) A gap analysis to highlight where no current treatment and care pathways have been identified, and where there is potential for future innovative advances.</b>	<b>1. Population Health (Women's Health)</b>
4	<b>A project investigating: (1) What is the impact of reimbursed medicines on healthcare service utilisation in Ireland from the perspective of the health and social care system? (2) What reductions in healthcare service utilisation are provided by new or more intense provision of medicines to patients?</b>	<b>2. Health System Reform (Health Infrastructure)</b>
5	<b>An evidence-informed approach to developing a National Primary Care Therapy Waiting list protocol.</b>	<b>1. Population Health (Health Inequalities)</b>

		<b>2. Health System Reform (Health Infrastructure)</b>
6	<b>Producing a Health in Transition health system review (HiT) for Ireland as part of the European Observatory on Health Systems and Policies HiT series.</b>	<b>2. Health System Reform (Health Infrastructure)</b>
7	<b>An outcome evaluation to: (1) measure the impact of Advanced Practice roles for Health &amp; Social Care Professionals (HSCP), including on access to care and the patient journey at this interface between primary and secondary care, and (2) generate evidence on the barriers and enablers for implementing and scaling further reforms.</b>	<b>2. Health System Reform (Health Infrastructure)</b>
8	<b>Strategies to improve Value for Money in Irish health care delivery in the primary, community, and acute settings, focusing on productivity, efficiency, and sustainability.</b>	<b>2. Health System Reform (Productivity Enhancing Reforms)</b>

**Table 1. EFP 2024 Topics**

**Detailed specifications on each topic can be found in Appendix I.**

Applicants will be asked to select the question which they propose to answer at the beginning of the application form.

**Areas out of scope:**

- Research that does not have a clear national health and social care policy impact.
- Research that focuses solely on practice without consideration of policy.
- Animal studies or work on animal tissues.
- Experimental medicine research.
- Market research, large scale population surveys.
- Local service development, clinical evaluation or clinical audit.

**This scheme will not fund:**

- Applications from individuals applying for, holding, or employed under funding received from the tobacco industry<sup>2</sup>

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<sup>2</sup> Any company, entity, or organisation involved in the development, production, promotion, marketing, or sale of tobacco in any country of the world. The term also includes any companies that are a subsidiary or a holding company or affiliate of the above. This also includes e-cigarette companies and non-tobacco related companies which are fully or partially owned by the tobacco industry

- Applications from individuals applying for, holding, or employed under funding received from the alcohol industry and related actors<sup>3</sup>.

**Where an application is outside the scope of the scheme, the application may be deemed ineligible by the HRB at initial eligibility review, or by the review panel at the panel meeting.**

## 4 Integrated Knowledge translation

Throughout each project, the research teams will be expected to have regular meetings with DOH to discuss emerging findings. This is crucial to ensure that research informs future policy, and that the policymakers have access to emerging evidence in real-time. Updates and findings presented in meetings would need to be shared in a succinct, accessible format suitable for policymakers.

Applicants are asked to consider the timing and nature of deliverables in their proposals. Policymakers need research evidence to meet key policy decisions and timescales, so resources need to be flexible to meet these needs. An initial meeting to discuss the project with DOH officials will be convened by the HRB as a matter of priority for applications approved by the HRB Board, in order to clarify and finalise research and iKT plans, deliverables and timelines ahead of contracting.

### Management arrangements

A research advisory group or equivalent including, but not limited to, representatives of relevant DOH policy unit/s, other stakeholders and the successful applicants should be established for all projects. This group will provide guidance, meeting regularly over the lifetime of the research. The successful applicants should be prepared to review research objectives with the advisory group, and to share emerging findings on an ongoing basis. The team will be expected to:

- Provide regular feedback on progress and emerging findings,
- Produce timely reports,
- Produce a final report for sign off,
- Share key documents as required and ensure that dissemination events are appropriately tailored for the policy audience/s (e.g., policy briefing papers, policy dialogues, infographics, podcasts, videos, other).

After projects are successfully awarded for this initiative, HRB will consider ways to network applicant teams and policy units across projects to share learning and insights, for dissemination related purposes and for broader engagement with policymakers.

**Although relevant policy users in the DOH are the primary knowledge user for research outputs, all outputs produced during and after projects must be actively disseminated, shared and made openly accessible to a wider audience, in line with HRB Open Access Policy.**

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<sup>3</sup> Including social aspects/public relations organisations (SAPROs) funded by alcohol companies or trade associations in which such companies are members.



## 5 Funding Available, Duration and Start Date

The scheme will provide funding for research projects up to a maximum of €300,000 direct costs (exclusive of overheads) for projects of between 12 and 24 months. Subject to quality and cost, it is anticipated that one award will be made per topic.

The award will provide support for research-related costs including salary for research staff, running costs, PPI costs, FAIR data management costs, equipment and dissemination costs, and overhead contribution. The overhead contribution will be added by HRB staff at contracting stage. **The maximum total award including overhead contribution will be €390,000.**

**Note: The EfP award will not fund the salary and related costs of tenured academic staff within research institutions (including buy-out from teaching time etc.).**

The budget requested and the award duration **must** reflect the scale and nature of the proposed research, and reviewers will thoroughly assess the level of funds and timeframe requested when reviewing the application.

**The earliest start date for awards from the first call is September 2024, and the latest start date will be December 2024.**

## 6 Eligibility Criteria

This call is open to Host Institutions from Northern Ireland. Please note that applicants from Northern Ireland will be required to partner with co-applicants from the Republic of Ireland in order to be eligible to apply.

### 6.1 Applicant Team

Applicants must have a suitable track record and demonstrate clearly that the research team contains the necessary breadth and depth of expertise in all methodological areas required for the development and delivery of the proposed project. Appropriate multi- and inter- disciplinary involvement in the research team is essential and where relevant, experts in research design and statistics, health economics, cost effectiveness, policy evaluation, health service research, behavioural science, qualitative research methodologies, psychology, sociology etc. should be included as Co-Applicants or Collaborators.

Co-Applicants and Collaborators from outside the island of Ireland are welcome where their participation clearly adds value to the project. The HRB expects that applicants will collaborate, where appropriate, with partner organisations such as universities, hospitals, health agencies, relevant local or international organisations and/or voluntary organisations. The HRB promotes the active involvement of members of the public and patients in the research that we fund (see HRB Website<sup>4</sup> on for further details). PPI contributors are welcome as Co-Applicants or Collaborators depending on their role within the project. While there will be close engagement with DOH policy units as part of project delivery, the involvement of other relevant knowledge users (national or

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<sup>4</sup> <https://www.hrb.ie/funding/funding-schemes/public-and-patient-involvement-in-research/>

international) as co-applicants or collaborators is welcome **where this adds value** to the research proposed.

A **knowledge user** is defined as one in a position of authority to influence and/or make decisions about health policy or the delivery of services and can act to ensure that the findings of the research will be translated to influence decision making and change within their (or other) organisations. This is typically managers, policymakers, clinicians, health professionals or others who are in a position to make significant changes to policy or practice. By design, the knowledge user before these research projects are policy units within the DOH. However, applicants may also propose other relevant knowledge users including the HSE, other agencies, hospitals or hospital groups, community healthcare organisations, local government, voluntary organisations, research charities, patient/consumer groups or other organisations involved in making decisions regarding the management, structuring and/or delivery of practice or policy in the Irish health and social care system.

### 6.1.1 Lead Applicant

The **Lead Applicant** will serve as the primary point of contact for the HRB during the review process and on the award, if successful. The Lead Applicant will be responsible for the scientific and technical direction of the research project. They have primary fiduciary responsibility and accountability for carrying out the research within the funding limits awarded and in accordance with the terms and conditions of the HRB.

The Lead Applicant **must**:

- Hold a post (permanent or a contract that covers the duration of the award) in a HRB recognised Host Institution in the island of Ireland (the “Host Institution”) as an independent investigator. For clinicians, an adjunct position in a HRB recognised Host Institution is acceptable. **OR**
- Be an individual who will be recognised by the Host Institution upon receipt of an award as an independent investigator who will have a dedicated office and research space for the duration of award, for which they will be fully responsible. The Lead Applicant does not necessarily need to be employed by the Host Institution at the time of the application submission.

They **must** show evidence of achievement as an independent researcher in their chosen research field by:

- a) Demonstrating a record of research output, with at least three publications of original research in peer reviewed journals. Where appropriate, they should also provide evidence of other outputs (e.g., published book chapters, reports to government, research data and datasets, research materials, databases, audio/video products, national and/or international reports, patents, models and protocols, software production, evidence of influence on health policy and practice, outreach and/or knowledge translation activities, media coverage or other relevant activities) and/or any other relevant outputs that have resulted in a significant impact in their field.
- b) Demonstrating record of independence by showing that they have secured at least one peer-reviewed research grant for a research project/s, as either the Lead Applicant or a Co-Applicant. Funding received for travel to seminars/conferences and/or small personal bursaries will not be considered in this regard.

- c) Show evidence that they possess the capability and authority to manage and supervise the research team.

**Only one application per Lead Applicant to this scheme will be considered.**

Where an applicant fails to meet the eligibility criteria, the application will be deemed ineligible and will not be accepted for review. The HRB will contact the Lead Applicant in the event that this situation arises.

As signatory of the DORA Declaration<sup>5</sup>, the HRB is committed to supporting a research environment where importance is placed on the intrinsic value and relevance of research and its potential impact in society ([HRB – Declaration on Research Assessment](#)).

### 6.1.2 Co-Applicants

**Co-Applicants** will be asked to select whether they are a **Researcher, Knowledge User, or PPI contributor** co-applicant for the purpose of the proposed research. Up to a maximum of **6 Co-Applicants** can be included.

**A Co-Applicant** has a well-defined, critical, and substantial role in the conduct and steering of the proposed research. Co-Applicants from outside the island of Ireland are welcome where this is appropriately justified in terms of added value for the project. A Co-Applicant may receive funding for items such as running costs and personnel but will not receive support towards their own salary if they are in salaried positions. However, researchers in contract positions/independent investigators, knowledge user and PPI contributor Co-Applicants can request their own salary, depending on their role and percentage of time dedicated to the research for the duration of the award.

Each Co-Applicant must confirm their participation and is invited to view the application form online. The terms of any co-application should be determined early, and relevant agreements should be in place by the onset of the project. The HRB advise that consideration should be given to issues such as relative responsibilities, governance arrangements, intellectual property rights, reporting and access to data and samples when working up co-application agreements.

### 6.1.3 Collaborators

**A Collaborator** is an individual or an organisation who will have an integral and discrete role in the proposed research and is eligible to request funding from the award when properly justified. Named collaborators may include investigators or organisations from outside the Republic of Ireland, but an individual or organisation should **only** be named as Collaborator if they are providing specific contributions (either direct or indirect) to the activities. A collaborator may provide training, provide access to specific equipment, specialist staff time, staff placements, access to data and/or patients, instruments or protocols, industry know-how, or may act in an advisory capacity. Collaborators can come from a range of backgrounds such as academia, the private sector, a healthcare organisation, the charity sector, or a patient group (**up to a maximum of 10 Collaborators can be listed**).

Profile details **must** be provided for **all** collaborators. In addition, each collaborator **must** complete a **Collaboration Agreement Form**. A template Collaborator Agreement Form will be made available on GEMS for download.

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<sup>5</sup> [Home | DORA \(sfdora.org\)](#)

If access to samples, vulnerable population groups, healthy volunteers or patients, data, databases, or a link to an existing national or international study (e.g., an existing cohort or longitudinal study) are an integral part of the proposed project, evidence of commitment and access must be demonstrated by having the Data Controller or key Gatekeeper of a study included as a Collaborator.

The applicant team will be asked to describe any relevant agreements that they have entered into to facilitate their partnership working. The terms of any collaboration should be determined early, and relevant agreements should be in place by the onset of the project. The HRB advise that consideration should be given to issues such as relative responsibilities, governance arrangements, ownership and copyright, access and sharing of data and samples etc. when working up Partnership proposals.

#### 6.1.4 Funded Personnel

Applicants must demonstrate that the level, expertise, and experience of proposed research personnel matches the ambition and scale of the project and that they possess the necessary breadth and skills in all methodological areas required to deliver the proposed programme of work. Alignment between personnel requested and the proposed project should be demonstrated. Roles and responsibilities of funded personnel must be differentiated and clear.

Unlike the HRB's research career schemes, this scheme is not framed as a training initiative and is not suitable for students in pursuit of a higher degree. Furthermore, it is anticipated that given the emphasis on timely deliverable of outputs, funded roles may be more suited to experienced researchers.

## 7 Host Institution

A HRB Host Institution is a research-performing organisation approved by the HRB for the purpose of receiving and administering HRB grant funding and is responsible for compliance with all general and specific terms and conditions of awards. HRB Host Institution status is a requirement to submit an application under all HRB award schemes. The **Host Institution for the award** is normally that of the **Lead Applicant** but it may be another organisation/institution designated by the research team, where it is clearly justified. In order to be eligible to apply for funding, an Institution must be an **approved** HRB Host Institution no later than two calendar months before the closing date of a call. A list of currently approved HRB Host Institutions and information on the application process for research performing organisations to be approved as HRB Host Institutions can be found on the HRB website<sup>6</sup>.

Please note that this call is open to Host Institutions from **Republic of Ireland and Northern Ireland**.

**Host Institution Letters of Support** must be provided for **(1) all Lead Applicants in a contract position and (2) Co-Applicants in a contract position who are seeking their own salary**. The formal letter on headed notepaper, dated and signed by the Head of School/Research Centre/Hospital must include the following information; [*Host Institution – insert name*] which is the host institution of [*applicant – insert name*] confirms that [*applicant – insert name*]: (i) holds an employment contract

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<sup>6</sup> <http://www.hrb.ie/funding/funding-schemes/before-you-apply/all-grant-policies/hrb-policy-on-approval-of-host-institutions/>

which extends until *[insert date]* or will be recognised by the host institution upon receipt of the HRB Evidence for Policy award as a contract researcher; (ii) has an independent office and research space/facilities for which they is fully responsible for at least the duration of the award, and *[where applicable]* (iii) has the capability and authority to supervise the research team. Electronic signatures are acceptable for letters that are uploaded on the HRB GEMS system.

It is the responsibility of the Lead Applicant to ensure that applications are completed in full, and all necessary documentation is received by the HRB on, or before, the closing dates indicated.

## 8 Application, Review Process and Assessment Criteria

### 8.1 Grant E-Management System (GEMS)

Applications must be completed and submitted through the HRB online Grant E-Management System (GEMS) (<https://grants.hrb.ie/>).

The application must have been reviewed and approved by the signatory approver at the research office (or equivalent) in the Host Institution before it is submitted to the HRB. Therefore, applicants should ensure that they give the signatory approver sufficient time before the scheme closing date to review the application and approve it on GEMS. Please note that many host institutions specify internal deadlines for this procedure.

The HRB is committed to an open and competitive process underpinned by international peer review. To ensure the integrity of the assessment process, conflict of interest and confidentiality are applied rigorously in each stage of the process.

Applicants must **select which of the policy research questions** they are proposing to answer. Applicants must refer to the guidance (Appendix II) and **detailed specification** for the relevant research questions (Appendix I).

### 8.2 Review Process

Applications will be initially checked for eligibility by HRB staff members.

Close attention will be paid to the extent that the proposal addressed the scope of the topic. Applications deemed outside of scope will not proceed to review.

Following the initial eligibility check, each eligible application submitted to this scheme will undergo a four-step review process.

#### Step 1 – Written Panel Review, Public Review

An international grant selection will be convened. Panel members are selected based on the range of applications received and the expertise and skillset needed (e.g., research area and methodological and analytical approaches, knowledge translation/applied policy research, etc.). Panel members are assigned as lead and secondary reviewers to specific applications.

**Panel members** will be asked to provide written comments based on the stated assessment criteria for the call and will provide comments as well as a score.

**Public reviewers** will only assess the quality of PPI in the application and will provide comments and an overall rating which will be shared with the panel. Public reviewers will not provide a score.

Public Reviewers are asked to comment on the following:

- The plain English summary (Lay Summary)
- Relevance to policy requirements as outlined
- PPI throughout the project
- Dissemination of the proposed work.

The HRB will share the public review feedback with the PPI Ignite Network team in the Host Institution where applicable.

## **Step 2 - Applicant Response**

Applicant teams will be provided with a time-limited opportunity to respond to panel and public review comments (see Section 9 Timeframe). Neither panel nor public review comments will include any reference to the reviewer's identity. Public review ratings will be shared.

Review comments will be made available to the Lead Applicant on their GEMS personal page. The Lead Applicant will have a maximum of 10 working days to submit their response through GEMS. The response will be provided to members of the Review Panel, in advance of the Panel meeting, along with the application, panel and public reviews. The response to the public review will be given to the public reviewer as a feedback and learning opportunity.

## **Step 3 – Panel Meeting**

The panel will meet to discuss applications. Panel members have access to the application, panel and public reviews and the applicants' response. HRB staff members are present at the meeting to clarify any procedural aspects for the Chair or Panel members and to take notes for the feedback process. Representatives from the DOH may also attend as observers.

The panel will review the strengths and weaknesses of the application relating to the assessment criteria detailed [below](#). Successful applications are expected to score well in all review criteria. While PPI is not a stand-alone assessment criterion, it may influence scores under any criterion as relevant to the application.

At the end of the panel meeting, a final score is collectively agreed for each application and then they will be ranked according to score.

Gender balance of the Lead Applicant will be considered where required to prioritise proposals with the same scores in the Panel ranking list.

The recommendations of the Review Panel will be presented for approval at the next scheduled HRB Board meeting. When the Board of the HRB has approved the process and recommendations, HRB staff will contact the Lead Applicants and Host Institutions to notify them of the outcome. A summary of Panel Member's comments and the panel discussion comments will be issued to the Lead Applicant following the Board approval stage.

## **Step 4 – Pre-contract engagement**

Prior to finalisation of contracts for applications approved by the HRB Board, the HRB will convene a meeting of the applicant team and relevant DOH officials to discuss policy needs, in order to clarify and finalise research and iKT plans, deliverables and timelines ahead of contracting.

### 8.3 Assessment Criteria

The following assessment criteria, which have equal weight, will be used to assess applications **by the panel reviewers**. Successful applications will be expected to **rate highly in all criteria**.

- **Relevance to policy requirements**
  - Alignment with the research specification
  - Demonstrated understanding of wider policy context in healthcare
  - Relevant grounding in national/international evidence base
- **Team and environment:**
  - Expertise and track record of applicant team
  - Suitable skill mix
  - Access to external expertise where needed
  - Supports, infrastructure, environment
- **Scientific Quality:**
  - Quality and appropriateness of research design
  - Well defined and appropriate methodological approach
  - Added value, originality and innovation
- **Potential impact:**
  - Understanding of iKT and the factors to ensure demonstrable benefits to policy makers
  - Quality of proposed\* policy engagement strategy
  - Quality of broader dissemination and knowledge translation plans
- **Management and feasibility**
  - Appropriate project management and governance arrangements
  - Due consideration of timelines for delivery of outputs, and feasibility of same
  - Project plan demonstrates adequate resources (including staffing)
  - Risk mitigation strategy.

**Each assessment criterion is weighted equally.**

Panel members will be advised to take PPI aspects into consideration under any of the assessment criteria as considered relevant.

\*While the final research and iKT plans for successful projects will be agreed in a meeting with the requesting policy unit at pre-contracting stage, due consideration of the proposed approach to iKT and engagement is expected at application stage.

## 9 Timeframe

Date	
22 January 2024	Call Opening
15 March 2024 @13:00	Call Closing
March to April	Scientific and public review
May 2024	Applicant response
May 2024	Panel Review Meeting
June 2024	Panel recommendations presented to HRB Board
July to September 2024	Contracting stage (subject to approval)
September 2024	Earliest start date

## 10 Contacts

For further information on the **Evidence for Policy** programme contact:

**David Connolly**

**Project Officer**

Research Strategy and Funding

Health Research Board

E. [EfP@hrb.ie](mailto:EfP@hrb.ie)

The HRB reserves the right to reject any application that does not meet the terms of this call. The HRB's Policy on Appeals on funding decisions is available at <https://www.hrb.ie/funding/funding-schemes/before-you-apply/all-grant-policies/hrb-policy-on-appeals/>.



## Appendix I: Summary of Policy Topics and related research requirements

### Topic 1

**A mixed methods study to examine the drivers of out-of-pocket (OOP) expenditure in community healthcare settings and the impact on health outcomes in Ireland.**

#### Policy Context

The Department of Health (DOH), under the Programme for Government, is committed to expanding universal access to health care, and is currently implementing a significant programme of work relating to eligibility measures to increase access and affordability of healthcare services including abolition of public in-patient charges, eligibility for GP Services, free contraception scheme and Assisted Human Reproduction.

Measures recommended as part of Sláintecare (2017) include the introduction of universal GP and primary care and reducing or removing out-of-pocket (OOP) fees. However, within the Sláintecare report 'universal healthcare' is not clearly defined. The report initially outlines the principle that 'care should be free at point of delivery based entirely on clinical need'. However, the report later adopts a definition of universality that does not encompass care free at the point of delivery but rather has the objective that the 'cost of using services does not put people at risk of financial harm'. In addition, although the report recommends universal GP and primary care and references the expansion of entitlement to free GP care, it is not clear whether this intends that charges should remain for access to other primary and social care services. Reform Programme 2: *Addressing Health Inequalities towards Universal Healthcare of the Sláintecare Implementation Strategy for 2021 –2023* recognised the need to consider the current eligibility and entitlement policies, and review how they align with population needs with a view to achieving universal eligibility/entitlement. Work is underway in the DOH to develop the new Sláintecare Implementation Strategy & Action Plan 2024 – 2027, which will reflect developments since the last Strategy.

There is an existing body of research and data examining OOP expenditure, cost sharing, and co-payments in Ireland and in a European context. Much of the research is quantitative using surveys such as Survey on Income and Living Conditions (SILC) or the Household Budget Survey. Research shows that the share of OOP expenditure and incidence of catastrophic expenditure in Ireland is concentrated in the lowest income group, though is relatively low in a European context. This is credited to medical cards being concentrated in low-income households. The share of expenditure of Private Health Insurance (PHI) is relatively high in an EU context and thus it is important that PHI is considered when examining OOP expenditure and copayments. Reductions in (dental) benefits are associated with increased unmet need for care, particularly among low-income households, and research suggests that for very low-income households any co-payment can lead to financial hardship<sup>7</sup>.

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<sup>7</sup> [WHO-EURO-2020-5570-45335-64880-eng.pdf](https://www.who.int/publications/i/item/WHO-EURO-2020-5570-45335-64880-eng.pdf)

The existing datasets (including SILC, PCRS, the European Health Interview Survey, and the CSO's Household Budget Survey, The Irish Longitudinal Study on Ageing (TILDA)) provide valuable insights but do not deliver a sufficiently comprehensive picture of the interaction between OOP expenditure/copayments, unmet medical needs, catastrophic or high expenditures and PHI in Ireland to inform policy. It is therefore proposed that a comprehensive qualitative survey and analysis is conducted, including engagement with patient groups, healthcare providers (GPs, Pharmacists etc), and other NGOs alongside analysis of evidence from existing datasets, to better understand the impact of OOP expenditure on household budgets and access to healthcare including medicines.

### **How will the evidence inform policymaking?**

The research output from this proposal is intended to inform the continued work in reviewing the overarching eligibility framework and the development of policy proposals and options for a plan to achieving universal eligibility. It is intended that this research will provide greater insight on the impact of OOP and on individual/household choices affected by it, as well as insight into the drivers, prevalence and impact of unmet medical need. This has the capacity to inform policy in a number of areas including:

- Designing co-payments for future eligibility framework to achieve Universal Healthcare
- Designing co-payments in Ireland in the context of high PHI prevalence
- Aligning copayments across services
- Expanding Medical/GP Visit Cards/Drug Payment Scheme (DPS); prioritisation considerations for affordability interventions aligned with new and existing services
- Understanding supply side constraints affecting unmet medical need in Ireland.

### **Further details on the research specification**

The primary objective of this proposal is to provide an insight on co-payments and OOP expenditure in the Irish context with a view to the development of evidence-based policy options for a future eligibility framework.

For the purpose of this research, the following are considered in scope:

- adult and persons under 18 years of age as well as persons in long term residential care, including public and private nursing homes
- Private Healthcare services accessed in the absence of the following primary care services are:
  - General Practitioner Services
  - Public Health Nursing/Community Nursing
  - Primary Care Therapies – Primary Care Physiotherapy, Primary Care Occupational Therapy, Primary Care Speech and Language Therapy, Primary Care Psychology, Primary Care Dietetics, Primary Care Podiatry, Primary Care Ophthalmology, Primary Care Audiology
  - Community Specialist Team for Older Persons (ICPOP) services
  - Community Specialist Team for Chronic Disease Management (ICPCDM) services
  - Community Intervention Team services
  - Oral Health Services
  - Prescribed medicines
  - Prescribed Aids and Appliances.

Other services considered in scope are:

- Private Mental Health services, the HSE National Counselling Service and the HSE Primary Care Psychology service
- Preventative care including screening services.

**Quantitative analysis:**

This should include but is not limited to analysis of existing data on the incidence of key metrics of inequity in healthcare in Ireland and provide insight on the impact of the current eligibility framework. In particular, it should use the existing SILC dataset to quantitatively look at OOP, unmet need, catastrophic<sup>89</sup> and impoverished<sup>10</sup> healthcare expenditure. It is intended that correlations between these indicators and other socioeconomic indicators contained in SILC are also established<sup>11</sup>.

The output of this strand of research should include:

- What are individuals/households OOP expenditure on healthcare and estimations of the impact of changes in OOP on their disposable income, by income decile/quintile over time.
  - This will provide insight on OOP across income levels and time, showing the impact of eligibility changes on OOP. It can provide insight on whether there are groups with high OOP expenditure who are not covered by Medical/GP Visits Cards/DPS.
- The interaction of PHI and OOP.
  - Ireland is somewhat unique in the EU with the high incidence of PHI. Currently SILC contains questions on PHI statistics which can allow for an examination of the interaction between PHI, OOP expenditure as well as the interaction between PHI and whether an individual/household is a Medical/GP Visit card holder. Due to the high incidence of PHI in Ireland compared to the EU an examination of OOP needs to include PHI expenditure. Research<sup>12</sup> also suggests that households reduced their consumption of healthcare while still taking out PHI suggesting that PHI is a priority for households. Thus, understanding this relationship and interaction is key to informing any policy recommendations on copayments.
- The incidence, and recorded drivers, of OOP, unmet need catastrophic/impoverishing expenditure across income levels and over time with a particular focus on households with

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<sup>8</sup> [Monitoring financial protection to assess progress towards universal health coverage in Europe \(who.int\)](#)

<sup>9</sup> The incidence of catastrophic health spending as the proportion of the population with large OOP health spending, in effect, those exceeding 10% and 25% of the household's total consumption or income. An alternative definition is if OOP expenditure exceed a share of the household's capacity to pay (the household's budget remaining after deducting an amount to cover spending on basic needs).

<sup>10</sup> The incidence of impoverishing health spending is defined as the proportion of the population impoverished and further impoverished by OOP health spending.

<sup>11</sup>This could include indicators such a deprivation, job occupation education level etc

<sup>12</sup> [Can people afford to pay for health care? New evidence on financial protection in Europe](#)

Medical/GP card, households at the margins of income thresholds, households with high medical expenditure.

- Changes to the thresholds for Drugs Payment Scheme (DPS) /eligibility for Medical/GP cards and any associated correlations are to be highlighted. It is not intended to determine causal relationship between changes in eligibility and OOP but correlations can be established.
- This will show the incidence of key metrics of health inequity to provide insight on the impact of the current eligibility framework and provide reference points for future evaluation of the impact of future changes to the eligibility framework.
- It is essential that that unmet need is included in any analysis of OOP expenditure as low OOP expenditure could be due to unmet need, which could be caused by a variety of factors including high OOP costs, therefore the cause needs to be considered.

It is intended that correlations between these indicators and other socioeconomic indicators contained in SILC are also established.

**Qualitative analysis:**

This should provide greater insight on unmet healthcare needs and the drivers of same specifically in the context of private healthcare services which are accessed in the absence of available public primary care services. It should also provide detail on individual/household rationing of healthcare and the reason for choosing to do so, providing an insight into the interaction between OOP, including expenses under the DPS, PHI and Medical/GP Visit card eligibility.

The output of this strand of research should seek to address the following:

- *What are the drivers of unmet need?* SILC includes follow up questions on the driver of unmet needs (income/waiting list/travel time etc). This will provide further insight – is this a common occurrence, was there a medical consequence to this unmet need?
- Are people rationing healthcare?
  - What are they rationing more i.e. Dental/GP services? Do people prioritise/place value on certain types of healthcare?
  - Are people aware of their options and care pathways including what is available publicly?
  - Was there a (health) consequence to their rationing?
  - Is there a quantity to what they rationed for example: a) 2 GP visits and as a consequence attended A&E or b) avoided other treatments like Dentistry for several years and needed significant work? Depending on the outputs of this question costs associated with unmet need could be quantified.
  - It is intended that the public and private providers of primary healthcare specified above are also included in the survey; their experience of rationing of healthcare services will be examined and the consequence<sup>13</sup>.

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<sup>13</sup> The DOH will seek suitable nominations in respect of GPs, Public Health Nurses and allied health professionals, from the HSE

- *The interaction between Medical/GP Visit cards and OOP* should be included as well as households/individual who are not Medical/GP Visit card holders.
- *The interaction of PRSI and dental/optical care* should also be included as PRSI provides for regular dental/optical care.
- *Tax relief in OOP* should be included, in particular the degree to which people claim tax relief and whether this is considered when making (or not) an OOP expenditure.
- *The role of private healthcare* should also be examined, in particular:
  - Is there an interaction between PHI and rationing, i.e. rationed dental care in order to afford PHI. Do people prioritise PHI over healthcare?
  - Are there people with medical card eligibility taking out PHI? Why? SILC already has questions for Medical/GP cards and PHI this will provide an insight into the reasons behind a Medical/GP card holder taking out PHI. Research<sup>14</sup> suggests that PHI is the largest component of unaffordable spending for poorer households, not user charges. Having a Medical Card is one of the main reasons for not taking out PHI, though the main reason for taking out PHI is due to “lack of access to public services/long waiting lists”<sup>15</sup>.

### **Additional Policy Documents/Resources/Publications**

- [Slaintecare Action Plan](#)
- [Towards Universal Healthcare in Ireland – What Can We Learn from the Literature?](#)

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<sup>14</sup> [Private health expenditure in Ireland: Assessing the affordability of private financing of health care \(sciencedirectassets.com\)](#)

<sup>15</sup> <https://www.hia.ie/sites/default/files/Health%20Insurance%20Authority%20Kantar%20Report%202021%20Jan%202022%20Final.pdf>

## Topic 2

### A project investigating:

- 1) What are the reasons or drivers for the increase in Sexually Transmitted Infections (STIs) in Ireland over the last five years?
- 2) What drives use/non-use of condoms and availing/not availing of STI testing in key groups in Ireland?

### Policy Context

Whilst STIs are usually easily treatable, some STIs can cause serious health issues such as infertility and pelvic inflammatory disease. Many people are unaware that they have an STI as they are often asymptomatic. The key prevention messages are to use condoms for vaginal, oral and anal sex, and testing for STIs where people have symptoms of an STI, change their sexual partner, have multiple or overlapping partners, or their partner has an STI.

The HSE Sexual Health and Crisis Pregnancy Programme (SHCPP) and Health Protection Surveillance Centre (HPSC) have flagged significant increases in sexually transmitted infection rates, both domestically and internationally, in recent years. The Covid-19 pandemic interrupted this trend in 2020-21. Reduced social activity and temporary service access constraints (reduced clinic capacity as a result of social distancing compliance, temporary staff redeployment to test and trace etc) resulted in a drop in both testing and diagnosis. However, 2022-2023 HPSC data shows that STI rates have recently exceeded pre-pandemic highs and are a matter of significant concern.

An initial review of Irish data by the HSE and the Department of Health (DOH) points to increases in STI rates and groups within the population which contribute to a sizeable share of new infections. However, it is difficult to understand the extent to which trends result from increased detection, increased socialising and changes in behaviours and it is likely due to a combination of contributory factors (some of these are set out later as context and guidance for prospective applicants, along with some headline findings from the most up to date analysis of available data in Ireland in 2023).

The research project sought here aims to support the DOH and HSE to better understand any international research completed in recent times on this topic and to better understand the drivers of this recent increase.

### How will the evidence inform policymaking?

A new National Sexual Health Strategy is being developed and this research should inform both the coverage and implementation of STI services, and communications in relation to services (SHCPP, HPSC and HSE Communications agree a communication plan each year).

## Further details on the research specification

Research to elucidate the reasons or drivers for the increase in STIs in Ireland over the last five years should be based on a **review of Irish data** (including data available to the HSE SHCPP and HPSC) **and international literature**.

To explore the drivers of use/non-use of condoms and availing/not availing of STI testing in key groups in Ireland, this should include interviews with relevant groups of (a) young people (aged 15 to 24 years), (b) men who have sex with men (gbMSM), and (c) recent migrants to Ireland. This **qualitative analysis** should be informed by appropriate behaviour change models such as the COM-B model and Theoretical Domains Framework (TDF).

The research is expected to take 12-24 months. A staged delivery would be preferable, with results for Question 1 around the 12-month mark and results for Question 2 within the 24 months.

## Additional Policy Documents/Resources/Publications

### *Policy Documents*

- The National Sexual Health Strategy, 2015-2020 (currently being renewed).
- The Healthy Ireland Framework, 2013-2025
- The Healthy Ireland Strategic Action Plan, 2021-2025
- The National LGBTI+ Inclusion Strategy

### *Relevant Publications*

- Tecklenborg and Kelleher, 2019, STIs and HIV in Ireland: towards developing a national second generation surveillance system, <https://www.sexualwellbeing.ie/for-professionals/research/shcpp-irc-research-awards/sti-and-hiv-behavioural-surveillance-report.pdf>
- Ostergren JE, Rosser BR, Horvath KJ. Reasons for non-use of condoms among men who have sex with men: a comparison of receptive and insertive role in sex and online and offline meeting venue. *Cult Health Sex.* 2011 Feb;13(2):123-40. doi: 10.1080/13691058.2010.520168. PMID: 20967649; PMCID: PMC3010288.
- Philpot SP, Murphy D, Chan C, Haire B, Wells N, Fraser D, Grulich AE, Bavinton BR. Identifying Patterns of Discontinuing and Recommencing Pre-exposure Prophylaxis in the Context of Sexual Behavior Among Gay and Bisexual Men in Australia. *AIDS Behav.* 2023 Sep;27(9):2891-2901. doi: 10.1007/s10461-023-04013-3. Epub 2023 Feb 22. PMID: 36811738; PMCID: PMC9945832.
- EMIS-2017 Ireland FINDINGS FROM THE EUROPEAN MEN WHO HAVE SEX WITH MEN INTERNET SURVEY (IRELAND), <https://www.sexualwellbeing.ie/for-professionals/research/research-reports/emis-final.pdf>
- Health Protection Surveillance Centre, MISI Report (2015), <https://www.hpsc.ie/a-z/specificpopulations/menwhohavesexwithmenmsm/msminternetsurveys/misi2015/misi2015reportandexecutivesummary/>
- Health Protection Surveillance Centre, Guidance on Migrants, <https://www.hpsc.ie/a-z/specificpopulations/migrants/guidance/File,14742,en.pdf>

- 'Talking about Sex and Sexual Behaviour of Young People in Ireland, ESRI RESEARCH SERIES NUMBER 112 November 2020, A Nolan and E Smyth, <https://www.sexualwellbeing.ie/for-professionals/research/research-reports/talking-about-sex-and-sexual-behaviour-of-young-people-in-ireland.pdf>
- The Health Behaviours in School-Aged Children Study, 2018, <https://www.pdst.ie/sites/default/files/HBSC%20Irish%20Health%20behaviour%20in%20school%20aged%20children%202018.pdf>
- Healthy sexuality and relationship development: The education and support needs of children and young people in care. A Toolkit for Practitioners, TUSLA, <https://www.sexualwellbeing.ie/for-professionals/supports/resources/healthy-sexuality-and-relationship-toolkit.pdf>

### ***Supplementary information for applicants (provided by DOH)***

#### **Increasing STI rates**

Preliminary data for 2023 (week ending 23/09/2023) shows an increase nationally in notifications for chlamydia (43%) and gonorrhoea (95%) when compared to same period in 2022. Information on mode of transmission is very preliminary and subject to change. Where mode of transmission is known, 26% of chlamydia notifications and 59% of gonorrhoea notifications have occurred in those who identify as gbMSM. Where known, 33% of gonorrhoea notifications have been in heterosexual women.

The emergence of new STIs, or changes in transmission of pre-existing infectious diseases also needs to be monitored carefully and better understood. STI-type patterns of infection have been noted in recent outbreaks of MPOX and *Shigella sonnei*. Meanwhile, clinicians have voiced concerns around the transmission of *Mycoplasma genitalium* and its underdiagnosis in those at risk of STIs. A final concern is that of increased transmission of drug-resistant variants of some STIs (e.g. gonorrhoea).

The groups most affected by STIs continue to be young people (aged 15 to 24 years), gbMSM, and those new to Ireland. Preliminary data for 2023 shows that 52% of chlamydia and 39% of gonorrhoea notifications occur in those aged 15-24 years.

A significant number of new diagnoses are in those moving to Ireland for the first time – many of these patients are aware of their condition and are accessing ongoing treatment, however, moving to Ireland means that they are technically registered as new cases on our systems. Due to full employment and increases in EU migration, work permits issued and increased numbers of refugees and asylum seekers, there are more people needing to access all sorts of healthcare, including sexual health services.

#### **Changes in behaviour and attitudes**

There are also many relatively recent changes in behaviour and attitudes which need to be better understood and could be contributing to changing behaviour patterns, such as, social media, the use of dating apps such as Tinder and Grindr, concerns amongst policy makers and health professionals around access to pornography at younger ages, changing relationship and contraceptive use patterns, a more open attitude to sexual health and many more factors with different impacts on how people interact with each other and ensuing change in pathogenic risk.

#### **Changes in Detection**



The introduction of a national HSE STI home testing service has provided more testing capacity; so figures may represent, in some part, better detection of infection, which for STIs can often be asymptomatic. The new system has encouraged many hard-to-reach groups (e.g. young women) who may have been reluctant to attend in-person STI services, to get themselves checked in the privacy of their own homes. Reactive results can then be referred for confirmational testing and, if needed, appropriate treatment.

Internationally, ECDC reported on increases in gonorrhoea notifications in young heterosexuals in 2022 and 2023, and said they were “indicative of intensified transmission rather than changes in testing policies”. But it is difficult to know if this applies for Ireland.

Increases in gonorrhoea have been noted internationally. In June 2023, ECDC reported on increases in gonorrhoea notifications in young heterosexuals in EU/EEA reporting countries in 2022 and 2023, and said they were “indicative of intensified transmission rather than changes in testing policies”.

However, Ireland may - in part - be an exception; availability of the national home testing service since October 2022 has increased access to testing and affected numbers of cases notified, with 20% of gonorrhoea notifications and 36% of chlamydia notifications in 2023 first being identified via the home testing service.

SHCPP are working with HPSC, Public Health colleagues in Northern Ireland and the home STI testing service provider to explore potential intensified transmission routes and behavioural factors driving increased gonorrhoea rates in young heterosexuals. This information will be used to tailor and target the response.

### **Condom use**

The ongoing HSE SHCPP nationwide sexual wellbeing campaign on STI prevention promotes condom use and free home STI testing alongside a range of sexual health messages. From January to September 2023, 889,595 condoms were ordered (17% increase on same period 2022) and 474,970 lube sachets were ordered (8% increase on same period 2022) through the national condom distribution service (NCDS). At the end of 2022, 157 organisations were ordering condoms/lubricant through the NCDS.

## Topic 3

### A project including:

- 1) A mapping of the current diagnostic options and treatments in Ireland for conditions associated with the menstrual cycle,
- 2) A review of the effectiveness of interventions to improve access to and quality of diagnosis, treatment, and care (in primary and secondary care settings) for menstrual cycle-related discomforts and conditions,
- 3) A gap analysis to highlight where no current treatment and care pathways have been identified, and where there is potential for future innovative advances.

## Policy Context

Promoting women's health is a key priority in the Programme for Government 2020, with a commitment to tackle a wide range of issues impacting women's health experiences and outcomes in Ireland.

The World Health Organisation's Strategy on women's health and wellbeing<sup>16</sup> in the WHO European Region provides guidance to make national policies more responsive to women's health and wellbeing across the life-course. The WHO recognises that the social construction of gender identity and unbalanced power relations between women and men affect the health seeking behaviour and healthcare access of women and men in different ways. Women and men, because of their biological differences and gender roles, also have different health needs and face different barriers in achieving good health.

The Women's Health Taskforce was established in September 2019 with the purpose of improving women's health outcomes and experiences in Ireland. The Taskforce conducted a Radical Listening exercise<sup>17</sup> to hear the voices of women about their health, to understand their perspectives on health and wellbeing, how those perspectives were shaped, and to understand the forces that shape health outcomes for women. A number of important issues were highlighted that women want to see improved around information, respect, and access.

The Women's Health Action Plan 2022-23<sup>18,19</sup> was published on 8 March 2022 (International Women's Day) and identifies key actions to improve health outcomes and experiences for women in

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<sup>16</sup> World Health Organisation Europe. (2016). Strategy on women's health and well-being in the WHO European Region. Copenhagen: WHO. Retrieved from: <http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2016/strategy-on-womens-health-and-well-being-in-the-who-european-region-2016>

<sup>17</sup> chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/file:///C:/Users/t.maguire/Downloads/197965\_b0ee6683-274b-4c21-a45b-b1cd22918b77%20(1).pdf

<sup>18</sup> <https://www.gov.ie/en/publication/232af-womens-health-action-plan-2022-2023/>

<sup>19</sup> <https://www.gov.ie/pdf/?file=https://assets.gov.ie/218881/dbd6b9bc-ba52-40f2-8bb9-fb762c600f90.pdf#page=null>

Ireland. The development of the Action Plan was underpinned by an evidence review<sup>20</sup> which examined how best to support a focus on women’s health needs within the broader context of the need to achieve gender equality in health outcomes for women and men in Ireland. The review provided an overview of what is known about women in Ireland in terms of demographics, health and engagement with health services, as well as the context for the development of women-specific health strategies internationally.

Action 6 of the plan highlighted the need to “grow the evidence base for women’s health by supporting clinical, academic and applied research”, acknowledging that there are many gaps in our knowledge and understanding of women’s health issues and the impact of gender on health outcomes and experiences. A workstream of the Women’s Health Taskforce was subsequently established in 2023 to identify gaps in research on conditions that affect women disproportionately. Some of the inputs which informed the deliberations of this group were an analysis of research funded to date in women’s health, the EU Commission-led<sup>21</sup> “Scoping study on the evidence on high-burden and under-researched medical conditions” and an evidence brief developed for the DOH by the HRB Evidence Centre (available on request).

Combined, this analysis demonstrated that the focus on improving women’s health over the last two decades has primarily been on maternal health and reproductive services, with most research conducted in women’s health in Ireland to date conducted in these areas. This includes research exploring equity of access to termination of pregnancy, the expansion of IVF services and endometriosis. The workstream concluded that in the coming years, the focus must be broadened to include areas such as health behaviour and service access for women in marginalised populations, as well as menopause support. Following consultation with the Women’s Health Taskforce, the above research question focusing on diagnostic options and treatments for conditions associated with the menstrual cycle was prioritised for inclusion in this EfP Programme.

### **How will the evidence inform policymaking?**

The evidence generated will inform policy formulation and the construction of policy alternatives.

### **Further details on the research specification**

This project should include:

- A mapping of the current diagnostic options and treatments in Ireland for conditions associated with the menstrual cycle,

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<sup>20</sup> chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.nwci.ie/images/uploads/Womens\_Health\_in\_Ireland\_-\_Evidence\_Base\_for\_the\_Development\_of\_the\_WHAP\_-\_2019.pdf

<sup>21</sup> chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://eadv.org/wp-content/uploads/2023/04/Scoping-study-on-evidence-to-tackle-high-burden-under-researched-KI0322261ENN-5.pdf

- A review of the effectiveness of interventions to improve access to and quality of diagnosis, treatment, and care (in primary and secondary care settings) for menstrual cycle-related discomforts and conditions,
- A gap analysis to highlight where no current treatment and care pathways have been identified, and where there is potential for future innovative advances.

This study will be mainly quantitative in nature with a focus on clinical diagnostics and treatments in primary and secondary settings.

Provider-led strategies to raise awareness and/or to enhance self-care are in scope but the evaluation of self-care strategies themselves is not in scope.

For illustrative purposes only (scope to be proposed by prospective researchers) some of the outcome measures of interest may include: Physical, mental and social health, functional status, health-related quality of life, symptoms and symptom burden, health behaviours, patient experience, timely access, quality of care, cost.

#### **Additional Policy Documents/Resources/Publications**

- Women's Health Taskforce: <https://www.gov.ie/en/campaigns/-womens-health/#>

## Topic 4

### A project investigating:

- 1) What is the impact of reimbursed medicines on healthcare service utilisation in Ireland from the perspective of the health and social care system?
- 2) What reductions in healthcare service utilisation are provided by new or more intense provision of medicines to patients?

### Policy Context

The effects of an illness can range in severity and require a broad range of services both for symptom management and treatment. Over the past 20 years, there has been a steady stream of new medicines and breakthrough therapies that have changed the outlook for millions of patients. Examples include oncology medicines, such as targeted therapies and immunotherapies, to tackle previously hard to treat cancers; medicines for Hepatitis C which can cure patients and replace cumbersome and often failing treatment alternatives (and liver transplants); and medicines for rare diseases, enabling treatment of conditions where previously no options were available.

European health systems dedicate a significant level of resources to funding the provision of pharmaceutical treatments to patients. In 2021, spending on retail pharmaceuticals accounted for one-sixth of overall healthcare expenditure in OECD countries<sup>22</sup>, representing the third largest component of healthcare expenditure after inpatient and outpatient care. Governments and compulsory insurance schemes are also the main payers of retail pharmaceutical expenditure, with an average of 58% of expenditure on retail pharmaceuticals in the OECD coming from this type of funding. This is even higher in Ireland, with 82% of retail pharmaceutical expenditure being government funded.

Many countries have also seen a high-level of growth in pharmaceutical expenditure over the last decade. In Ireland, medicines expenditure has increased from €1.3bn in 2012 to €2.6bn in 2022, with expenditure likely to rise to €3bn in 2023<sup>23</sup>. This increased expenditure is a result of both increases in the price and volume of medicines purchased as a result of demographic pressure for existing medications, and the introduction of new treatment options for specialised therapies at increasingly high-prices<sup>24</sup>. Budgetary pressures from pharmaceutical expenditure are a shared concern for OECD countries, with recent innovative treatment options often targeting small patient populations at a comparatively high cost per patient treated<sup>25</sup>.

While the cost of the provision of pharmaceutical treatment options to patients can be high, these treatments are often of great benefit to patients and healthcare systems. Patient benefits are

<sup>22</sup> OECD Health at a Glance 2023 ([Health at a Glance 2023 : OECD Indicators | OECD iLibrary \(oecd-ilibrary.org\)](https://www.oecd-ilibrary.org/health-at-a-glance))

<sup>23</sup> Prior, S., Hennessy, M., Scott, R., & Walker, E. (2021). *Review of High-Tech Drug Expenditure*. Dublin: Government of Ireland.

<sup>24</sup> HIQA. (2016). *A Guide to Health Technology Assessment at HIQA*. Dublin: Health Information and Quality Authority.

<sup>25</sup> OECD. (2018). *Pharmaceutical Innovation and Access to Medicines*. Paris: Organisation for Economic Cooperation and Development.

provided via improvements in the length and quality of a patient's life upon receipt of a therapy. While the many different illnesses treated by pharmaceuticals can make these improved clinical outcomes hard to directly compare, it is common for the enhanced length and quality of life from treatment to be summarised with reference to changes in terms of "Quality-Adjusted Life Years" (QALYs) as part of a Health-Technology Assessment (HTA) Process<sup>26</sup>. Equally, pharmaceutical treatments can have significant benefits for healthcare systems in terms of reductions in resource utilisation through for example, emergency department visits, hospitalisations, or substitution of other inpatient or outpatient care for patients. These benefits are often also captured for each new therapy on an ex-ante basis as part of a HTA, with HIQA guidelines for economic evaluation of new technologies recommending the inclusion of cost savings<sup>27</sup> as a result of reductions in healthcare utilisation in other areas.

While reductions in healthcare utilisation are well understood for individual therapies on an ex-ante basis, there is still a significant knowledge gap for the Department of Health (DOH) in terms of the ex-post impact of these therapies on healthcare utilisation, especially in an environment where polypharmacy is common and the range of medical services available to patients is continually changing. Moreover, the level of reductions in healthcare utilisation from new drug introductions is important not only for approval of funding of individual drugs for reimbursement, but also for contextualising the return on the system-wide expenditure on pharmaceuticals in community and acute care settings. Namely, the high-level of expenditure growth for pharmaceuticals represents a challenge of affordability, and this affordability challenge must be contextualised where possible with the savings investment in pharmaceuticals provides to the publicly funded health and social care system in Ireland.

The pipeline for new medicines remains strong, with increased demand for and greater availability of new pharmaceutical interventions further impacting on the finite resources of the health system. The availability, affordability, and access to new medicines will continue to be a focus for national health systems. It is essential, therefore, to be able to quantify the benefit of medicines usage to the healthcare system to provide an evidence base to support ongoing decisions about investment in, and access to, necessary medicines for as many people as possible in Ireland who need them.

The State must seek on the one hand to ensure the sustainability of medicines expenditure and health expenditure more broadly, while at the same time striving to maximise the available investment to provide as many people as possible with access to the necessary medicines. There are various initiatives ongoing in the DOH and the HSE to support the medicines sustainability agenda. Here, we are interested in the economic impact of medicines usage on the health system.

### **How will the evidence inform policymaking?**

This research will provide important evidence which will contribute to the assessment of alternative scenarios and policy options and inform decisions around access to medicines and the sustainability of medicines expenditure. In particular, investigation and categorisation of the ex-post impact of pharmaceuticals on broader healthcare service utilisation will be an important consideration for overall budget setting in this context in Ireland. The extent of reductions in other healthcare service

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<sup>26</sup> HIQA. (2016). *A Guide to Health Technology Assessment at HIQA*. Dublin: Health Information and Quality Authority.

<sup>27</sup> From the perspective of the "publicly-funded health and social care system (the HSE) in Ireland"

utilisation offered by pharmaceutical access could to a greater or lesser degree allow for additional funding for pharmaceuticals, including expanded access for existing therapies and the provision of additional funding for new medicines.

The audience for the proposed research will be the DOH, the HSE, and the agencies<sup>28</sup> within the medicines pricing and reimbursement system.

## Further details on the research specification

While researchers are best placed to advise on how to achieve the specified objectives of this proposal, there are likely a range of options available to researchers to determine the ex-post reductions in healthcare utilisation offered by new drug introductions. As the overall objective is to contextualise this spend across the whole of the pharmaceutical budget, the research should where possible align the specific impact of pharmaceuticals on conditions / therapies with their overall budgetary cost to the health and social care system in Ireland. Aligning with this specification, pharmaceutical expenditure and utilisation data from the Primary Care Reimbursement System (PCRS) could be examined to determine high-cost / impact drugs to the health and social care system in Ireland for further examination. For example, drugs for further examination could be specified so that:

- A high-level of total annual pharmaceutical expenditure is represented by the drugs under examination and;
- A diverse set of indications / conditions are treated by the drugs under examination.

Once a set of drugs have been identified to this effect, researchers could then pursue several options to determine the net impact of each pharmaceutical on overall healthcare utilisation. For example, on an ex-ante basis researchers could collate and update the assessed reductions in healthcare utilisation for each drug as assessed through National Centre for Pharmacoeconomics (NCPE) / European Medicines Agency (EMA) HTAs. Where no existing HTA is available researchers could instead originate a perspective on the reduction in healthcare utilisation offered by the therapy based on existing clinical and economic research. Equally, researchers would need to consider the current system of health service provision in Ireland when making a determination on the extent of healthcare service utilisation reduction offered by each therapy. On an ex-post basis, researchers could employ interrupted time-series or other real-world evidence approaches to determine the impact of new therapies on healthcare service utilisation. In this context, The Irish Longitudinal Study on Ageing (TILDA) could be an option as a source of data, as it tracks pharmaceutical use and a range of healthcare outcomes for each surveyed participant. Equally, PCRS transaction-level micro-data, once available could be used to track the use of therapies at an individual patient, county, or health-administrative region level<sup>29</sup> with this information then compared to contemporary healthcare

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<sup>28</sup> The agencies are: The HSE's Corporate Pharmaceutical Unit (CPU), the National Centre for Pharmacoeconomics (NCPE), the HSE Medicines Management Programme (MMP), the Health Products Regulatory Authority (HPRA), and the HSE National Cancer Control Programme (NCCP).

<sup>29</sup> For example, the use of a given pharmaceutical within each hospital-group or HSE Health Region.

utilisation data (for example, activity data from HSE Management Data Reports (MDRs) within each Healthcare region) to determine the net impact of a therapy on healthcare utilisation.

Beyond these approaches, researchers could also draw on broader international literature for how pharmaceutical treatments impact healthcare utilisation or could examine models of disease trends and the impact of new medicines for particular groups or diseases and contextualise these sources of information to Ireland through information on Irish disease incidence and drug utilisation.

### **Relevant Datasets**

There are a number of datasets that are relevant to this project.

- The National Centre for Pharmacoeconomics (NCPE) and HSE-Corporate Pharmaceutical Unit (CPU) on data for medicines approvals, and the medicines reimbursement list.
- NCPE Health Technology Assessment reports for individual pharmaceuticals.
- HSE-Primary Care Reimbursement Service (PCRS) data, including at a patient-level through reference to PPSN or an alternative unique identifier.

### **Additional Policy Documents/Resources/Publications**

- [OECD Indicators Pharmaceutical Expenditure at a glance 2023 - Chapter 9: https://www.oecd-ilibrary.org/sites/5370e641-en/index.html?itemId=/content/component/5370e641-en](https://www.oecd-ilibrary.org/sites/5370e641-en/index.html?itemId=/content/component/5370e641-en)
- NCPE Rapid Reviews and Health Technology Assessments of individual therapies: <https://www.ncpe.ie/>
- Mazars Review of the Governance Arrangements and the Resources currently in place to support the Health Service Executive reimbursement and pricing decision-making process: <https://www.gov.ie/pdf/?file=https://assets.gov.ie/258773/70942321-d13b-49b4-b24d-28e097076ba5.pdf#page=null>  
<https://www.gov.ie/pdf/?file=https://assets.gov.ie/248326/90ff0ded-9ab8-41fa-9b9a-b5660775d767.pdf#page=null>



## Topic 5

### An evidence-informed approach to developing a National Primary Care Therapy Waiting list protocol.

#### Policy Context

There is wide variation across the country and across various Primary Care Therapy waiting list processes and practices. For example, there is geographical variation in the referral and access criteria, lack of core set of protocols including referral information, assessment of need visibility, prioritisation, and validation.

There is now a need to bring a more consistent approach at a national level to waiting list management in Primary Care to ensure that there is a standardised user-friendly approach to the management and scheduling of patients on waiting lists within each Community Healthcare Network and across Health Regions. It is envisaged that such standardisation will be brought about by the implementation of a National Primary Care Therapy Waiting List Management Protocol, similar to the Waiting List Management Protocols that have been developed by the National Treatment Purchase Fund (NTPF) for Acute Hospital Waiting Lists. This would provide guidance to staff working in these services to ensure that there is a consistent and standardised approach to the management and scheduling of patients on these waiting lists.

The primary goals and objectives of a Protocol are to:

- promote the safe, timely and effective access to Primary Care Therapies regardless of location (the therapies in question are Primary Care Psychology, Occupational Therapy (OT), Speech & Language Therapy (SLT) and Physiotherapy. These are exclusive of the services offered by Child and Adolescent Mental Health Services (CAMHS) and the Childrens Disability Network Teams (CDNTs).)
- inform governance from a 'bottom up, top down' perspective
- provide guidance to staff (administrative, clinical, management, other) working in these services to ensure that there is a consistent and standardised approach to the management and scheduling of patients on these waiting lists
- ensure collection and reporting of accurate, quality assured data and information
- ensure greater understanding of the scale of demand, the drivers of demand and allow for improved planning, interventions and investment considerations.

A protocol will enable a series of improvements to waiting list administration and as the systems moves to the establishment of the Health Regions, this Protocol will be subject to review and updating on an ongoing basis.

#### How will the evidence inform policymaking?

Outputs from this research are expected to inform work to develop a new National Protocol and will inform implementation steps and subsequent reporting/tracking. It is envisaged that the research team will engage with stakeholders to input into the development of the draft protocol and they will present it and learnings they have gleaned that can guide any and all future

implementation/reporting stages to the DOH as early as practically possible in 2026. It will be the responsibility of DOH/HSE to finalise, implement and report/track accordingly from that point as part of routine business.

## Further details on Research Specification

The therapies in scope for this research are Primary Care Psychology, OT, SLT and Physiotherapy.

These are exclusive of the services offered by CAMHS and the CDNTs.

It is anticipated that research in response to this request will comprise a mixed methods study, with the following elements:

### (a) System and Process Mapping

Develop process maps of current practice from receipt of a referral letter to discharge from the waiting list. This will require direct engagement with service providers at a local level to understand how the process is supposed to work at present, how it works in practice, and what should be included in a new Waiting List Management Protocol. Key stakeholders include DOH, HSE Primary Care Operations, CHO leadership (Chief Officer/Head of Service – Primary Care), local service delivery (Primary Care teams), HSE Clinical Governance and HSE Transformation.

(b) Summary of relevant findings from the international literature if there is available literature regarding best practice management of waiting lists in primary care, addressing non-attendance, barriers to attendance, improving communications with patients, patient-safety regarding discharge of patients, and/or balancing urgent versus non-urgent care to ensure all patients are seen in a timely manner. However, this should be informed by stakeholder engagement re: challenges experienced in timely access complement national/local learning.

### (c) Draft Waiting List Management Protocol

Based on the above work, propose a draft Waiting List Management Protocol similar to equivalent protocols published by the NTPF (e.g., National Outpatient Waiting List Management Protocol 2022<sup>30</sup>) to include, at a minimum, details regarding the following (not exhaustive):

- Source of Referral
- Acceptance or Non-Acceptance of Referral
- Case Assessment and Assignment of Clinical Priority
- Adding a Patient to the Waiting List and minimum data requirements
- Cancellations
- Did Not Attend (DNA)
- Validation
- Insourcing Arrangements

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<sup>30</sup> [Outpatient \(OP\) Waiting List Management Protocol 2022.pdf \(ntpf.ie\)](#)

- Outsourcing Arrangements
- Removing a Patient from a Waiting List

**Additional Policy Documents/Resources/Publications**

- Referral, Waiting List and Activity data is available from HSE Business Intelligence Unit (BIU).
- Some waiting list and activity data is reported in Management Data Report (MDR) and Performance Profile on the HSE website; note publication of such reports typically has a time delay of several months).

## Topic 6

### Producing a Health in Transition health system review (HiT) for Ireland as part of the European Observatory on Health Systems and Policies HiT series.

#### Policy Context

The Health Systems in Transition (HiT) series, led by the European Observatory on Health Systems and Policies<sup>31</sup>, systematically describes the functioning of health systems in countries as well as analysing the system's ability to deal with issues, reforms and policy options. The HiT health system reviews cover the countries of the WHO European Region as well as some additional OECD countries. They are updated on a regular basis and are the starting point for comparative analysis.

HiTs give an in-depth description of a country's health system and are building blocks that can be used to:

- learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems
- describe the institutional framework, process, content and implementation of health care reform programmes
- highlight challenges and areas that require more in-depth analysis
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries, and
- assist other researchers in more in-depth comparative health policy analysis.

Ireland's last HiT was conducted in 2009<sup>32</sup>, and in advance of Ireland assuming the EU Presidency in 2026 this is an opportune time to update Ireland's HiT Health System Review. A team of suitably qualified researchers are invited to complete an updated HiT review for Ireland.

#### How will the evidence inform policymaking?

A detailed description of Ireland's Health System will facilitate analysis at all stages of the policy lifecycle (Fig 1, p 4 of this document). In particular, it will be useful at the initial stage of the policy cycle (Problem Definition/Agenda Setting) by providing an understanding of the existing system in Ireland and facilitating international comparisons.

The HiT is not just relevant for academics and policymakers in Ireland, but also for academic and policy makers working in other European countries and further afield as part of their policy making process.

#### Further details on research specification

Each HiT is produced by country experts in collaboration with the staff of the European Observatory on Health Systems and Policies, who undertake the main editing tasks through a dedicated technical

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<sup>31</sup> <https://eurohealthobservatory.who.int/>

<sup>32</sup> <https://eurohealthobservatory.who.int/publications/i/ireland-health-system-review-2009>

editor (and who will also be a co-author). In order to facilitate comparisons between countries, the HiT reviews are based on a prescribed template (see additional resources below), which covers a comprehensive range of topics on health system organization, financing, delivery, reforms and performance.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs should be the subject of wide consultation throughout the writing and editing process and are then subject to a rigorous review process. The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible and that HiT meet the required standard and can support both national decision-making and comparisons across countries.

While the Observatory team support the production of the HiT, the development of the content for the publication itself will be undertaken by the prospective research team. The authors of the HiT will need substantial knowledge of the Irish health system and have the ability to source and analyse the information required to accurately complete the HiT. Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including data from national statistical offices, the Organisation for Economic Co-operation and Development (OECD)<sup>33</sup>, the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors, including national and regional policy documents, and other published literature. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data has been officially approved by national governments.

**The authors of the new edition of the health system review (HiT) for Ireland will:**

1. Identify and review relevant literature and data
2. Draft all of the chapters as outlined
3. Revise the text, tables and figures as necessary in light of comments from editors, external reviewers and internal review, in an iterative process to produce the final version
4. Finalise the manuscript in line with requirements to submit for production
5. Answer copyediting questions and check proofs prior to publication.

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<sup>33</sup> The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical organisations and health ministries.

The expected timeframe for completion of the HiT is approximately 12-18 months, starting no later than September 2024 with a view to submitting the finalised report to the European Observatory on Health Systems and Policies by December 2025. This ensures publication in time for Ireland assuming the EU Presidency in the second half of 2026.

**In addition to the HiT**, DOH and HRB are seeking complementary deliverables including but not limited to:

6. Provide a summary of identified evidence gaps that arise during the course or arising from the work to produce the report
7. Provide a summary of identified data gaps or developments that arise during the course or arising from the work to produce the report
8. Host a policy dialogue to discuss and debate the findings.

### **Additional Policy Documents/Resources/Publications**

- [OECD Country Profile - Ireland](#)
- [Department of Health Statement of Strategy 2021-2023](#)
- [Committee on the Future of Healthcare: Sláintecare Report](#)
- [Sláintecare Implementation Strategy and Action Plan 2021-2023](#)
- [HiT template for authors 2019](#)

## Topic 7

**An outcome evaluation to (1) measure the impact of Advanced Practice roles for Health & Social Care Professionals (HSCP), including on access to care and the patient journey at this interface between primary and secondary care, and (2) generate evidence on the barriers and enablers for implementing and scaling further reforms.**

### Policy Context

Sláintecare's focus on community care services and community healthcare networks is transforming healthcare delivery with a focus on care closer to home. This has seen an unprecedented increase in numbers of health and social care professional (HSCP) posts in community and primary care services. Supporting HSCPs to work at the top of their licence is an objective of workforce reform under the Sláintecare Reform Programme. There are plenty of examples of innovative and progressive practice by HSCP within our health service to deliver improved access to care, reduce waiting times (MSK triage programme), and in integrated care in the community (pathfinder, community diagnostics).

The health care professionals delivering in these roles must be supported and valued by having the appropriate health system reform to enable them to deliver patient care at the lowest level of complexity. There are barriers to this in our health system that have been identified by Clinical Care programmes and the Integrated Care Programme in the HSE.

By way of example, The National Clinical Programme for Trauma and Orthopaedic Surgery (NCPTOS) and the National Clinical Programme for Rheumatology (NCPH) established a pathway of care in 2012 whereby Clinical Specialists Physiotherapists (CSPs) lead care of the patients waiting to see an orthopaedic surgeon or rheumatologist. The vision of the National Clinical Programmes for this initiative was for CSPs working at an advanced practice level to become the first contact practitioners working in the GP/community setting. It is envisaged that this could result in a 60% reduction of appropriate referrals being added to the acute hospital waiting list for orthopaedics and rheumatology. This is aligned with Sláintecare principles and would optimise the utilisation of resources within the acute hospital setting. Up to the end of July 2021, 194,105 patients had been removed from the Outpatient Department (OPD) waiting lists and the number is now above 200,000.

Other innovations in the delivery of specialist care at this interface between primary and secondary care include advanced practice physiotherapists seeing patients with musculoskeletal complaints that otherwise would be placed to wait on an acute hospital orthopaedic or rheumatology waiting list; advanced practice radiographers setting up community based clinics to complete diagnostic scans which may otherwise require an acute hospital visit; and advanced practice speech and language therapists seeing patients and completing specialist diagnostic assessment in the place of the need for an acute hospital visit or to wait on an Ear, Nose & Throat Specialist Waiting List.

These types of initiatives are delivering in both capacity and productivity, however in the absence of an agreed policy on the development of Advanced Practice roles for HSCP, it is difficult to quantify and record the impact of these initiatives.

Advanced HSCP Practice roles are well established in other jurisdictions, in particular Australia, England, Wales, and Northern Ireland. Establishing advanced practice roles is of huge importance for the retention of highly trained and skilled HSCP across the health service. The health sector in Ireland is already experiencing challenges in the recruitment and retention of health professionals, with the lack of opportunity for career progression being cited as a key barrier.

The Chief HSCP Officer was appointed to the Department of Health (DOH) in May 2023 to have the specialist knowledge required for policy development in this area. The development of an evidence-based policy is progressing, with work underway by officials in the DOH, and there has been a collaborative approach with the HSE National HSCP office. This includes consideration of the most appropriate regulatory framework for the Irish context, education and training, and legislative changes where necessary, as informed by the evolving clinical needs of the population. This policy will enable these roles and initiatives to be scaled and delivered throughout the health regions in accordance with Sláintecare goals.

An outcome evaluation which measures the impact of Advanced Practice roles for HSCP, including on access to care and the patient journey at this interface between primary and secondary care, can provide evidence-based information on the effectiveness and impact of this policy reform. It can also provide useful learning on implementation matters for policymakers and other key stakeholders. To aid in the identification of barriers and enablers for implementation by policymakers and other key stakeholders, an evaluation which adopts an implementation science approach would be welcome. This could highlight the context in which implementation occurs, and the factors that influence implementation such as acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, coverage, and sustainability etc.

### **How will the evidence inform policymaking?**

This outcome evaluation should inform the design, implementation and monitoring of Advanced Practice roles for HSCPs. The research should identify the enablers and commonalities, as well as potential barriers and risks associated with implementing this reform to inform policy development for the Workforce Reform Unit and the DOH.

The evaluation will be developed alongside the Policy on Advanced Practice for HSCPs and should provide data to evaluate the impact of the new roles on access to care, patient outcomes, staff retention and satisfaction, and clinical and financial efficiencies in the health system.

### **Further details on the research specification**

While the international evidence from jurisdictions that have already introduced Advanced HSCP Practice are useful in assessing the benefits of implementing these roles, there is a growing evidence base in Ireland from small initiatives and pilots where skills and experience of HSCPs and/or Advanced Practice nurses were used to develop an innovative approach to care within integrated care teams. The HSE Framework on Advanced Practice includes a number of pilot initiatives which demonstrate the positive impact of expanding the scope of practice of HSCPs. These health care professionals and innovative roles are often working at the interface between primary and secondary care, to deliver specialist assessment and treatment to patients. These roles have been developed often through frontline clinical leadership in small pockets of the health service. Examples are demonstrated in the Sláintecare Integration Innovation Fund projects, the HSE Excellence Awards,



Spark Innovation funding initiatives, the National HSCP Office and in data sent to the Chief HSCP Officer from clinical services. These roles are not established as Advanced Practice roles due to the lack of a regulatory framework, grade codes, funding mechanism.

The first step in implementing and scaling these Advanced Practice roles is to identify the clinical and service needs that would benefit the implementation. The DOH are engaging with the HSE under the auspices of the National Lead for Integrated Care and the Clinical Design and Innovation team. The DOH have sought input on the clinical and service needs through this forum to include the National Clinical Programmes. A request was sent to the National Clinical Advisors and Group Lead forum through the National Lead for Integrated Care to assist in identifying Clinical Programmes and models/pathways of care where there is relevance and readiness for Advanced Practice in HSCP. The rationale and any impact data to support this e.g., waiting list numbers, admission avoidance, integrated care, improved patient outcomes etc. was requested, and was due to be fed back to the DOH by end of November 2023.

This information will be collated and analysed, and this will inform the implementation of these roles across the health service, as to which professions and specific clinical areas will be progressed in the first phase of implementation of the policy. It is likely that the initial roll out will include between 3 to 5 professions and between 4 to 8 specific clinical areas that meet the threshold for Advanced Practice. The Stakeholder group for Advanced Practice will meet in early 2024 with expected implementation phase (for the relevant clinical areas) commencing in Quarter 3 2024.

It is anticipated that the outcome evaluation will be advanced through working closely with the DOH and the Group overseeing policy development and making decisions on introduction of new roles. Relevant stakeholders, on the Steering Group and otherwise will provide advice, support and access to sites and datasets for the project. Data is collected by some of the clinical programmes on outcome variables which should support a pre-post dimension to the evaluation. The DOH can also support the research team with the identification of comparison sites which can be used as a control.

The research will at a minimum focus on waiting list data, OPD - Activity data, and the National Clinical Programmes activity and performance data.

### **Additional Policy Documents/Resources/Publications**

- WHO Health and care workforce in Europe: Time to Act (2022) <https://www.who.int/europe/publications/i/item/9789289058339> WHO Bucharest Declaration on health and care workforce (2023) <https://www.who.int/europe/publications/i/item/bucharest-declaration>
- WHO Framework for action on the health and care workforce in the WHO European Region 2023–2030 <https://iris.who.int/handle/10665/372563>
- WHO Towards a sustainable health workforce in the WHO European Region: Framework for Action (2010) <https://www.who.int/europe/publications/i/item/WHO-EURO-2018-3069-42827-59770>
- SLÁINTECARE IMPLEMENTATION STRATEGY <https://assets.gov.ie/22607/31c6f981a4b847219d3d6615fc3e4163.pdf>

- HSE Health Regions Implementation Plan (2023)  
<https://www.gov.ie/pdf/?file=https://assets.gov.ie/266115/7b86800b-934d-4849-88ae-e8fc4b809465.pdf#page=null>
- HSE Health Services People Strategy (2019-2024)  
<https://www.hse.ie/eng/staff/resources/hrstrategiesreports/health-services-people-strategy-2019-2024.pdf>
- HSCP Deliver A Strategic Guidance Framework for Health & Social Care Professions (2021-2026)  
<https://www.hse.ie/eng/about/who/health-and-social-care-professionals/hscp-strategic-framework/hscp-deliver-a-strategic-guidance-framework-for-hscp-2021-2026.pdf>
- Working Together for Health A National Strategic Framework for Health and Social Care Workforce Planning (2017) <https://www.gov.ie/en/publication/f303a9-working-together-for-health-a-national-strategic-framework-for-health/>
- Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions (2022). (Unpublished, available upon request)
- HSE HSCP Framework on Advanced Practice <https://www.hse.ie/eng/about/who/health-and-social-care-professionals/final-draft-hscp-ap-framework-for-consultation-dec-2022.pdf>  
(Final published version available from HSE, available upon request)
- National Office for Health and Social Care Professionals. Progressing advanced practice in health and social care professions: Senior clinical decision making and advanced level of practice to enhance safe, effective and timely person centred care. 2020. (Unpublished, available upon request).
- Acute Hospital Waiting Lists and Times: International Comparison of Determinants of Inflows and Outflows Waiting Lists Series, Robert Murphy & Ailish Kelly, Research Services & Policy Unit, DOH March 2023 <https://assets.gov.ie/250968/cde1a2e4-4ae3-4bfb-a6a7-6de36fef08c4.pdf>

## Topic 8

**Strategies to improve Value for Money in Irish health care delivery in primary, community and acute settings, focusing on productivity, efficiency and sustainability.**

### Policy Context

Decision makers globally are increasingly faced with the challenge of reconciling growing demand for health care services with available funds. The Irish healthcare system is not immune from this and continues to face immediate and longer-term challenges, including substantial budgetary pressures, a hospital-centric model of care, workforce retention challenges, long waiting lists for inpatient procedures, and a growing and ageing population, all of which will demand a greater level of healthcare service delivery.

While healthcare investment has risen to an unprecedented level in recent years in Ireland, rising from €11.8bn in 2016 to €22.5bn in 2024, these challenges persist demanding a new approach focused on enhancing the efficiency or value for money of healthcare service investments undertaken. Instead of relying on further increases in resources alone, these challenges will need to be addressed through innovative and evidence-informed approaches to healthcare service delivery, both in terms of infrastructure investment in the right areas to facilitate better patient care, such as physical and digital infrastructure investment, and productivity enhancing reforms of existing services and resources use. Health system reform requires purposeful strategies to improve the efficiency of healthcare service delivery in both an incremental and structural way, such as research pertaining to acute care productivity enhancement, integrated healthcare delivery, enhanced community care and population-based allocation among other approaches.

Improvements to health system productivity are essential to ensuring the healthcare system can meet the care needs of the Irish population in a fiscally sustainable manner. The need for dedicated research focused on productivity improvement in this area is further emphasised by what is internationally referred to as the “productivity puzzle”, where healthcare activity is failing to keep up with the level of investment dedicated to patient treatment. This is not a phenomenon purely caused by Covid; clearly productivity fell dramatically during the worst of the crisis as health systems re-oriented to respond to a new threat. But in Ireland, for example, the acute care system has seen a real expenditure increase of over 50% between 2016 and 2023, while activity over the same period in hospitals has increased by just 10-20%.

### How will the evidence inform policymaking?

This topic is more open than the others in this round of the EfP programme and is not prescriptive in terms of themes or settings for prospective applicants. We welcome all innovative research ideas into issues of productivity, efficiency and sustainability that have the potential to make a transformational difference to health and social care provision in Ireland.

**Please note:** we do not invite applications under this topic that focus on diagnostic, therapeutic or device interventions – such applications should be submitted to the dedicated HRB scheme (DIFA)

which supports the generation of evidence on the efficiency, effectiveness and costs of pilot, feasibility and/or definitive trials and interventions.

The evidence generated will inform policy formulation to improve productivity and value for money in the healthcare system. It will support accountability for the investment made in healthcare delivery both in terms of financial governance and patient impact.

### **Further details on the research specification**

The DOH is interested in ensuring that the best possible outcomes are delivered for the inputs provided. The research community can support the DOH in improving the delivery of existing services through research focused on productivity enhancing strategies or approaches in both acute and community settings.

Research teams should explore ways that health, or health and social care services could increase value, and provide more for less. Proposed research projects must be practically oriented and have a strong potential for implementation. This may lead to the introduction of efficient strategies, approaches and practices but equally to the termination of those that have proven to be inefficient.

By way of guidance only (this is not an exhaustive list), such approaches could include:

- projects focused on developing a better understanding of the likely impact of health care policy and process change on cost, capacity, value, productivity and efficiency,
- Projects focusing on cost and allocative efficiency and efficiency incentives,
- projects focusing on technical and scale efficiency,
- projects focusing on the effect of new health care technologies on productivity and efficiency,
- projects focusing on focused on workforce productivity, staff retention and sustainability,
- projects focusing on factors that optimise the spread and diffusion of efficient practice and innovation in health and social care.

Areas of particular interest from a value for money perspective include major spending lines such as enhanced community care, chronic disease management, pharmaceutical expenditure in acute and community settings, capital investment in new facilities and ICT.

The EfP call welcomes applications using a broad range of methodologies, and it will be up to the research team to identify and justify the chosen methodology.

### **Additional Policy Documents/Resources/Publications**

- [OECD Economic Surveys: Ireland 2022](#)
- [Hospital Performance: An Analysis of HSE Key Performance Indicators \(Conor Clancy, Conan Shine, Mark Hennessy, Department of Health, 2023\)](#)

## Appendix II: Detailed Guidance on the Application Form

Only registered users of the GEMS system can apply for grants. In order to submit an online application to the HRB, applicants are required to register at the following address:

<https://grants.hrb.ie>

Please refer to the **GEMS Technical Guidance Note**<sup>34</sup>, available on the left-hand column of your GEMS profile homepage, for further information.

The **Lead Applicant** must create the application, but it can then be jointly completed with named Co-Applicants.

Lead Applicants can register on GEMS and they will receive an email to confirm their registration and log in details. The Lead Applicant can then add information on their contact and CV details in 'Manage My Details' section of GEMS.

Lead Applicants previously registered on GEMS can login to GEMS and update any information regarding their contact and CV details in 'Manage my details'.

Once logged in to GEMS applicants are taken directly to the Home page which is the starting point to create a new Grant application.

The Applicant will be asked to complete a check list of mandatory questions. In order to access the application form, the Lead Applicant must satisfy the conditions of this check list:

Lead Applicant Eligibility	
I have read the Guidance Notes for the EFP 2024 call.	<input checked="" type="checkbox"/>
I am clear about the role of the authorized signatory in the nominated Host Institution (HI) and I am aware that I need to build sufficient time into the application process for the HI to access, review and approve my final application for submission to the HRB through the GEMS system.	<input checked="" type="checkbox"/>
Consent	
By submitting this application, I consent to (a) sharing of my data outside of the European Economic Area (EEA) for the purpose of international peer review, and (b) the use of my data for assessment of my application; monitoring of successful awards; and evaluation of HRB's approach to funding and investment in research, in line with HRB policies and as detailed in the EFP 2024 Call Guidance Notes.	<input checked="" type="checkbox"/>

The Lead Applicant will be then able to start the application. Further details for completing each of the main sections of the application form are provided below:

<sup>34</sup> <https://research.ie/assets/uploads/2020/05/CCGT-Grant-Application-System-Technical-Guidance-Notes.pdf>

## Host Institution

For the purposes of contracting, payment, and management of the award, HRB funds can only be awarded to HRB approved Host Institutions. Please note this call is open to Host Institutions from the Republic of Ireland and from Northern Ireland\*. The Host Institution for the award is normally that of the **Lead Applicant**, but it may be another organisation/institution designated by the research team, where it is clearly justified. In GEMS you will be asked to identify a Host Institution (from [this list](#)) and type it in full (do not use acronyms such as UCD, TCD, NUIG). Once you have entered the first 3-4 characters of the Host Institution, you will be assisted with auto-select options. It is important that the Host Institution name is entered accurately and in full as an incorrect entry may result in delays in attaining Host Institution approvals.

If you wish to propose a Host Institution which is not on the HRB list, you are advised to contact the HRB at [gemshelp@hrb.ie](mailto:gemshelp@hrb.ie).

**Note:** In order to be eligible to apply for funding, an Institution must have been approved as a HRB Host Institution **no later than two calendar months** before the closing date of a call, only pre-approved Host Institutions will appear in this list.

**\*Please note that applicants from Northern Ireland will be required to partner with co-applicants from the Republic of Ireland in order to be eligible to apply.**

## Signatory Notification (within Host Institution)

Once the **Host Institution** is selected at the initial stages of application creation, this will allow the Lead applicant to notify the **authorised signatory** (Dean of Research or equivalent person authorised to endorse research grant applications for the Host Institution) in that Host Institution of the Lead Applicant's intention to submit an application to EfP 2024. The signatory's details are pre-populated in the system, so the applicant just needs to click 'NOTIFY' within GEMS. We recommend that **you notify the Host Institution signatory** of your intention to apply as soon as possible in the application process. The signatory will receive an email from GEMS with the name and email details of the Lead Applicant and if they have any queries or clarifications, they can engage directly to resolve them with the Lead Applicant. The Host Institution signatory must confirm their willingness to participate as Host Institution for the application through GEMS and once they do this a PDF of the application will be available for them to review with a view to them ultimately approving the final version for submission to the HRB.

## Topic selection

Applicants are expected to respond directly to requirements laid out in the research specification for one of eight pre-defined topics.

Please select from the dropdown menu which Topic your research is proposing to address.

## 1 Lead Applicant's Details

Before entering their details Lead Applicants are asked to confirm that they are not applying for, holding, or employed under funding received from either the tobacco industry or alcohol industry or related actors, as per HRB's position statement of January 2024<sup>35</sup>.

Details are requested about the **Lead Applicant** including their position and status (contract or permanent), their supervisory experience, and whether they are seeking salary-related costs. Please note that a **letter of support from the Host Institution** must be provided if the Lead Applicant is on a contract position.

**Host Institution Letters of Support** must be provided for (1) all Lead Applicant- in a contract position and (2) Researcher Co-Applicants in a contract position who are seeking their own salary. The formal letter on headed notepaper, dated and signed by the Head of School/Research Centre must include the following information; *[Host Institution – insert name] which is the Host Institution of [applicant – insert name] confirms that [applicant/co-applicant – insert name]:* (i) holds an employment contract which extends until *[insert date]* or will be recognised by the Host Institution upon receipt of the HRB EfP award as a contract researcher; (ii) has a dedicated office and research space/facilities for which they is fully responsible for at least the duration of the award, and *[where applicable i.e. supervisory role in project]* (iii) has the capability and authority to supervise the research team.

Electronic signatures are acceptable for letters that are uploaded on the HRB GEMS system.

The Lead Applicant's **contact and CV** details (Name, institution, present position, employment history, profession, and ORCID iD) are managed in 'manage my details' section of GEMS and **are automatically included in any application created involving that individual**. You are asked to select your 5 most relevant publications for this application.

**Note:** The HRB is now an ORCID member. Lead applicants are encouraged to include an ORCID iD by updating their GEMS profile under 'Manage my Details' and this will feed automatically into the application form. You have also the option to import your publication record from ORCID iD in addition to PubMed. Please note this is not a mandatory field for submitting your application. For more information and to register please see <https://orcid.org/>.

### Publications and Funding Record

Publications are automatically included in any application created involving the Lead Applicant Researcher. To update this information, edit the 'My Research Outputs' section on the Home page of GEMS. You can then use the Publication selection tool in the relevant section of the application form to select your **5 most relevant publications** for this application.

You should also include your **5 most relevant funding awards** as Principal Investigator or Co-Applicant.

For the purpose of this application form, Funding Record details should be added directly on to the application form and will not be pulled through from the 'manage my details' section of GEMS.

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<sup>35</sup> <https://www.hrb.ie/funding/manage-a-grant/grant-policies/tobacco-and-alcohol-industry-funding/>

### **Additional evidence of experience and expertise relevant to this application**

The Lead Applicant can describe any additional experience or expertise that will provide evidence of their ability to successfully lead the proposed project. This section focuses on the applicant contribution to the generation of knowledge, new ideas and hypotheses/methods, translation of evidence to policy or practice. This can include how ideas and research results were communicated (written and verbally), as well as funding and awards received. The word limit is **400 words**.

**Note:** Research outputs can include datasets, software, publications, commercial or entrepreneurial or industrial products, educational products, clinical practice developments, policy publications, and other similar items. These should be examples of rigorous science following high standards, that are reproducible, and others can build upon.

**Please do not** include information related to H-indexes, impact factors, or any type of metric that refers to the journal, publisher, or publication platform. The scientific content of a paper is much more important than publication metrics or the identity of the journal in which it was published.

### **Breaks from research**

In this section the Lead Applicant may want to mention breaks from research, such as statutory leave, secondments, flexible work arrangements or other relevant changes (e.g., sector or discipline) that may have affected or influenced their progression as researcher. Please state the period and the reason. The word limit is **150 words**.

## **2 Co-Applicants' Details**

The Lead Applicant can add **up to 6 Co-Applicants** to an application by entering their name on GEMS. If the Co-Applicant is already registered on GEMS, the system will find them and will allow the Lead Applicant to select them. Alternatively, a Co-Applicant can be added manually by entering their name and email details. GEMS will send them an email with login details for completing the registration process and will inform them that they have been invited by the Lead Applicant to participate on the application as a Co-Applicant. **Registered Co-Applicants** can decide whether to accept or reject their participation and **must consent to the application being submitted jointly in their name**. If a Co-Applicant rejects participation on an application the Lead Applicant is informed and may revise the application accordingly. Co-Applicants who accept participation in an application will be able to edit the application. **The system will flag if another user is working on the application form at the same time via a pop-up warning. A member of the applicant team may choose to over-ride this pop-up message and continue to enter data, but it is advisable that they contact the other person directly to avoid losing data when applying the override function.**

Each Co-Applicant can manage their **contact and CV details** (Name, contact information, institution or organisation, present position, employment history, profession, membership details of professional bodies, and ORCID iD) under 'Manage my Details' section of GEMS and this information will be automatically included in any application that involves this individual.

Co-Applicants will be asked to select whether they are a **Researcher, Knowledge User, or PPI contributor Co-Applicant** for the purpose of the proposed research. If a Co-Applicants contributes from more than one perspective, please select the dominant role.



## 2.1 Researcher Co-Applicants

Researcher Co-Applicants will be asked to provide additional information in the application form, including their **5 most relevant publications** in peer-reviewed journals, their **relevant funding record** (past or current grants held, including HRB grants), and their **current position and status** (contract or permanent).

### **Additional evidence of experience and expertise relevant to this application**

The Researcher Co-Applicant can describe their contribution to the generation of knowledge, new ideas and hypotheses/methods, translation of evidence to policy or practice. This can include how ideas and research results were communicated (written and verbally), as well as funding and awards received. The word limit is **400 words**.

### **Breaks from research**

In this section the Researcher Co-Applicant may want to mention breaks from research, such as statutory leave, secondments, flexible work arrangements or other relevant changes (e.g., sector or discipline) that may have affected or influenced their progression as researcher. Please state the period and the reason. The word limit is **150 words**.

For Researcher Co-Applicants holding contract positions who are seeking their own salary, a [Letter of Support](#) from the Host Institution must also be included.

## 2.2 Knowledge User Co-Applicant

While there will be close engagement with DOH policy units during project delivery as the key knowledge user, the involvement of other relevant knowledge users (national or international) as co-applicants is welcome **where this adds value** to the research proposed.

**Knowledge User Co-Applicants** will be asked to provide information regarding **their expertise and experience in influencing decision making within knowledge user organisation(s)**.

Knowledge User Co-Applicants will be asked to highlight their previous and current roles in influencing decision-making processes within their organisation or other relevant organisations. They should also use this space to highlight their specific experiences and expertise for the Knowledge User Co-Applicant role in relation to the proposed research. The word limit is **300 words**.

**Knowledge User Co-Applicants** will be asked to provide information regarding potential **Additional experience and expertise relevant to this application**. For example, they may wish to include any relevant research experience/expertise, previous experience of working in collaboration or links with researchers to produce research or evidence for health, evidence of Public and Patient Involvement in your knowledge user role, and roles/responsibilities as a constructive and effective change agent. The word limit is **300 words**.

## 2.3 PPI Contributor Co-Applicants

**PPI Co-Applicants** should provide some information regarding their experience and expertise relevant to this application. For example, they may wish to include relevant experience as a service user or carer, relevant experience from their personal lives, prior experience in PPI or any other useful background information. The word limit is **400 words**.

### 3 Collaborators' Details

The Lead Applicant can add **up to 10 collaborators** per application. Unlike Co-Applicants, the information for Collaborators **is not** automatically drawn from the 'Manage my Details' section of GEMS but must be entered by the Lead Applicant. The Lead Applicant must enter **contact and CV details** for all Collaborators including name, contact information, institution or organisation, present position, employment history, profession and membership details of professional bodies, **Publications and Funding Record** (if applicable) (**five most relevant** publications in peer-reviewed journals and details of any past or current grants held (including HRB grants) relevant to this application where the Collaborator has acted as Principal Investigator or Co-Applicant).

If access to data, databases, or a link to an existing national or international study (e.g., an existing cohort or longitudinal study) are an integral part of the proposed project, evidence of commitment and access must be demonstrated by having the Data Controller or key Gatekeeper of a study included as a Collaborator.

In addition, for each Collaborator a signed **Collaboration Agreement Form** must be provided. A template Collaboration Agreement Form is available for download from GEMS. Forms must be completed, signed, dated, and uploaded where indicated on HRB GEMS. Please label each form with the name of the relevant Collaborator. Electronic signatures are acceptable on letters/forms that are uploaded on GEMS.

### 4 Project Details

#### 4.1 Project Title

You are asked to provide a title that clearly describes the research to which this application is related. This should be descriptive and concise and should reflect the aim of the project. There is a **200 characters** maximum limit.

#### 4.2 Project Duration and Start Date

Please indicate the expected length of the proposed project in months (minimum duration of 12 months and maximum duration is 24 months) and the proposed start date. The earliest start date is 01 September 2024, and the latest start date is 01 December 2024.

#### 4.3 Project Lay Summary

This lay summary is similar to the Project Abstract in that you are asked to describe what you propose to do, why you think it is important and how you are going to go about conducting, analysing and drawing conclusions from the research. The difference is that it **needs to be written as a plain English summary** such that it is clear, easy to understand, and is easily accessible to a lay audience. It should not be copied and pasted from elsewhere in the application. The lay summary may be used when providing information to the public with regards to the variety of research funded by the HRB and may be posted on the HRB website. A well-written lay summary will enable peer reviewers and Panel members to have a better understanding of your research application. The word limit is **300 words**.

## 4.4 Project Abstract

This should be a succinct summary of the proposed research. This structured summary should clearly outline the background to the research, the aims and hypotheses of the project. The objectives of the project and what the work is expected to establish should be described. It provides a clear synopsis of your application and should set the research application in context. The word limit is **300 words**.

## 4.5 Keywords

Please enter up to **5 keywords** that specifically describe your research project.

## 5 Project Description

Please ensure that your application is focused, and that sufficient evidence is provided to enable the international peer reviewers and grant selection panel members to reach a considered judgement as to the quality of your research application, its potential health impact and its feasibility.

The Project Description must include:

1. Background to the proposal
2. Overall Aim
3. Objectives and Deliverables (plus Gantt chart or alternative)
4. Research Design and Methodological Approach
5. Integrated Knowledge Translation (iKT) and Dissemination
6. Project Management
7. FAIR Data Management and Stewardship
8. Public and Patient Involvement (PPI) in the Research Project
9. Gender and/or Sex Issues in the Research Project
10. Potential Safety Risks and Ethical Concerns
11. Project Description Figures (where appropriate)
12. References

### 5.1 Background to the proposal

Describe the background to the research application, grounding your proposal in the national\* and international context and evidence.

Demonstrate your understanding of why this research is both important and timely and how your research will address the policy evidence gap identified and, where applicable, advance the state of the art in this area.

\*Be aware that the peer reviewers reading your application are based outside of Ireland, so it is critical to describe the healthcare delivery context in Ireland when discussing issues around the need (including specific needs of any under-represented groups), relevance, timeliness, and feasibility. The word limit is **1200 words**.

## 5.2 Overall Aim

Please state the overall aim of the research project. The word limit is **100 words**

## 5.3 Objectives and Deliverables

Please add a **minimum of 3** research objectives. Objectives should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-bound). For each objective, list a subset of deliverables which will be used to monitor progress throughout the lifetime of the award if successful. Objectives/deliverables should be mapped against estimated completion timelines in a Gantt chart, and any milestones highlighted.

The word limit is **60 words for each objective and 150 words for the deliverables**.

You must upload a **Gantt chart** which lists the above objectives and deliverables against the estimated timelines for completion, together with any additional milestones/key dates (e.g., PhD submission). **Where specific milestones and deliverables have been specified within the research topic, please ensure that the Gantt chart captures these.** Please note that the preparation and submission of Data Management Plans should also be added as deliverables/milestones of the Project, where applicable.

## 5.4 Research Design and Methodological Approach

We acknowledge that the topic and research questions vary greatly in this programme, so the designs and research methodologies will also vary. In some instances, the research specification set out by the requesting DOH policy unit references specific types of evidence required whereas in others it is completely open to the prospective applicant team to propose the preferred approach (and some are a hybrid). Applicants should, therefore, read the topic specification in detail and then use this section optimally to ensure that the necessary details are provided to describe to the panel reviewers that the methods proposed can answer the questions posed, and are aligned with best international practice.

Summarise the proposed research plan including details of the study design, techniques/ methodologies/ measures that will be used, and rationale for same, as appropriate to the research specification.

Where research involves human participants/data on a particular population, please describe the selection criteria and rationale for participant/population selection considering the relevant population for the issue under study. Are under-served populations/groups considered?

### Notes:

You are strongly advised to seek advice and input from an experienced **research design and statistics** expert in advance of submitting your application. **Discrepancies and incorrect approaches in this section represent the most common source of feedback in unsuccessful HRB applications.**

Where applicable, power calculations and sample sizes must be described and justified, and aligned with the study aim, objectives and goals and the context of the study.

Where new methods are being developed, arrangements for establishing validity and reliability should be described. Examples of non-standard questionnaires, tests, etc. should accompany the application or their content be clearly indicated.

Useful links and resources are summarised in [Appendix III](#).

The word limit is **4500 words**.

## 5.5 Integrated Knowledge Translation (iKT) and Dissemination

An important design feature of this programme is integrated knowledge translation (iKT), where researchers and DOH policy units will engage throughout the research cycle. This will include structured meetings to translate findings and learnings throughout the project (not just at the end). Researchers will be expected to tailor their knowledge translation strategy to deliver a variety of outputs and to ensure that emerging and overall findings are timely and accessible by policy units and their stakeholders (e.g., policy briefs, highlights videos etc). While the policy engagement strategy **will be refined together with policy owners** for applications approved for funding, due consideration of the proposed approach to engagement is expected at application stage. Furthermore, while the primary knowledge user for the outputs of this research project is the DOH policy owner, applicants will be expected to ensure that all outputs are disseminated and shared more widely and made openly accessible, in line with HRB Open Access Policy<sup>36</sup>.

With that in mind please outline:

- The processes or steps that will be undertaken on an ongoing basis to ensure that emerging findings, or changes in the external environment, can help shape and refine the plan and support the uptake of research findings to influence health and social care policy and/or practice. It should detail the management process that will be used to ensure that the knowledge from the research is not just shared but is actively translated and/or refined further, including reference to relevant KT frameworks where applicable.
- A clear dissemination and knowledge translation plan to ensure all research outputs will be disseminated and shared and made openly accessible, in line with HRB Open Access Policy<sup>37</sup>. Research outputs include peer-reviewed publications, non-peer reviewed publications and conference proceedings, reports, policy briefings, guidelines, training materials and so on. Protection of Intellectual Property should be considered before data are disseminated<sup>38</sup>.

The word limit is **600 words**.

## 5.6 Project Management

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<sup>36</sup> <https://www.hrb.ie/funding/funding-schemes/before-you-apply/all-grant-policies/open-access>

<sup>37</sup> <https://www.hrb.ie/funding/funding-schemes/before-you-apply/all-grant-policies/open-access>

<sup>38</sup> All HRB Host Institutions must subscribe to the National Intellectual Property Protocol 2019, 'A Framework For Successful Research Commercialisation', prepared by Government/Knowledge Transfer Ireland to ensure transparent and consistent procedures for managing Intellectual Property from publicly funded research.

Please describe how the research project will be managed. The role of each applicant team member and research personnel member should be clearly outlined. Describe any oversight, advisory or governance structures that are crucial to delivery of the project, including a steering committee if applicable. Governance structures should be appropriate to the scale and scope of the project. Outline the processes that will be put in place to ensure that the project is well managed, commenting on project management, meetings schedules, financial management etc. Describe contingency plans, including how you intend to manage any risks to the delivery of the project. The word limit is **600 words**.

## 5.7 FAIR Data Management and Stewardship

Describe the general approach to data management and stewardship that will be taken during and after the projects, including who will be responsible for data management and data stewardship. With the support of data stewards or other data-related services support in the institution (typically library and ICT and digital service, etc) all Applicants should address the management of the research data to be generated and/or re-used during the research project.

The word limit is **500 words**.

## 5.8 Public and Patient Involvement (PPI) in the Research Project

*The HRB recognises that the nature and extent of meaningful public involvement is likely to vary depending on the context of each study. Please note PPI does **not** include the recruitment of study participants in research projects. It also does **not** include work aimed at raising awareness of the public around research, such as media publications of research findings, and outreach activities such as open days in research facilities.*

Useful resources including practical examples of involving members of the public in your research can be found in [Appendix III](#). Please be aware there are PPI Ignite Network offices in some host institutions.

### Are you including PPI in your application?

#### If Yes

**Please describe all PPI at each stage of the research cycle:**

- Design
- Conduct
- Analysis
- Oversight
- Dissemination

**For each stage, please include the purpose of this involvement and where applicable how PPI has influenced/changed what work has been planned.**

This section should be a succinct summary of public involvement activities. Provide information on the individuals/groups and the ways in which they will be involved. PPI contributors should be representative of the relevant people and communities impacted by the research topic. **Where**

**members of the public or patients are involved, they should be compensated for their time and contributions; this should be reflected in the project budget.**

**Please ensure to provide more detail in other sections as appropriate.**

**Important:** The PPI section needs to be written as a plain English summary such that it is clear, easy to understand, and is easily accessible to a lay audience.

#### **If No**

Please explain why PPI is not relevant to your project.

The word limit is **600 words**.

### **5.9 Gender and/or Sex Issues in the Research Project**

A key objective of the HRB is to strive for gender balance in Irish health research. We encourage a balanced participation of genders in all research activities.

Please note this section is intended to focus researchers on the **research content**, and **not** the gender balance within the research team.

Please identify and explain how you address sex and/or gender issues for this project.

**Are there potential sex (biological) considerations for this research?**

**Are there potential gender (socio-cultural) considerations for this research?**

If so, outline how sex and/or gender analysis will be integrated in the design, implementation, evaluation, interpretation, and dissemination of the results of the research application.

If not, you must clearly demonstrate why it is not relevant to the research application; have you done a literature search to confirm this?

Please see [Appendix III](#) for resources on gender and sex considerations in research applications.

The word limit is **400 words**.

### **5.10 Potential Safety Risks and Ethical Concerns**

If relevant, please address any potential risk and/or harm to patients or human subjects/participants in the research. Please highlight any potential ethical concerns during this study and/or at the follow-up stage. Describe any potential ethical concerns that may arise as a result of this research, even if not part of this application, and how you propose to deal with them. If the proposed research includes vulnerable groups, what additional considerations are there for these participants? The word limit is **400 words**.

### **5.11 Project Description Figures**

**A file upload option is available to include an attachment to support your Project Description. A maximum of 5 figures**, which can be a combination of images, graphs, tables, scales, instruments, or surveys, may be uploaded as a single document on HRB GEMS. They must **not** be embedded within the text of the Project Description. Additional references should not be included here. The maximum size is **2MB**. Files should be doc, docx, or pdf.

## 5.12 References

A full description of the Publications cited in the Project Description should be provided. You can enter a maximum of **30 publications**. Please enter references in the same format.

### For publications:

Gallagher PA, Shoemaker JA, Wei X, Brockhoff-Schwegel CA, Creed JT. Extraction and detection of arsenicals in seaweed via accelerated solvent extraction with ion chromatographic separation and ICP-MS detection. *Fresenius J Anal. Chem.* 2001 Jan 1;369(1):71-80. PMID: 11210234.

### For book and printed source citations:

Farrell M, Gerada C and Marsden J (2000) *External review of drug services for the Eastern Health Board*. London: National Addiction Centre.

### For data citations:

Authors, year, article title, journal, publisher, DOI

Author(s), year, dataset title, data repository or archive, version, global persistence identifier

## 6 Details of Research Team

### 6.1 Roles of Applicant team members

Describe the roles, responsibilities, and contributions of all applicant team members including lead applicant, co-applicants, and collaborators in delivering the project.

For the Lead Applicant and Co-Applicants please indicate the proposed amount of time to be dedicated to working on **this project** as a proportion of a full-time-equivalent (FTE).

The word limit is **500 words**.

### 6.2 Personnel

Describe the roles, responsibilities, and contributions of all team members for whom you are requesting salary from the award. State the proportion of a full-time equivalent (FTE) that each person will spend on the project and describe what aspects of the proposed research they will be involved in over the lifetime of the project. Note that you must justify the nature of all research personnel relative to the scale and complexity of the project (please see [section 6.1.4 Funded Personnel](#) for more guidance on alignment between the chosen personnel and the project). If funding is requested for known personnel, please include the following details: Name, present position, academic and professional qualifications. The word limit is **400 words**.

## 7 Infrastructure and Support

### 7.1 Host Institution Infrastructure and Support

Describe the infrastructure, facilities, specialist expertise and other support available at the Host Institution and/or at other sites where the research will be conducted. Please include details of



critical supports in areas such as statistics, research methods, or regulatory expertise where this is being provided above and beyond the activities/expertise of members of the research team. The word limit is **400 words**.

## 8 Project Budget

Please provide a summary and justification of the costs and duration associated with the project.

A **full detailed breakdown of costings and justification for all funding** is required for items listed under each subheading within GEMS.

**Note: You are strongly advised to seek guidance from the research office/finance office in the Host Institution** before completing this section of the form. **The HRB will not provide additional funding in the case of either under-estimates or over-expenditure.**

**The total funding available (exclusive of overheads) will be €300,000 over 12-24 months. Allowable costs include:**

1. Personnel costs	Must be listed for each salaried personnel under each of the following subheadings (a-e):
a) Salary	<p>Gross Annual Salary (including 5% employee pension contribution) negotiated and agreed with Host Institution. Applicants should use the IUA website scales for the most up-to-date recommended salary scales for academic researchers <a href="http://www.iua.ie/research-innovation/researcher-salary-scales/">http://www.iua.ie/research-innovation/researcher-salary-scales/</a>. Please note employee pension contribution of 5% has already been incorporated into the IUA gross salary figure.</p> <p><b>Applicants <u>should</u> include annual pay increments for staff and related costs (pension contribution and employer's PRSI contribution) in the budget.</b></p> <p>In line with the proposed new pay agreement for State employees please apply a salary contingency of 3% from 1<sup>st</sup> October 2024 onwards. Please note this contingency should be applied cumulatively year on year.</p> <p><b>Note:</b> The HRB does not provide funding for the salary or benefits of academic staff within research institutions that are already in receipt of salary or benefits. The HRB does not provide salary or buy-out time for collaborators</p>
b) Employer's PRSI	Employer's PRSI contribution is calculated at 11.05% of gross salary.
c) Employer Pension Contribution	<p>Pension provision <u>up to a maximum of 20%</u> of gross salary will be paid to the Host Institution to enable compliance with the Employment Control Framework (an additional 5% employee contribution is part of the salary).</p> <p>If applicable, state the amount of employer contribution based on the pro rata salary and note the % of pro rata salary used to calculate this for reference. Exceptions apply where Circular letter 6/2007 applies. Circular Letter 6/2007 states that the pension contribution of all Public Health Service employees who, on or after 1 June 2007, are granted secondments or periods of special leave with pay to enable them take up appointments with other organisations, including other Public Health Sector organisations, will be increased to 25% of gross pensionable pay. The rate of 25% of gross pensionable pay referred to in this context is the pension contributions to be paid by the body to which the employee is seconded – it does not include any pension contributions which employees make themselves. Where no such arrangements are in place, the HRB will not be liable for costs.</p>

<p><b>2. Running Costs</b></p>	<p>For all costs required to carry out the research including materials and consumables, survey costs, travel for participants, transcription costs, data access costs etc.</p> <p>Access to necessary special facilities or services which are not available in the host academic or clinical institutions. i.e., consultancy fees, methodological support, Clinical Research Facilities support, MRI facilities etc. will be considered under running costs if they are detailed in an accompanying 'Infrastructure Agreement Form'.</p> <p>The following costs are ineligible and will not be funded: training courses/workshops with the exception of training in public and patient involvement in research, inflationary increases, cost of electronic journals.</p> <p><b>Note:</b> Please see a list of costs that fall within the overhead contribution below and which should not be listed under running costs.</p>
<p><b>3. PPI Costs</b></p>	<p>All PPI-related costs for the grant (except salaried personnel), such as but not limited to:</p> <ul style="list-style-type: none"> <li>• Compensating PPI contributors for their time (for example for time spent reviewing material/ participation in advisory groups)</li> <li>• This can be as: <ul style="list-style-type: none"> <li>○ A cost for their expertise, e.g. as hourly rate, under <u>PPI costs</u> or</li> <li>○ As salaries under personnel which should be labelled PPI contributors <u>under salaries</u>.</li> </ul> </li> <li>• Travel expenses for PPI contributors</li> <li>• Costs associated with PPI contributors attending conferences, workshops, or training</li> <li>• PPI event facilitator costs</li> <li>• Compensation of public or patient organisations for their time.</li> <li>• Room hire for PPI events/meetings</li> <li>• Hospitality for PPI events/meetings</li> <li>• Companionship or childcare costs for PPI contributors while attending events, meetings, etc.</li> <li>• Training in PPI in research.</li> </ul> <p><b>Note:</b> PPI contributors supported by salaries, should be listed and justified under the personnel heading. All costs should be in line with Host Institution policies.</p>
<p><b>4. Equipment</b></p>	<p>Funding for suitably justified equipment can be included in this section. We do not expect equipment costs in excess of €10,000. Personal/Stand-alone computers will not be funded as these are considered a standard piece of office equipment, i.e., overhead. Dedicated laptops or similar equipment that is required specifically for the project because of the nature of the research, will be considered where appropriately justified, and should not exceed €1,200. All costs must be inclusive of VAT, where applicable. Depending on the nature of the project, high-spec computers may be eligible and clear justification and rationale for the costs requested must be provided. All costs must be inclusive of VAT, where applicable.</p>
<p><b>5. Dissemination Costs</b></p>	<p>Costs associated with publication of results, seminar/conference attendance (provide details of name and location, where possible) and any other means of communicating/reporting research outcomes as detailed in the dissemination and knowledge translation plan, as well as costs related to data sharing. Please refer to the HRB policy on Open Access to Published Research<sup>39</sup>. Please list dissemination costs under the following categories: publications, conferences, and other activities (expanded as necessary).</p>

<sup>39</sup> <http://www.hrb.ie/research-strategy-funding/policies-and-guidelines/policies/open-access/>

	<p><b>Publications:</b> Typically, the average HRB contribution towards publication costs is €1,750/per article or <b>HRB Open Research:</b> rapid open peer-reviewed and open access platform for all research outputs, with all publication charges covered centrally by the HRB at no expense to the grantee. (<a href="http://www.hrbopenresearch.org">www.hrbopenresearch.org</a>) free of charge.</p> <p><b>Conferences:</b> We envisage that conference costs will be typically around €500 for national conferences and €1,500 for international conferences per person and year.</p>
<b>6. FAIR Data Management Costs</b>	Costs related to data-related and data management activities in line with best practice of data management and stewardship and the FAIR principles <b>incurred during the lifetime of the project.</b> Please see the table below for further guidance.

**Overhead Contribution** will be added by HRB staff during contract negotiations for successful applications. It is not requested as part of the application budget. In accordance with the HRB Policy on Overhead Usage<sup>40</sup>, the HRB will contribute to the indirect costs of the research through an overhead payment of 30% of Total Direct Modified Costs (TDMC excludes student fees, equipment, and capital building costs) for **laboratory or clinically based research** and 25% of Total Direct Modified Costs for **desk-based research**.

The following items are included in the overhead contribution: recruitment costs, bench fees, office space, software, contribution to gases, bacteriological media preparation fees, waste fees, and bioinformatics access. Therefore, these should not be included in the budget as direct costs.

### 8.1 Additional guidance to FAIR Data Management Costs

<b>People</b>	Staff time per hour for data collection, data anonymisation, etc
	Staff time per hour for data management/stewardship support, training, etc
<b>Storage and computation</b>	Cloud storage, domain hosting charge
<b>Data access</b>	Costs for preparing data for sharing (e.g., anonymisation)
<b>Deposition and reuse</b>	Costs for depositing research data and metadata in an open-access data repository
	Defining semantic models, making data linkable, choosing the licence, defining metadata for dataset, deploying/publishing
<b>Others</b>	Please further explain
<b>Notes</b>	The HRB is currently not covering the cost of long-term preservation of data
	This list is not exhaustive and aims to provide examples only of eligible costs

## 9 Ethical Approval and Approvals for Use of Animals

Ethical approval is required for all research work funded by the HRB that involves human participants, human material (including tissue) or animals (pre-clinical models only). Applicants are responsible for ensuring that all necessary approvals are in place prior to the start of the research.

Applicants should allow sufficient time to obtain ethical and/or competent authority approval and/or animal licenses as a copy of such approvals must be submitted to the HRB before the initiation of the

<sup>40</sup> <http://www.hrb.ie/funding/funding-schemes/before-you-apply/all-grant-policies/hrb-policy-on-usage-of-research-overheads/>

award. It is suggested that these are sought in parallel to the submission of the application to the HRB.

## 10 Supporting Documentation

The following documents must be uploaded to complete the application:

### **Mandatory documents:**

- Objectives and Deliverables Gantt Chart

### **If applicable:**

- Letter of Support for Lead Applicant or Co-Applicants in contract positions seeking their own salary,
- Collaboration Agreement Form(s) – required for all collaborators,
- Project Description Support file – A maximum of 5 figures which can be a combination of images, graphs, tables, scales, instruments, or surveys.

## Submission of Applications

**The deadline for submission of complete applications is 15 March 2024 at 13:00.**

1. After successful validation, the Lead Applicant may submit the application. It will then be routed to the designated signatory at the Host Institution for their approval.
2. If a signatory rejects the application the Lead Applicant will be notified, along with any feedback the signatory has supplied.
3. The application can then be re-submitted; it will be returned to the signatory and will continue through the approval process as before.
4. On completion of the final approval by the Host Institution signatory, a grant application number is assigned to the application.
5. The application automatically gets submitted to the HRB through GEMS for consideration for funding.

***Please note that the HRB will not follow up on any supporting documentation related to the application, such as the Host Institution's Letters of Support, Collaborator Agreement Form, Gantt charts etc. It is the responsibility of the Lead Applicant to upload all supporting documentation prior to submission. If the documentation is not received by the HRB on time, in the correct format or is not properly signed or submitted, the application will be deemed ineligible without further review.***

The HRB reserves the right to reject any application that does not meet the terms of this call. The HRB's Policy on Appeals on funding decisions is available at <https://www.hrb.ie/funding/funding-schemes/before-you-apply/all-grant-policies/hrb-policy-on-appeals/>.

## Privacy Policy and Retention Policy

To understand why we collect the information we collect and what we do with that information, please see our Privacy<sup>41</sup> and Retention Policies<sup>42</sup>.

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<sup>41</sup> <https://www.hrb.ie/about/legal/privacy-policy/>

<sup>42</sup> [https://www.hrb.ie/fileadmin/user\\_upload/HRB\\_Document\\_retention\\_policy..docx](https://www.hrb.ie/fileadmin/user_upload/HRB_Document_retention_policy..docx)

## Appendix III: Resources/Useful Links

### EVIDENCE SYNTHESIS

**Evidence Synthesis Ireland:** aims to build evidence synthesis knowledge, awareness and capacity among the public, health care institutions and policymakers, clinicians, and researchers on the Island of Ireland.

<https://evidencesynthesisireland.ie/>

**The Cochrane Library:** online collection of databases in medicine and other healthcare specialties which summarise and interpret the results of medical research.

[www.thecochranelibrary.com](http://www.thecochranelibrary.com)

**The Campbell Collaboration:** promotes positive social and economic change through the production and use of systematic reviews and other evidence synthesis for evidence-based policy and practice.

<https://www.campbellcollaboration.org/>

**The Campbell Collaboration UK & Ireland:** hub at Queens University Belfast.

<https://www.qub.ac.uk/research-centres/CampbellUKIreland/>

**EQUATOR Network Library for health research reporting:** an international initiative that seeks to improve reliability and value of health research literature by promoting transparent and accurate reporting of research studies.

<http://www.equator-network.org/resource-centre/library-of-health-research-reporting/>

### PUBLIC AND PATIENT INVOLVEMENT IN RESEARCH & RESEARCH PRIORITIES

**The National PPI Ignite Network**

<https://ppinetwork.ie/>

**NIHR PPI resources**

<https://www.nihr.ac.uk/documents/ppi-patient-and-public-involvement-resources-for-applicants-to-nihr-research-programmes/23437>

**Patient-Centred Outcomes Research Institute (PCORI)**

<http://www.pcori.org>

**Public Involvement Impact Assessment Framework:** Provides tools for successful involvement of members of the public in research projects and for assessment of impacts.

<http://piiif.org.uk/>

**NIHR Payment guidance for researchers and professionals**

<https://www.nihr.ac.uk/documents/payment-guidance-for-researchers-and-professionals/27392>

**European Patient Forum Value + Handbook: For Project Co-ordinators, Leaders and Promoters on Meaningful Patient Involvement.**

[http://www.eu-patient.eu/globalassets/projects/valueplus/doc\\_epf\\_handbook.pdf](http://www.eu-patient.eu/globalassets/projects/valueplus/doc_epf_handbook.pdf)

**The James Lind Alliance Priority Setting Partnerships: Research priorities in disease areas set jointly by patients, clinicians, and researchers.**

<http://www.jla.nihr.ac.uk/>

**Campus Engage: Supporting Irish HEIs to embed civic engagement in their work. Includes resources, how-to-guides, and case studies for engaged research.**

<http://www.campusengage.ie/what-we-do/publications/>

**UK Standards for Public Involvement: The six UK Standards for Public Involvement provide clear, concise statements of effective public involvement against which improvement can be assessed.**

<https://sites.google.com/nihr.ac.uk/pi-standards/home>

**The Involvement Matrix: A tool for researchers/project leaders to promote collaboration with patients in projects and research.**

<https://www.kcrutrecht.nl/involvement-matrix/>

**The Evaluation Toolkit:** is a resource designed for practitioners of the health sector, produced after the completion of a rigorous systematic review of patient and public engagement evaluation tools.

<https://ceppp.ca/en/evaluation-toolkit/>

**GRIPP2 reporting checklists:** Tools to improve reporting of patient and public involvement in research

<https://researchinvolvement.biomedcentral.com/articles/10.1186/s40900-017-0062-2#Tab1>

## **GENDER AND/OR SEX ISSUES IN RESEARCH**

**Examples of case studies in Health & Medicine where gender/sex in research matters**

<http://genderedinnovations.stanford.edu/case-studies-medicine.html>

**Gender Toolkit in EU-funded research for examples and guidance**

[http://www.yellowwindow.be/genderinresearch/downloads/YW2009\\_GenderToolKit\\_Module1.pdf](http://www.yellowwindow.be/genderinresearch/downloads/YW2009_GenderToolKit_Module1.pdf)

**Sex/Gender Influences in Health and Disease**

<https://orwh.od.nih.gov/sex-gender/sexgender-influences-health-and-disease>

**Methods and Techniques for Integrating Sex into Research**

<https://orwh.od.nih.gov/sex-gender/methods-techniques-integrating-sex-research>

**NIH Policy on Sex as a Biological Variable**

<https://orwh.od.nih.gov/sex-gender/nih-policy-sex-biological-variable>

## KNOWLEDGE TRANSLATION RESOURCES

### Health Service Executive Research & Development Main Page

<https://hseresearch.ie/research-dissemination-and-translation/>

### Health Service Executive Research & Development: Knowledge Translation, Dissemination, and Impact A Practical Guide for Researchers

<https://hseresearch.ie/wp-content/uploads/2021/04/Tools-and-templates-.pdf>

### Integrated Knowledge Translation (iKT) NUI Galway

<https://www.nuigalway.ie/hbcrg/ikt/>

### The Canadian Institutes of Health Research: Guide to Knowledge Translation Planning

<https://cihr-irsc.gc.ca/e/45321.html>

### Training Institute for Dissemination and Implementation Research in Health: Open Access Course

<https://cancercontrol.cancer.gov/is/training-education/TIDIRC-open-access>

## IMPLEMENTATION SCIENCE RESOURCES

### Centre for Effective Services

<https://www.effectiveservices.org/resources/implementation>

### UCC Implementation Science Training Institute

<https://www.ucc.ie/en/cpd/options/medhealth/cpd1778uccimplementationsciencetraininginstitute/>

### European Implementation Collaborative

<https://implementation.eu/resources/>

## CO-CREATION RESOURCES

### ACCOMPLISSH Guide to impact planning

<https://www.accomplish.eu/publications-and-deliverables>

### Working together to co-create knowledge: A unique co-creation tool – Carnegie UK Trust

<https://www.carnegieuktrust.org.uk/publications/working-together-to-co-create-knowledge-a-unique-co-creation-tool/>

## STUDY DESIGN

**SQUIRE Guidelines:** provides a framework that authors can use when developing applications or writing research articles about quality improvement

[www.squire-statement.org](http://www.squire-statement.org)



**HIQA Guidelines for the Economic Evaluation of Health Technologies in Ireland (2018)**

<https://www.hiqa.ie/reports-and-publications/health-technology-assessment/guidelines-economic-evaluation-health>

**HIQA Guidelines for the budget Impact Analysis of Health Technologies in Ireland (2015)**

[https://www.hiqa.ie/system/files/Guidance\\_on\\_Budget\\_Impact\\_Analysis\\_of\\_Health\\_Technologies\\_in\\_Ireland.pdf](https://www.hiqa.ie/system/files/Guidance_on_Budget_Impact_Analysis_of_Health_Technologies_in_Ireland.pdf)

**HIQA Guidelines for Evaluating the Clinical Effectiveness of Health technologies in Ireland (2011)**

<http://www.hiqa.ie/system/files/HTA-Clinical-Effectiveness-Guidelines.pdf>

## REPORTING

**COMET (Core Outcome Measures in Effectiveness Trials) Initiative:** development and application of agreed standardised sets of outcomes, known as 'core outcome sets'

<http://www.comet-initiative.org/>

**EQUATOR Network Library for health research reporting:** an international initiative that seeks to improve reliability and value of health research literature by promoting transparent and accurate reporting of research studies

<https://www.equator-network.org/library/>

**Registry of Research Data Repositories**

<http://www.re3data.org/>

**Zenodo Data Repository (OpenAIR)**

<https://zenodo.org/about>      <https://zenodo.org/>

## DATA MANAGEMENT AND SHARING AND FAIR PRINCIPLES

**Digital Curation Centre:** How to develop a data management and sharing plan and examples DMPs.

<http://www.dcc.ac.uk/resources/data-management-plans/guidance-examples>

**FAIR data principles FORCE 11**

<https://www.force11.org/fairprinciples>

**UK Concordat on Open Research Data (July 2016)**

<https://www.ukri.org/wp-content/uploads/2020/10/UKRI-020920-ConcordatonOpenResearchData.pdf>

**Guidelines on FAIR data management plans in Horizon 2020**

[http://ec.europa.eu/research/participants/data/ref/h2020/grants\\_manual/hi/oa\\_pilot/h2020-hi-oa-data-mgt\\_en.pdf](http://ec.europa.eu/research/participants/data/ref/h2020/grants_manual/hi/oa_pilot/h2020-hi-oa-data-mgt_en.pdf)

**FAIR at the Dutch centre for Life sciences**

<https://www.dtls.nl/fair-data/>

**Registry of Research Data Repositories**

<http://www.re3data.org/>

## **RESEARCH DATA MANAGEMENT PLANS**

**Data Stewardship Wizard created by ELIXIR CZ and NL**

<https://dmp.fairdata.solutions/>

**DMPonline of the Digital Curation Centre (DCC), UK**

<https://dmponline.dcc.ac.uk/>

**DMPTool of University of California Curation Center of the California Digital Library (CDL), USA**

<https://dmptool.org/>

**RDMO Research Data Management Organiser of the German Research Foundation, Germany**

<https://rdmorganiser.github.io/en/>

**Guidelines on FAIR data management plans in Horizon 2020**

[http://ec.europa.eu/research/participants/data/ref/h2020/grants\\_manual/hi/oa\\_pilot/h2020-hi-oa-data-mgt\\_en.pdf](http://ec.europa.eu/research/participants/data/ref/h2020/grants_manual/hi/oa_pilot/h2020-hi-oa-data-mgt_en.pdf)