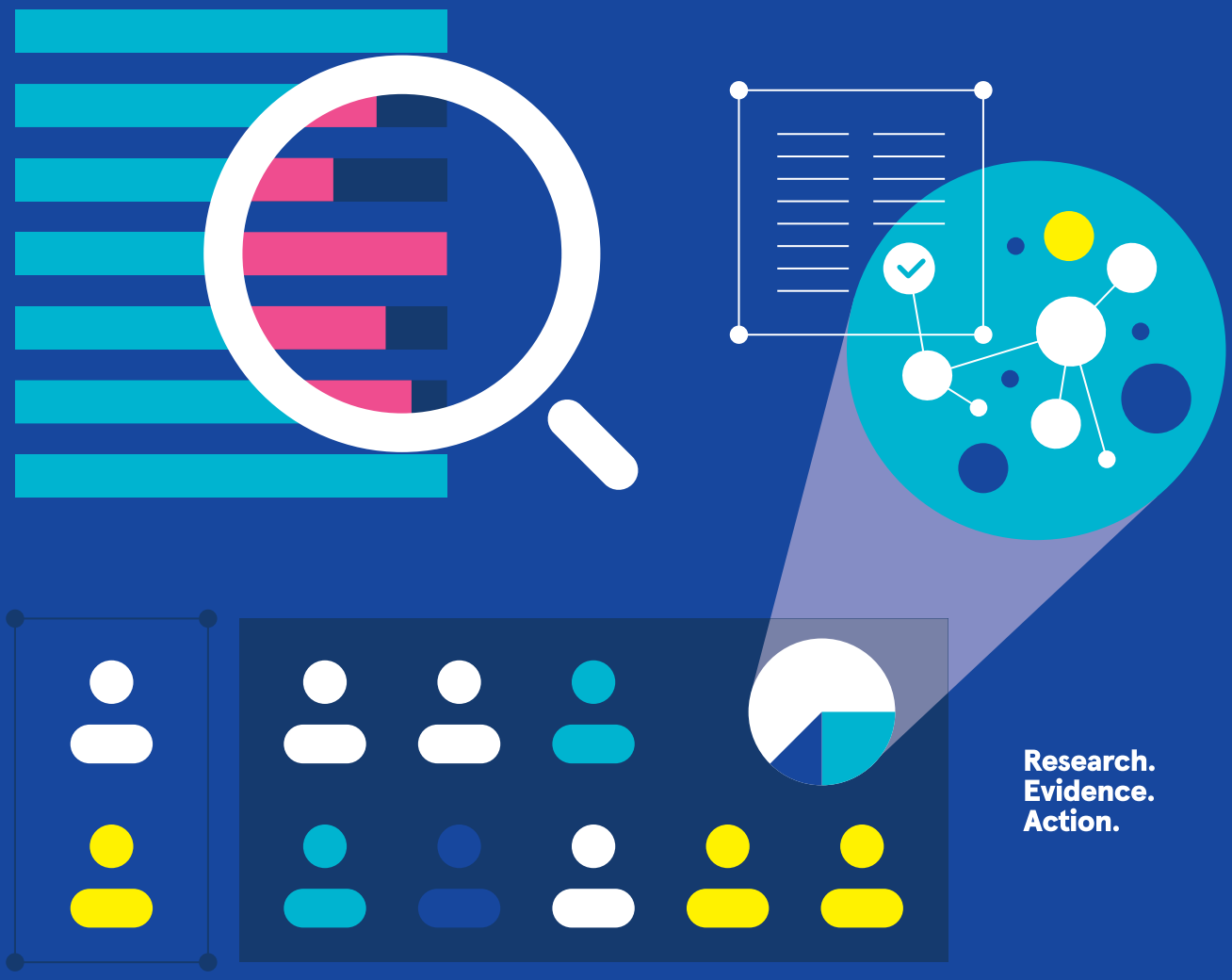
An assessment of the evidence support system for health policy-making in Ireland

HRB Health Research Board

A Rapid Evidence Support System Assessment (RESSA)



Research. Evidence. Action.

EVIDENCE SYNTHESIS IRELAND

Cochrane Ireland

Global Commission on Evidence to Address Societal Challenges

An Roinn Sláinte
Department of Health

Dublin: Published by the
Health Research Board
Grattan House,
67-72 Lower Mount Street,
Dublin 2,
D02 H638

© 2026

ISBN: 978-1-903669-38-9

e hrb@hrb.ie
w www.hrb.ie

Table of contents

Foreword 4
Executive summary 6
1 Background and introduction 11
1.1 Scope of the research 13
2 Methods 14
2.1 Data collection 15
2.1.1 Document review 15
2.1.2 Interviews 15
2.2 Data analysis and synthesis 16
2.3 Ethical considerations 16
3 Findings 17
3.1 Overall sample and data sources 18
3.2 Demand for evidence 19
3.2.1 Commitment to evidence-informed policy-making 19
3.2.2 Capacity and enablers for evidence use 20
3.2.3 Approaches to evidence use and integration in health policy-making 23
3.2.4 Prioritisation of evidence 25
3.2.5 Lessons from evidence support during the COVID-19 pandemic 26
3.3 Supply of evidence 27
3.3.1 Forms and sources of evidence 28
3.3.2 Transparency and quality of evidence 30
3.3.3 Requesting research evidence 32
3.4 Interface 33
3.4.1 Structured collaboration between researchers and policy-makers 34
3.4.2 Proactive engagement and relationship building at the interface 35
3.4.3 Limitations of informal systems and over-reliance on relationships 36
3.5 Summary of findings across domains and sub-themes 36
4 Discussion 38
4.1 Key findings 39
4.2 Findings in relation to other studies 40
4.3 Strengths and limitations of the assessment 45
4.4 Implications for policy and practice 45
4.5 Implications for future research 52
5 Conclusion 53
6 References 55
Appendix A Document review 59
Appendix B Data extraction framework 67
Appendix C Examples of questions in the interview guide 69
Appendix D Rapid evidence support system assessment (RESSA) - Ireland Oversight Group membership 74

Foreword



Teresa Maguire
Director of Research Strategy and Funding, Health Research Board

As someone who has been involved with this project since its inception, I am incredibly proud to welcome this report, which offers a clear and practical assessment of the evidence support system for decision making within the Department of Health in Ireland. By applying the Global Evidence Commission framework, it highlights how evidence is sought, generated and mobilised, and the crucial role of intermediaries in connecting these functions.

The Health Research Board has a longstanding commitment to strengthening Ireland's evidence ecosystem - through our national information systems, the HRB Evidence Centre, our investments in evidence synthesis and our role as the lead agency supporting health and social care research. This report reinforces why sustained investment in evidence infrastructure and capability is essential for effective decision making.

I want to thank the project team for their rigorous work and the RESSA Ireland Oversight group for their guidance. I also wish to acknowledge the Department of Health for its leadership and openness in supporting this assessment. The honesty and engagement shown by staff reflects a genuine commitment to learning and improvement- the hallmark of any strong evidence system.

Finally, although centred on health, the findings are relevant across government and have learning beyond Ireland. Decisions in health, social care and public policy involve difficult trade-offs, competing priorities and profound consequences. Robust, timely and trustworthy evidence is more important than ever.

The actions here are practical and achievable. The HRB looks forward to working with partners to advance them, and I hope readers across all sectors find the report both useful and constructive.



Teresa Maguire
Director of Research Strategy and Funding,
Health Research Board



John O' Neill
Head of Research Policy and Innovation Unit, Department of Health

On behalf of the Department of Health and as a participant in the RESSA project, I very much welcome this report and the opportunity it provides to reflect on how we organise, access and use evidence in support of policy and decision making.

We appreciate the thorough and constructive approach taken by the HRB and the project team in progressing this important piece of work and we are very grateful for the key contributions from the wide range of participants who engaged openly on the project and who helped inform the assessment.

The assessment highlights both areas of good practice and opportunities to strengthen processes and capabilities to ensure that research is better utilised to support policy and health service delivery. The findings and recommendations from the RESSA will enable the Department to look at how research and evidence products can better inform policy development and related decision-making processes.

We look forward to continuing to collaborate with the HRB and other partners in developing evidence-based products that not only links the Department of Health with the wider health research ecosystem, but also provide a basis to inform how we serve the health system and the public.



John O' Neill
Head of Research Policy and Innovation Unit,
Department of Health

Executive summary

Key messages

Ireland has strong foundations for evidence-informed health policy-making, including established evidence pathways, committed leadership, and a growing analytics capacity. However, the overall evidence support system is not yet consistently integrated end to end. Practice varies across policy areas, and rapid access to evidence can be dependent on informal networks. Key challenges for policy-making include fragmentation and duplication, uneven skills and capacity (including modelling, evaluation, and analytics), and barriers to timely access and linkage of data.

This report sets out 11 practical recommendations, grouped by audience, with short examples of what these would look like in practice, in order to support implementation. Strengthening the evidence support system will support better, faster, and more transparent policy decisions; improve preparedness for emergency events; and improve the value of public investment.

Purpose and scope

This report presents findings from a Rapid Evidence Support System Assessment (RESSA) of Ireland's evidence support system for health policy-making (e.g. policy development, prioritisation, planning, and system decision-making). Evidence support systems include the people, processes, structures, and resources that help decision-makers access and use research evidence, data, and analysis in a timely and transparent way.

The assessment is not an evaluation of individual staff performance or of clinical care delivery.

RESSA is best understood as a structured, evidence-informed starting point that identifies current strengths and gaps in an evidence support system, and points to practical options for improvement, recognising that learning and iteration will be needed as the system evolves.

What we did

We triangulated a targeted review of 50 policy-relevant documents published between 2018 and 2024 with 19 semi-structured interviews involving 20 stakeholders across the Department of Health, national agencies, research bodies, and roles working at the research policy interface.

Findings were analysed using the RESSA framework across three domains: demand (the culture, capacity, and enablers that shape evidence needs, prioritisation, and how evidence is used in policy-making); supply (how policy-relevant evidence is produced, commissioned, and quality assured); and interface (how evidence users and evidence producers connect, including coordination and knowledge broker functions).

What we found

Ireland has many of the building blocks of a strong evidence support system. Stakeholders described a clear organisational commitment to evidence use within the Department of Health and several established pathways for structured evidence input. At the same time, the RESSA has identified persistent challenges within the evidence support system that reduce consistency, speed, transparency, and reuse of evidence across policy areas.

Strengths and assets

Senior leaders and many policy teams expect evidence to inform decisions, and value access to credible analysis. Structured approaches exist for specific decision types, including health technology assessment (HTA), clinical effectiveness guidance, and population-level screening processes. National agencies and research groups use their expertise and international linkages to provide high-quality evidence products. Newer analytics and evaluation functions within the Department of Health are helping to strengthen the system, including by providing the ability to interrogate data and commission research and evaluation more systematically. The COVID-19 pandemic demonstrated that Ireland can mobilise expertise quickly when needed, including through informal networks and cross-organisation relationships.

Challenges and gaps

Evidence activity is often distributed across multiple organisations and teams without providing a shared view of what has already been commissioned or produced, which leads to duplication in some areas and gaps in others. Not all policy teams have the same capability or space to frame evidence questions, commission work, appraise evidence, and integrate findings into decision-making processes. Challenges highlighted by stakeholders include constraints on timely access to relevant datasets, a lack of clarity around data ownership and governance, and difficulty linking datasets for planning, modelling, and evaluation. Standards for reporting and appraisal of evidence, as well as data quality/governance, can vary depending on the type of evidence product and who is commissioning it. Existing relationships between researchers and policymakers often enable evidence to move quickly, but reliance on these informal connections creates vulnerability during staff turnover, busy periods, or cross-organisational handovers. Finally, stakeholders highlighted the need to strengthen capacity in modelling (epidemiological, health system, and economic), evaluation, analytics, and other methods needed for evidence-informed decision-making.

Findings by domain

Demand: how evidence needs are identified and used

There is a strong stated commitment to evidence use among policy stakeholders, but demand frequently exceeds available evidence support capacity. Evidence requests vary widely in urgency and complexity. Without consistent prioritisation approaches and shared expectations, policy teams may experience uneven access to support, and decisions about which requests to progress, which to defer, and which not to pursue can be difficult to explain. Opportunities for improvement in this area include clearer prioritisation and triage processes; shared expectations for turnaround and outputs; training and support for policy teams that make it easier to frame questions and use evidence consistently; and more transparent documentation of how evidence was considered in decision-making.

Supply: how evidence is produced, commissioned, and quality assured

Evidence products can range from rapid summaries to complex evaluations and modelling. Ireland has strong producers of policy-relevant evidence, but commissioning pathways and quality expectations are not always consistent. The RESSA suggests that there is scope to strengthen the consistency of commissioning processes, reporting and appraisal standards, and the reusability of outputs. Opportunities include proportionate quality standards for different evidence types, flexible commissioning approaches for urgent or complex briefs, and better recording and reuse of commissioned work to reduce duplication.

Interface: how evidence users and producers connect

Connections between evidence users and evidence producers can work extremely well, particularly where relationships already exist. However, a system that depends heavily on personal relationships is less resilient and less equitable across policy areas. Opportunities to improve in this area include strengthening knowledge broker and connector roles; establishing regular, structured forums to match policy questions to expertise; and implementing rapid response mechanisms with clear triage criteria and agreed service expectations.

Recommendations

This report presents 11 recommendations, grouped by primary audience, each accompanied by a short illustration of what this would look like in practice. See Section 4.4 for full details.

Policy-makers (within the Department of Health)

Recommendation 1 (Prioritisation of Evidence Needs) proposes piloting a system of structured prioritisation of evidence requests so that policy units can distinguish planned evidence needs from urgent requests and make the logic behind their prioritisation of decisions explicit. Recommendation 2 (Capacity and Culture for Evidence Use) focuses on strengthening evidence capacity and culture by embedding evidence-informed policy-making competencies into performance and development processes, and supporting foundational training for policy staff. Recommendation 3 (Transparency and Accountability for Evidence Use) addresses improving transparency by providing guidance on how evidence is documented and considered in policy submissions and decision-making processes. Recommendation 4 (Knowledge Management and Repositories) focuses on developing a central, accessible repository for commissioned research and evidence products in order to reduce duplication and make existing work easier to find and reuse.

Researchers and evidence producers

Recommendation 5 (Quality Assurance and Standards) calls for clear, proportionate guidance on reporting, appraisal, and data governance standards across different forms of policy-relevant evidence. Recommendation 6 (Rapid and Proportionate Research Approaches) proposes piloting rapid forms of research (e.g. rapid evaluation and rapid qualitative inquiry) to complement rapid evidence reviews when urgent policy questions arise.

Evidence intermediaries (connecting evidence and policy)

Recommendation 7 (Flexible Procurement and Delivery Models) suggests piloting a lead contractor model for urgent, complex briefs so the right mix of expertise can be assembled quickly under agreed terms. Recommendation 8 (Knowledge Broker Roles) proposes piloting a system where knowledge broker roles are embedded within evidence-producing organisations, where these roles have clear responsibilities for policy liaison and agreed performance expectations, alongside consolidating regular 'Research & Policy' forums for matchmaking and shared learning. Recommendation 9 (Rapid Response Evidence Service) proposes piloting a rapid response evidence service with clear triage criteria and a target turnaround time (within 10 working days) for urgent questions, with outputs logged for reuse. Recommendation 10 (Evidence Synthesis Hub) proposes establishing a standing hub with rapid activation protocols and a catalogue of living reviews in order to support both routine and crisis evidence needs.

System-level shared responsibility

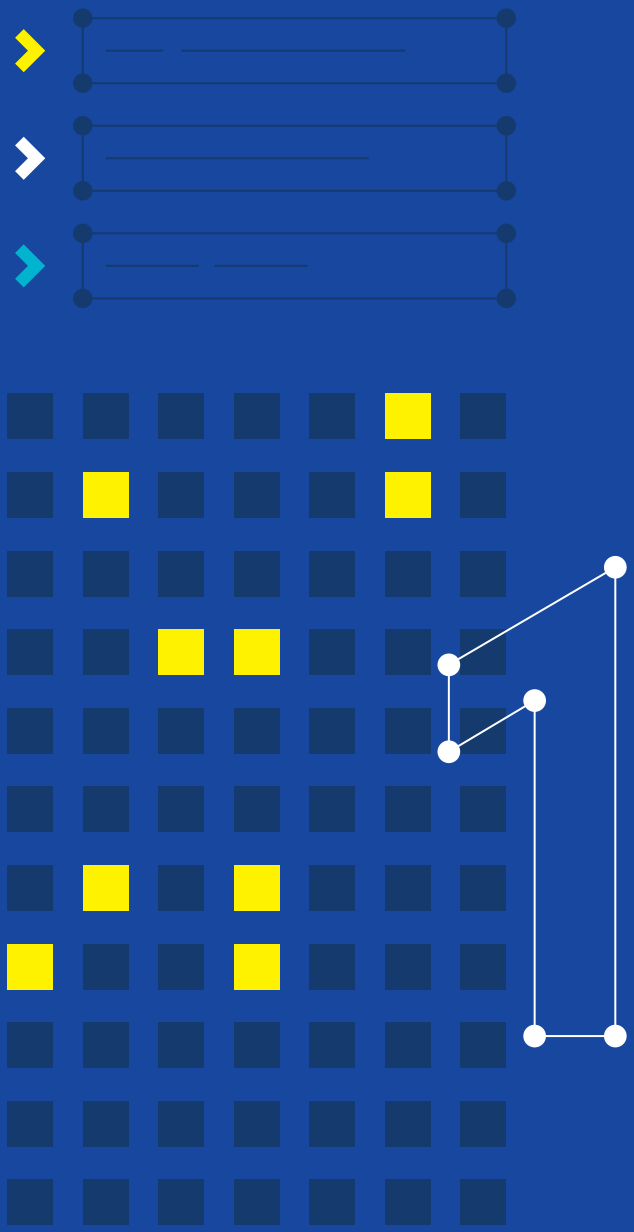
Recommendation 11 (Analytical, Modelling, and Evaluation Capacity) addresses expanding capability to address gaps through fellowships, secondments, and academic-agency partnerships, and exploring a coordinating function for public health modelling.

Implementation and accountability

Turning these recommendations into routine practice will require sustained leadership, clear ownership of recommendations, and practical monitoring of implementation. Implementation of recommendations could be supported by assigning a named lead with supporting partners for each recommendation; sequencing quick wins alongside longer-term capability building; agreeing simple service expectations to ensure consistent turnaround, outputs, and reuse of evidence; using a lightweight monitoring approach (e.g. quarterly check-ins where progress is assessed against a small set of agreed indicators); and reviewing pilots after an initial period in order to identify what aspects should be scaled up, adapted, or stopped. Progress could be reviewed annually against agreed milestones.

Companion outputs

These findings are also published as a peer reviewed research article in *Health Research Policy and Systems*. This report and accompanying plain language summary are designed to reach wider audiences and support practical uptake.

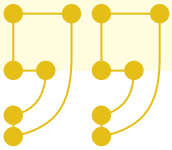


1 Background and introduction

Evidence-informed policy-making (EIPM) refers to the systematic and transparent use of the best available evidence across all stages of the policy process, including agenda setting, policy and programme development, implementation, and monitoring and evaluation (Oxman *et al*. 2009). It emphasises the identification, appraisal, and application of research evidence as core inputs in decision-making processes. An evidence support system is fundamental to EIPM because it provides the frameworks and support that connect evidence to policy. These can include functions such as coordinating evidence generation, synthesis, and use across government; making research more relevant to specific policy areas; providing timely responses to evidence requests; and supporting the use of evidence in a fair and practical manner. It also involves building capacity, for example, through providing targeted training, establishing decision-maker checklists, and using tools to track how evidence is utilised (Global Commission on Evidence to Address Societal Challenges 2022). However, strengthening an evidence support system is not without its challenges, including limited capacity among policy teams, such as a lack of time, skills, and institutional support to access and use evidence; unclear standards for what counts as robust evidence; and the complexity of aligning evidence use with political, ethical, and practical considerations (Organisation for Economic Co-operation and Development 2020a).

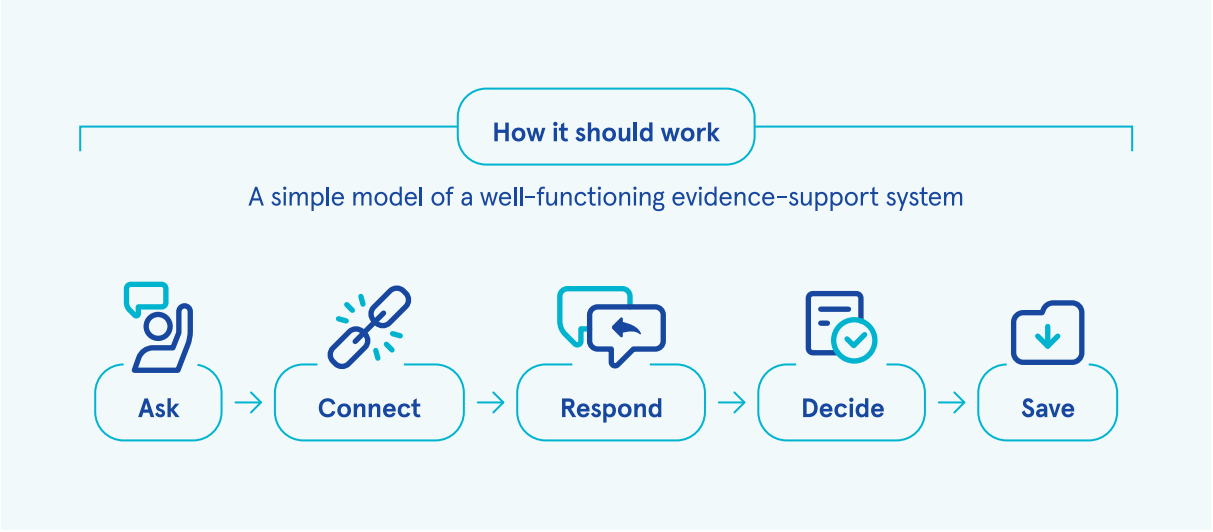
The COVID-19 pandemic highlighted the importance of a well-functioning evidence support system, underscoring the need for robust infrastructure capable of delivering timely, relevant, and trustworthy evidence in order to facilitate prompt decision-making amid significant uncertainty. This experience demonstrated both the value of rapid evidence mobilisation and the vulnerability of systems that depend too heavily on informal networks and relationships. The Global Commission on Evidence to Address Societal Challenges (hereafter 'the Global Evidence Commission') proposed a framework consisting of three domains aimed at enhancing national evidence support systems: the evidence demand side, which refers to whether there is a culture that values the use of evidence, as well as the capacity and enablers in place to use it; the evidence supply side, which includes the organisations and processes that produce timely, demand-driven evidence; and the interface with coordination mechanisms that connect these two sides (Global Commission on Evidence to Address Societal Challenges 2022). The Global Evidence Commission notes that how policy questions are framed shapes which forms of evidence are appropriate, underscoring the need to build capacity for question formulation and triage.

The COVID-19 pandemic highlighted the importance of a well-functioning evidence support system, underscoring the need for robust infrastructure capable of delivering timely, relevant, and trustworthy evidence in order to facilitate prompt decision-making amid significant uncertainty.



It also emphasised that policy-making draws on multiple forms of research evidence – including data analytics, modelling, evaluation, behavioural/implementation research, qualitative insights, evidence syntheses, technology assessment/cost-effectiveness assessment, and guidelines – each contributing in different ways to decision-making. It also distinguished 'best evidence' from other inputs that are sometimes presented as evidence, such as a single study, expert opinion, a research interest group, or jurisdictional scans. Building on this, the Global Evidence Commission developed the Rapid Evidence Support System Assessment (RESSA), a tool that helps countries and Government Departments to identify strengths, gaps, and opportunities across the three domains of the evidence support system (Global Commission on Evidence to Address Societal Challenges 2023).

Ireland's publicly funded health system serves approximately 5.3 million people, with public funding at around €28 billion in 2024 (Central Statistics Office, 2025). Policy leadership rests with the Department of Health, while the Health Service Executive (HSE) delivers services. Statutory agencies such as the Health Information and Quality Authority (HIQA) and the Health Research Board (HRB) act as key producers of evidence and as intermediaries. In 2024, the Department of Health, HRB, Evidence Synthesis Ireland and Cochrane Ireland, and the Global Evidence Commission formed a collaboration in order to conduct a RESSA of health policy-making in Ireland. This assessment was overseen by an HRB-convened oversight group with representation from across government and academia.



1.1 Scope of the research

This report presents the findings from the RESSA of health policy-making in Ireland, drawing on both documentary analysis and stakeholder interviews. Guided by the RESSA framework, we examined how evidence is requested, produced, and integrated into health policy-making across the demand, supply, and interface domains. We highlight existing assets, persistent challenges, and actionable opportunities to strengthen Ireland's evidence support system. Our focus in this report is the evidence support system for policy-making, not clinical guideline uptake or service delivery operations.



2 Methods

This research was part of a RESSA conducted in Ireland to assess the evidence support system for health policy-making. The RESSA methodology, created by the Global Evidence Commission, employs a flexible multi-methods design to investigate three main components of an evidence support system: (i) the demand for evidence, (ii) the supply of evidence, and (iii) the interface, or coordination mechanisms, that connect the two. We combined a targeted document review with semi-structured stakeholder interviews to generate a comprehensive picture of how evidence is requested, produced, and integrated into health policy. A detailed protocol has been published elsewhere (Whelan *et al*. 2025); below, we summarise the main methods.

2.1 Data collection

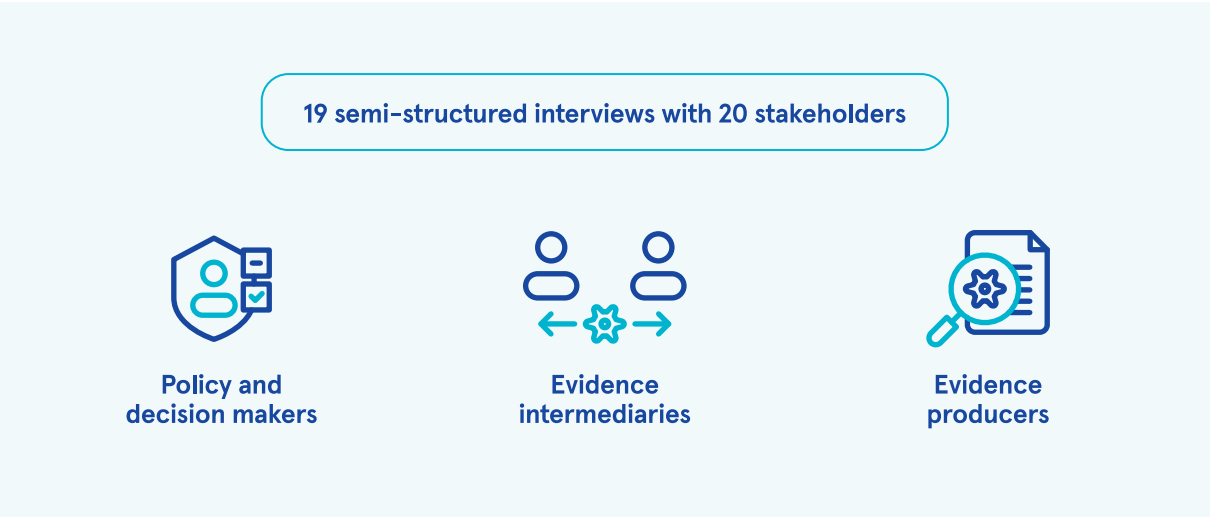
2.1.1 Document review

We conducted a targeted search of the Department of Health website using combinations of keywords (e.g. "evidence-informed policy", "evidence and research and policy") to identify documents relevant to the evidence ecosystem. We included materials published from 2018 to 2024, covering strategic frameworks, evidence-use processes, evaluation reports, and governance structures. The review focused on capturing developments since the introduction of Sláintecare and the COVID-19 pandemic. Two reviewers independently screened titles and full texts against predefined inclusion criteria (see Appendix A), resolving disagreements through consensus.

Documents that met the inclusion criteria were extracted using the READ (Ready, Extract, Analyse, Distil) method of document analysis (Dalglish *et al*. 2020). We piloted and refined a structured extraction framework (Appendix B) and then coded data in NVivo 20 (QSR International, Melbourne, Australia). Our coding aimed to identify enablers, barriers, and opportunities across the RESSA domains, particularly concerning the culture of evidence use, requesting processes, evidence infrastructure, and governance arrangements.

2.1.2 Interviews

We conducted 19 semi-structured interviews with 20 stakeholders between October 2024 and February 2025. Participants were purposively sampled in order to ensure diversity across three groups: (i) policy- and decision-makers within the Department of Health, (ii) evidence producers from organisations such as HIQA and the HRB, and (iii) evidence intermediaries (sometimes called knowledge brokers) working at the research policy interface. Additionally, three participants held roles spanning multiple areas, providing cross-cutting perspectives across the evidence ecosystem.



Recruitment for the interviews included direct email invitations from a member of the research team (BW), referrals from the HRB-convened oversight group, and snowball sampling. Prospective participants received an information sheet about the purpose of the interview and provided their written informed consent to take part.

Interviews explored the strengths and challenges of the evidence support system, as well as both enablers and barriers to evidence use, and participants provided suggestions for improvement. The interview guide was developed based on the RESSA framework, document review findings, and considerations concerning living evidence products, quality standards, and evidence intermediaries identified in global analyses (Appendix C).

2.2 Data analysis and synthesis

Interview transcripts were analysed thematically using NVivo 20, employing a coding framework that combined deductive categories from the Global Evidence Commission (e.g. types of evidence, roles of intermediaries) with inductively identified themes. Results were organised under the three RESSA domains (demand, supply, and interface) and were iteratively discussed with the research team and informed by feedback from the oversight group.

We triangulated findings from documents and interviews using a side-by-side matrix organised by the demand, supply, and interface domains. We compared corroborating evidence, explored incongruent cases, and mapped emerging opportunities onto the Global Evidence Commission's menu of system-strengthening options.

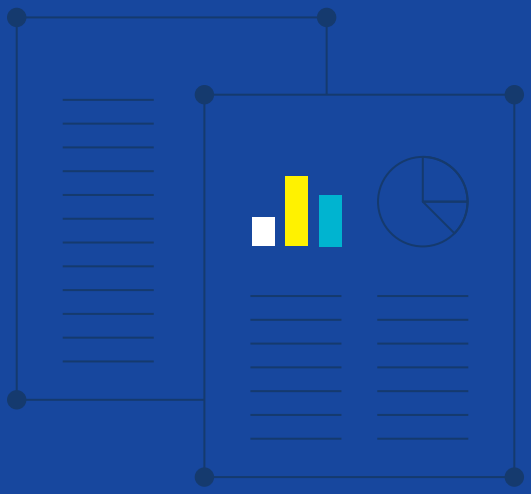
2.3 Ethical considerations

Ethical approval for this study was obtained from the University of Galway Research Ethics Committee (Ref.: 2024.01.003). Interview participants provided informed consent, and all transcripts were anonymised. Data are stored on encrypted, password-protected servers in compliance with the General Data Protection Regulation (GDPR).





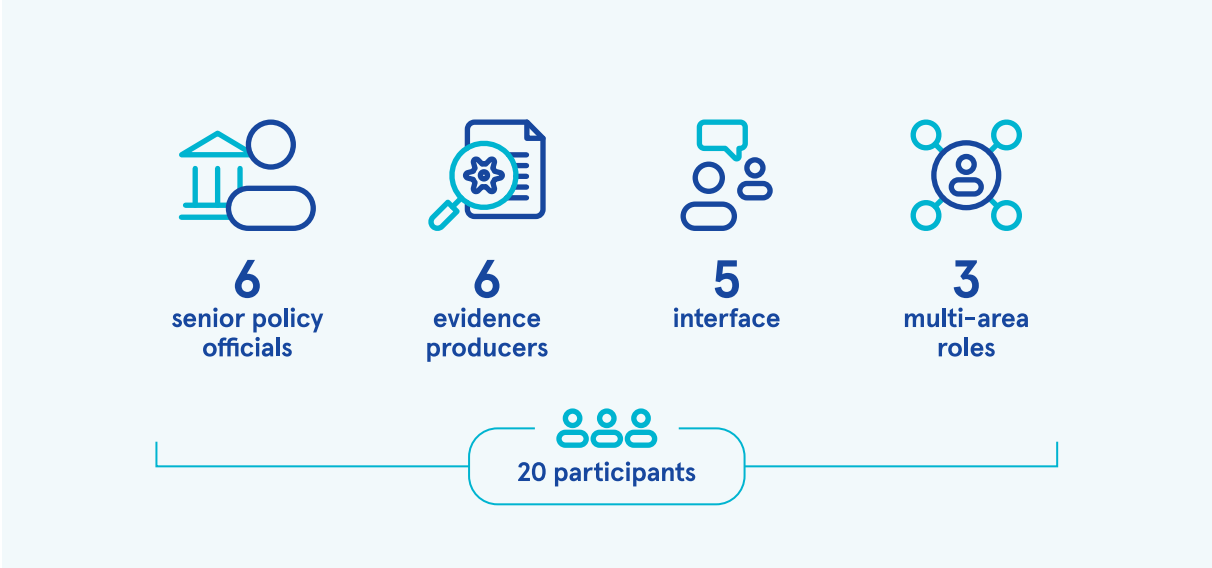
3 Findings



3.1 Overall sample and data sources

This section presents findings from a triangulated analysis of Ireland's evidence support system for health policy-making, drawing on a structured document review and 19 semi-structured interviews. The document review involved a systematic screening of 632 documents, with 50 ultimately included for data extraction (Appendix A). They included strategies, frameworks, evidence support approaches, committee terms of reference, evaluations, and a representative sample of evidence products published between 2018 and 2024. Most documents originated from the Department of Health and national agencies such as HIQA and the HRB.

The interviews captured perspectives from 20 stakeholders representing various roles within the evidence support system. These included senior policy officials from the Department of Health on the evidence demand side (n=6); evidence producers from national agencies and research organisations such as the HRB, the Economic and Social Research Institute (ESRI), HIQA, Evidence Synthesis Ireland and Cochrane Ireland, and analytical or research units within the Department of Health on the evidence supply side (n=6); and individuals working at the interface between research and policy (n=5), as well as three participants whose roles spanned multiple areas. Participants represented a range of seniority levels, including Assistant Principal Officer, Principal Officer, and senior analytical and research roles.



Findings are presented thematically and organised around the three RESSA domains: demand, supply, and interface. This structure highlights strengths, challenges, and opportunities within each domain. Because some issues span multiple domains, they are addressed in more than one section of this report to reflect their broader relevance. To maintain participants' anonymity while distinguishing between their voices, direct quotations are identified only by interview number (e.g. "Interview 1").

3.2 Demand for evidence

We begin with the demand side of the evidence support system, which considers the culture, capacity, and enablers for evidence use within the Department of Health. Within this domain, five sub-themes were identified: (i) commitment to evidence-informed policy-making, (ii) capacity and enablers for evidence use, (iii) approaches to evidence use and integration in health policy-making, (iv) prioritisation of evidence, and (v) lessons from evidence support during the COVID-19 pandemic.

3.2.1 Commitment to evidence-informed policy-making

Both the document review and interview findings revealed a commitment to evidence-informed health policy-making. Strategic documents, such as the *Statement of Strategy 2023-2025* (Department of Health 2023a) and the *Statement of Priorities: Health & Social Care Research 2023-2025* (Department of Health 2023b), emphasise the importance of embedding research evidence into the policy-making process. Most interviewees agreed that evidence-informed policy-making is valuable and that there is an expectation within the Department of Health that evidence should be sought and utilised in decision-making. Interviewees also observed a rising demand for evidence, indicating a shift towards more evidence-driven decisions.

At the organisational level, the Department of Health's *Statement of Strategy 2023-2025* identifies evidence-based policy-making as well as strengthening data, research, and analytical capability as key enablers in order to support health policy implementation, including Sláintecare reforms (Department of Health 2023a). The *Statement of Priorities: Health & Social Care Research 2023-2025* represents a strategic effort to align research activities with national policy objectives, highlighting the Department of Health's commitment to evidence-informed policy-making (Department of Health 2023b).

> *"It's a bedrock … we're very much evidence driven and analytics driven because we have to be, because we have to be able to stand over both the science and the numbers to be able to point out why we did something. A lot of money gets spent on health, and if we can't point to the evidence base for why we're making any given decision, it's not going to go well. So you're talking about a community that's highly conscious of that."* (Interview 13)

The Department of Health's financial commitment to the HRB further underscores its focus on evidence generation, serving as a significant investment in research that informs both clinical practice and health policy, reinforcing the Department of Health's ongoing dedication to an evidence-based approach. In addition, there is a greater initiative within the Department of Health to include individuals with a research evidence perspective in discussions about scoping or designing a new care programme or service, or introducing a new intervention. We identified an institutional commitment to evidence-informed policy within the Department of Health through its establishment of entities such as the National Clinical Effectiveness Committee (NCEC), which was established to create national clinical guidelines and audits aimed at improving healthcare quality, consistency, and cost-effectiveness by integrating national and international best practices (National Clinical Effectiveness Committee 2022). We also identified a commitment within the Department of Health to aligning health policies with comprehensive performance frameworks.

For example, we found that *Implementation Plan 2022–2024: Sharing the Vision: A Mental Health Policy for Everyone* (Department of Health and Health Service Executive, 2022) aimed to align with the Health System Performance Assessment (HSPA) Framework, which established a reliable method for evaluating health system performance through measurable, outcomes-based indicators, reflecting a strategic commitment to outcomes-based governance.

3.2.2 Capacity and enablers for evidence use

Interviews provided the richest insights into the structures, processes, and other enablers and capacities that support evidence use within the Department of Health. While the document review referred to organisational units, such as the Research Services and Policy Unit (since renamed the Strategic Research & Evaluation Unit), it offered limited detail on how they operate in practice. Interviews, by contrast, provided greater clarity and insights into such units, highlighting key strengths and gaps in the system.

A key enabler identified by interviewees is the Department of Health's Research and Development and Health Analytics Division, which since 2024 has comprised several units, including the Strategic Research & Evaluation Unit, which undertakes internal research to support decision-making, and the Research Policy and Innovation Unit, responsible for the direction and oversight of external health research policy, including governance and funding of the HRB. The Division also includes the Statistics and Analytics Unit (with seconded Central Statistics Office (CSO) statisticians), the Health Information Policy Unit, the North-South, EU and International Unit, and the Policy, Strategy and Integration Unit, all of which collectively contribute to the wider research ecosystem in the Department of Health. This division covers multiple forms of research evidence (e.g. data analytics, modelling, evaluation, behavioural/implementation research, qualitative insights, evidence syntheses, technology assessment/cost-effectiveness, and guidelines). The Strategic Research & Evaluation Unit undertakes research to inform and support decision-making across the Department of Health. In addition, it helps policy units refine their evidence needs, select appropriate research methods, and broker strategic connections with external evidence providers, including the HRB Evidence Centre, thereby bridging the research and policy contexts and facilitating access to the most relevant evidence for a given policy question.

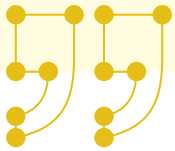
> *"There is a team whose job it is to actually focus on research, evidence, data, modelling, and how to support people in the Department."*
> (Interview 3)

Interviewees used this language to refer to the multiple forms of research evidence listed earlier (i.e. data analytics, modelling, evaluation, qualitative insights, evidence syntheses, technology assessment/cost-effectiveness, and guidelines).

Overall, interviewees identified evidence synthesis as a notable strength, underpinned by a formal collaboration between the Department of Health and the HRB Evidence Centre, and by established processes within the Department to access it. In addition, structured programmes like the HRB-DOH Evidence for Policy (EfP) Programme (launched in 2023), which was co-designed by the HRB Research Strategy and Funding directorate and the Research Policy and Innovation Unit in the Department of Health, invites policy units to identify priority gaps, inform and refine research protocols, and remain engaged throughout the research project lifecycle, helping to align timelines and ensure that findings are policy-ready and actionable.

Data analytics capacity has also expanded through staff from the Irish Government Economic and Evaluation Service (IGEES) and the National Statistical Service (NSS) working within the Department. IGEES is a cross-government initiative led by the Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation that recruits graduates with quantitative skills and offers structured placements across Government Departments. The Department of Health's Strategic Research & Evaluation Unit houses its IGEES cohort, approximately 15 economists and social scientists at full complement, making it one of the largest IGEES units in the Civil Service at the time of writing. The NSS, a network managed by the CSO, similarly enhances analytical capacity across the Civil Service, with the Department of Health's Statistics and Analytics Unit representing one of the largest statistical units across government at the time of writing. Together, these resources further strengthen the Department of Health's analytical and evidence functions. Interviewees highlighted that these resources have improved access to routine data, such as daily hospital emergency department data, Hospital In-Patient Enquiry (HIPE) data, and prescribing data; provided support through tools like dashboards and 'bite-sized' data briefings; and created learning opportunities, such as 'Lunch and Learn' seminars, to build data literacy.

Data analytics capacity has also expanded through staff from the Irish Government Economic and Evaluation Service (IGEES) and the National Statistical Service (NSS) working within the Department.



However, broader issues persist, particularly ongoing data linkage barriers, the absence of unique patient identifiers, and modelling capacity that remains dispersed and mobilised ad hoc (e.g. epidemiological, health system, and economic evaluation modelling, as well as predictive analytics). Together, these issues make it harder to integrate evidence quickly.

> *"It can be difficult to know what data is out there, who owns it and how to get access to it … if someone has a policy question, it's difficult for them to know if there's actually any data out there that can be used to address it or not."* (Interview 4)

> "We don't know how many people have most diseases here. We don't have registries, and the data is very hard to work with." (Interview 10)

Sláintecare has acted as a key enabler for evidence use by focusing on the evidence needs in priority policy areas, ensuring alignment with the overall reform agenda. This alignment with significant national health system reform demonstrates how strategic policy frameworks can promote the systematic use of evidence and build momentum for evidence-informed approaches.

> *"I think with something like Sláintecare, when that came on the scene, there was a clear path of what is required or what policy-makers needed when it comes to healthcare. So that could be expanding the medical card system or free universal GP [general practitioner] care and so forth. So we would have the research oriented towards reaching those kinds of medium-term goals."* (Interview 6).

Despite a commitment to evidence-informed policy-making in the Department of Health and these enablers, interview findings suggest that confidence, skills, and resources for sourcing, interpreting, and applying evidence vary across policy units.

> *"We've got really smart senior civil servants and most of them are smart and work really hard, it's rare you meet one that doesn't or isn't. But they don't have the skills to be able to pick out which evidence is good, evidence is not good, or understand where it could be really helpful and where it can't. And I think if we could give them all those skills that would make a real difference."* (Interview 5)

For a policy unit tackling a new question the process can feel disorienting. One interviewee described thinking, *"Where do I start?" "What are my data sources?"* and *"Where are my evidence sources?"*, an experience likened to feeling like *"rabbits in the headlights"* (Interview 14). There is no mandatory training on evidence use and policy-making, and as such motivated individuals are left to their own devices to seek out relevant courses and development opportunities. Some interviewees suggested that policy units should be able to conduct initial scoping themselves, doing preliminary work to refine their evidence needs before engaging with the broader evidence support system, thereby making the process more efficient. Interviewees viewed this approach as crucial for embedding evidence-informed decision-making within the Department of Health and reducing over-reliance on external expertise while building internal capability.

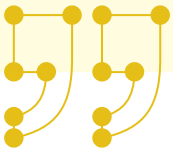
There is no mandatory training on evidence use and policy-making, and as such motivated individuals are left to their own devices to seek out relevant courses and development opportunities.

In addition to skill gaps, interviewees discussed time pressures, with competing demands such as responding to Parliamentary Questions (PQs), advancing legislation, preparing briefing materials, and attending Oireachtas committee meetings. As one interviewee observed, finding even an hour a week for policy development can be challenging, making it difficult to sustain momentum in this area. Policy-makers, therefore, often rely on informal networks and on-the-job learning to navigate the use of evidence, resulting in inconsistent practices across units and vulnerability when staff members change roles.

Although training opportunities have increased for policy-makers in the Department of Health, their impact varies based on timing and application. This ad hoc approach to capacity building highlights the need for clearer guidance and structured support to ensure that staff feel confident in their ability to effectively engage with evidence throughout their careers.

"I think there is something about a Department of Health having more easy access for interested staff to learn about you know good quality research [evidence] in an accessible way and in an empowering way so that the staff feel that they also are developing the research skills … I think the Department could do more to try and improve the awareness, confidence and accessibility to the staff doing their own pieces of even tiny research but just keeping that questioning stance in their head as they deliver their work." (Interview 19)

In areas where evidence is successfully used to inform policy, success is often linked to strong researcher–policy-maker relationships, clear decision-making pathways, and an organisational culture that values evidence.



Some interviewees proposed systematic events, such as regular 'evidence forums' – where civil servants could discuss how evidence is used, what works, and why. In areas where evidence is successfully used to inform policy, success is often linked to strong researcher–policy-maker relationships, clear decision-making pathways, and an organisational culture that values evidence. In contrast, weaker engagement is typically associated with fragmented processes, a lack of internal capacity, or an over-reliance on informal networks. One interviewee proposed incorporating evidence-informed policy-making into performance goals through the Performance Management and Development System (PMDS); however, others stressed the need to first raise awareness and build internal confidence in evidence use before formalising accountability mechanisms.

3.2.3 Approaches to evidence use and integration in health policy-making

Across both the document review and interviews, processes for integrating evidence into policy-making varied considerably, ranging from well-structured frameworks in some areas to relationship-dependent, ad hoc practices in others. The document review highlighted strong examples of formalised processes. For example, the NCEC employs a hierarchical approach to evidence integration, relying on established guidelines and, where available, evidence synthesis (Department of Health 2019a). The National Screening Advisory Committee (NSAC) similarly commissions evidence reviews from HIQA and uses structured methodologies that incorporate ethical, legal, and societal dimensions (National Screening Advisory Committee 2022a, 2022b). Other strategies – such as the National Drugs Strategy (Department of Health, 2023d), which incorporates evaluation, evidence syntheses, and data analytics, and the National Skin Cancer Prevention Plan (Department of Health and the HSE National Cancer Control Programme 2023), which draws on evaluation – include regular review processes to integrate new evidence into policy implementation as research evolves.

Interviewees highlighted the existence of formal pathways for evidence use and integration into policy-making in areas such as pharmaceuticals and screening, supported by longstanding relationships with HIQA, the HRB, and the National Centre for Pharmacoeconomics. These mechanisms facilitate timely access to relevant evidence.

However, many policy units would benefit from clearly defined structures for sourcing, appraising, and applying evidence. Instead, evidence use is often informal and relationship-based, relying on personal networks, institutional memory, and individual initiative rather than established processes. Interviewees noted several instances where evidence influenced policy decisions; for example, the expansion of the GP visit card to median-income groups was a result of internal analysis and cross-departmental negotiations among the Department of Health; the Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation; and the Department of the Taoiseach, ultimately leading to its inclusion as a budgetary measure. Some participants suggested that the strength of researcher–policy-maker relationships often determine the impact of evidence. This creates risks to continuity, especially during staff turnover, and results in uneven access to evidence across the Department of Health. A reliance on individual relationships rather than institutionalised processes represents a key vulnerability in the evidence support system, one that requires structural solutions.

> *"If it were to come down to it, the relationships – what is the thing that makes evidence get into policy. It's that the people who have done the research talk to the decision-maker and tell them what they've got."* (Interview 5)

To help address this issue, the Department of Health organised two 'Research and Policy' conferences aimed at showcasing academic research and bringing policy-makers and researchers together. The goal was to facilitate conversations and help re-establish connections that had been disrupted during the COVID-19 pandemic. Interviewees also described challenges in evidence commissioning. While the HRB Evidence Centre provides a structured route for planned evidence synthesis, some interviewees considered its annual call process to be too rigid to meet urgent or unanticipated needs. Some interviewees called for greater agility, including rapid reviews and 'living' evidence syntheses that can respond to time-sensitive policy questions.

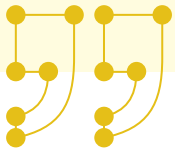
> *"The annual call is limiting when we need an evidence synthesis at other times."* (Interview 14)

Concerns about duplication and lack of coordination emerged most strongly from the interviews. One example an interviewee gave involved an organisation conducting a review requested by the HSE, only to discover that another organisation was nearing completion of a similar review commissioned by the Department of Health. While the first organisation had engaged with the Department of Health to establish an expert advisory group for their review, the Department of Health did not realise that it had already commissioned a separate team to investigate a closely related topic. Interviewees noted weak systems for tracking previously commissioned research and requested evidence, leading to inadvertent duplication of evidence and inefficient use of resources.

Although informal communication channels and ad hoc coordination efforts help mitigate this risk to some degree, interviewees suggested that a centralised knowledge management platform would provide a more effective solution by creating a searchable repository of past and ongoing evidence initiatives (with basic metadata such as the commissioner or requester, topic/keywords, lead unit, status, outputs, and contacts).

> *"I could be wrong because I don't sit at a management board table, but I don't know that there is enough effort made to coordinate the requests and to actually say, 'well, actually, the HRB looked at this maybe last year or the year before and has your unit looked at that because actually its quite similar?'"* (Interview 14)

while some parts of the system have established structured processes for integrating evidence into decision-making, many units operate without clear standards or support structures. This creates a dependence on informal networks, which can be helpful in the short term but in the longer term may undermine the resilience and consistency of the evidence support system.



In summary, while some parts of the system have established structured processes for integrating evidence into decision-making, many units operate without clear standards or support structures. This creates a dependence on informal networks, which can be helpful in the short term but in the longer term may undermine the resilience and consistency of the evidence support system. The interview and document review findings highlight the need for the Department of Health to further develop comprehensive structures, capabilities, and standards for defining, requesting, delivering, and reporting high-quality evidence for policy and programme development and evaluation.

3.2.4 Prioritisation of evidence

The approach to prioritisation of evidence needs was articulated more clearly in the interviews than in the document review. While high-level strategies (e.g. *Statement of Strategy 2023-2025* (Department of Health, 2023a) and *Statement of Priorities: Health & Social Care Research 2023-2025* (Department of Health, 2023b)) set broad goals, they offer limited detail on how priorities are identified, coordinated, or reviewed across units at an operational level. In contrast, interviewees described structured approaches in place for producing policy-relevant evidence in specific areas. They viewed the previously mentioned HRB-DOH EfP Programme, introduced in 2023, as a positive development. This initiative allows policy units to submit research questions aligned with evidence needs, which are then addressed by research projects through a structured process involving alignment meetings and ongoing engagement throughout the research lifecycle. Another example of structured prioritisation was the process described for HTA requests, where a dedicated advisory group reviews and ranks topics based on clinical need and potential impact.

However, interview participants also pointed to gaps in the system. Urgent, deadline-driven tasks often take precedence over long-term strategic priorities, meaning that evidence use is not always as structured or coordinated as it could be, and it sometimes becomes reactive rather than proactive.

> *"A weakness of the Department is prioritising, like it's well acknowledged. I'm not saying anything that will shock anybody. But we try to do too many things. And we don't have the resources to do all these things."* (Interview 14)

Finally, participants emphasised the need for clearer structures and frameworks in order to identify and prioritise urgent evidence needs, ensuring that these can be addressed without undermining routine work.

3.2.5 Lessons from evidence support during the COVID-19 pandemic

A limited number of documents briefly addressed evidence supporting policy responses to emergencies, most notably those related to the COVID-19 pandemic (e.g. the National Public Health Emergency Team (NPHET) COVID-19 Subgroup on Guidance and Evidence Synthesis (2020) and the Public Health Reform Expert Advisory Group (2023) recommendations). These documents highlight the importance of rapid response mechanisms, collaborative networks, and clear communication between evidence producers and decision-makers during crisis situations. The NPHET COVID-19 Subgroup (2020) demonstrated that diverse stakeholders – including HIQA, the HSE, the Health Protection Surveillance Centre (HPSC), and academic partners – could be mobilised quickly to produce guidance and evidence syntheses. However, the processes for coordinating this evidence and ensuring transparency were not always clearly documented, and quality assurance mechanisms were described inconsistently across different evidence products.

Interviewees agreed that, although the COVID-19 pandemic heightened awareness of the need for contingency planning, Ireland still lacks a fully institutionalised framework for mobilising evidence support in the event of future crises. The ability to quickly scale up evidence synthesis, modelling, or stakeholder engagement remains dependent on ad hoc coordination and existing informal networks, rather than established protocols and structures.

Interviewees described how the COVID-19 pandemic fostered stronger international connections for the Department of Health, particularly with the World Health Organization (WHO), the European Medicines Agency, and the Directorate-General for Health & Food Safety (DG SANTE) creating ongoing opportunities for evidence exchange that outlasted the immediate crisis. Interviewees noted how the crisis illustrated the power of a globally connected and locally responsive evidence support system that could quickly integrate international insights into national policy responses.

One example provided was that Evidence Synthesis Ireland leveraged its connections with global actors in evidence synthesis, to strategically harness collective capacity and resources during a time of unprecedented demand. Protocols and findings were published and shared, facilitating open evidence sharing and minimising duplication of effort. Interviewees also described how the COVID-19 pandemic enabled more direct engagement between researchers and policy-makers. Researchers were asked to provide guidance on various aspects of the crisis response (although this was not considered formal research evidence), and senior policy-makers proactively sought their expertise through direct consultation rather than formal commissioning processes. This shift involved moving away from structured procurement procedures, formal advisory group appointments, and lengthy contracting arrangements towards immediate expert consultation. While this increased engagement between researchers and policy-makers facilitated valuable real-time exchange of expertise, the experience raises questions about what barriers normally constrain such engagement, and whether urgency alone should drive this level of direct access. The COVID-19 pandemic demonstrated that direct researcher–policy-maker engagement is possible, but it also highlighted the need to balance rapid access to expert insights with systematic quality assurance and diverse expert input.

The experience highlighted both opportunities and challenges. While the urgency of the pandemic enabled policy-makers to benefit from rapid input from experts, it underscored the importance of ensuring diverse perspectives and avoiding over-reliance on individual researcher views. The most effective policy decisions made during the pandemic drew on global evidence analysed using established quality criteria, complemented by national data from reputable centres and units, demonstrating the value of institutional evidence sources. The COVID-19 pandemic also shifted mindsets towards greater acceptance of rapid reviews, with interviewees recognising their value for timely insights while also cautioning that they differ from systematic reviews and require careful interpretation within the context of available evidence.

While the urgency of the COVID-19 pandemic justified accelerated evidence processes, interviewees emphasised the importance of recalibrating expectations about what evidence processes are appropriate in non-emergency contexts, and ensuring that sustainable, evidence-informed decision-making accommodates both rapid and more rigorous synthesis depending on the context, rather than consistently defaulting to emergency approaches.

These insights highlight lessons learned and gaps that persist in the ongoing process of establishing a sustainable, resilient, and responsive evidence support system for future emergencies that can uphold both speed and quality.

3.3 Supply of evidence

This section examines the supply side, focusing on the availability, quality, and responsiveness of evidence provided to support health policy-making. It addresses the types of evidence produced, how it is commissioned, and the roles of key organisations that produce evidence. Three sub-themes were identified within this domain: (i) Forms and sources of evidence; (ii) Transparency and quality of evidence; and (iii) Requesting research evidence.

3.3.1 Forms and sources of evidence

The Department of Health draws on a diverse mix of evidence – including data analytics, modelling, evaluation, qualitative insights, behavioural and implementation research, technology assessments, evidence syntheses, and guidelines – to inform policy decisions. Fig 3.1 shows the range of forms in which evidence is typically encountered.

These forms of evidence are often integrated with other information; for example, the development of the HSPA Framework (Academic Medical Centre of the University of Amsterdam 2021) combined evidence synthesis, which is one key form of evidence, with policy document reviews, citizen and stakeholder panels, health information system assessments, and expert consultations. Interviewees confirmed that policy decisions routinely integrate data analytics, evidence syntheses, and qualitative findings from multiple sources.

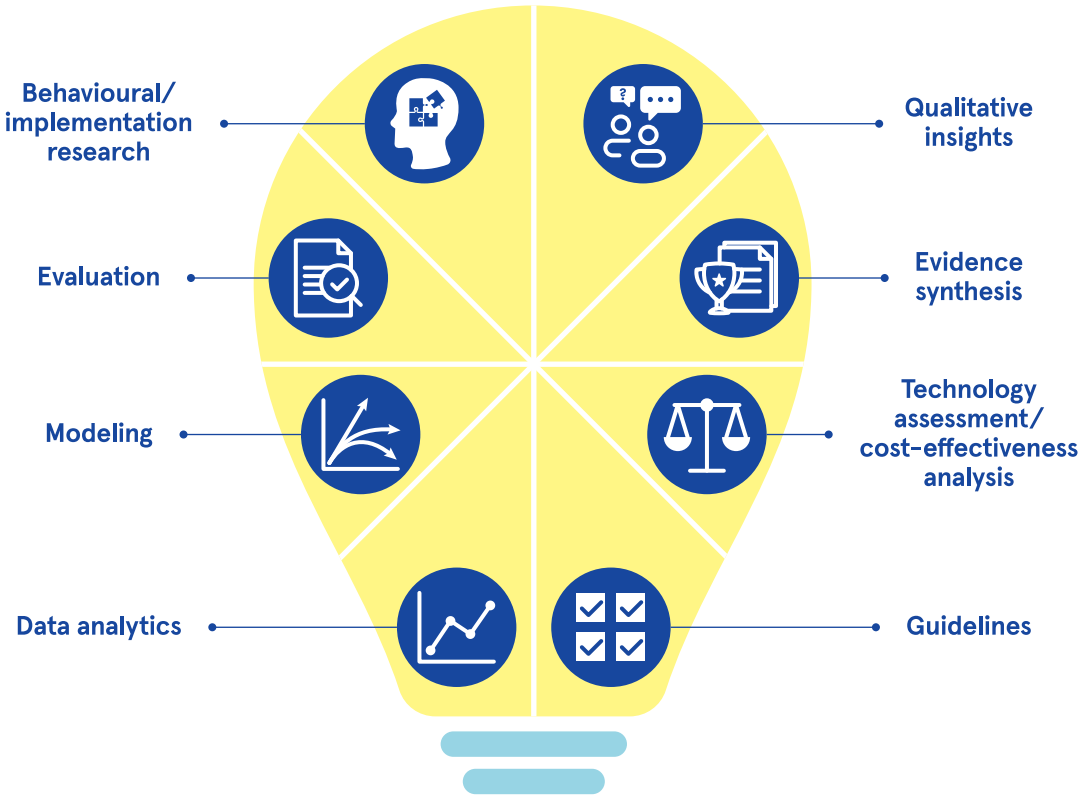


Fig 3.1. Forms in which evidence is typically encountered in decision-making

Reproduced with permission from The Evidence Commission report: A wake-up call and path forward for decision-makers, evidence intermediaries, and impact-oriented evidence producers. (Global Commission on Evidence to Address Societal Challenges, 2022).

The HRB Evidence Centre supports this work by coordinating evidence syntheses through the Department of Health's annual business planning cycle and aligning research with policy needs. Beyond formal evidence synthesis, some interviewees considered deliberative processes and qualitative interviews, involving stakeholders, particularly influential with senior decision-makers who valued hearing directly from those affected by policy decisions.

Additionally, interviewees considered a reference group with lived experience in a specific health area to be essential for providing rapid, real-world feedback. However, gaps still exist in the production of some forms of evidence, such as epidemiological modelling, predictive analytics, and evaluation. In addition, challenges remain when it comes to accessing detailed epidemiological data, which underpins the generation and use of this evidence.

Some interviewees pointed out that Ireland's modelling expertise is spread across universities and agencies, and is mobilised only on an ad hoc basis, echoing calls for the creation of a single 'critical-mass' hub in order to coordinate forecasting and scenario analysis for more consistent and reliable projections.

> *"There's no way of knowing how many people have type 1 diabetes because there's no properly managed register. It's fundamentally problematic for decision-making."* (Interview 9)

> *"We're getting better and I'm speaking about my own unit there as well, but we need to push an evaluation culture. … We are working on a thing at the moment and we've asked that this is evaluated. And there's so much kick back against it."* (Interview 17)

The documents highlighted diverse sources of evidence, both domestic and international, reflecting the Department of Health's effort to combine local insights with global evidence. Domestic sources include the HRB, HIQA, HSE, and CSO, which primarily provide Irish-specific data analytics, evaluations, and other research-based evidence inputs. International organisations include the WHO, the Organisation for Economic Co-operation and Development (OECD), and Eurostat, which primarily provide secondary data, indicators, and guidance derived from evidence syntheses (rather than new primary research) (Department of Health and Healthy Ireland, 2022a; Health Information and Quality Authority 2022; Murphy and Kelly 2023b). External consultancy firms – such as Ipsos B&A, Crowe Ireland, and Mazars – typically deliver a range of products (e.g. surveys/opinion polling, other information types, and evaluations or evidence syntheses as forms of research evidence). Mazars produced an evidence synthesis on adult safeguarding in the health and social care sector (Department of Health 2024), Crowe Ireland combined evaluation and evidence synthesis in its review of *The National Sexual Health Strategy 2025-2035* (Crowe 2023), and Ipsos B&A delivered the Healthy Ireland Survey, a primary research study of population health behaviours (Ipsos B&A 2023). Interviewees noted a shift in the Department of Health towards building internal capacity and producing evidence in-house in order to maintain greater control over quality and relevance.

The Department of Health is also a producer of policy documents that assemble and apply multiple forms of research evidence, with outputs such as strategic reviews, evaluation reports, and business cases that draw on different forms of evidence and other information, such as qualitative research (e.g. stakeholder interviews in the business case for Regional Health Areas), evidence synthesis (e.g. umbrella reviews of interventions to reduce waiting lists), and data analytics/modelling (e.g. OECD health statistics, National Treatment Purchase Fund and HSE data, statistical modelling) (Murphy and Kelly 2023a; Murphy *et al.* 2024; Department of Health, 2022b). This is supported by the Research and Development and Health Analytics Division, which includes a Strategic Research & Evaluation Unit (partially staffed by IGEES analysts) and a Statistics and Analytics Unit. Interviewees emphasised that the Strategic Research & Evaluation Unit coordinates evidence production across five key areas: (i) strategic and workforce planning; (ii) capital investment, including capacity and productivity; (iii) expenditure evaluation in primary community and older persons' services; (iv) behavioural economics in public health and productivity; and (v) health system financing and expenditure projections, which align with departmental priorities.

These areas map onto the forms of research evidence as follows: (i) strategic/workforce planning: data analytics, qualitative insights, and modelling; (ii) capital investment: data analytics and modelling; (iii) expenditure evaluation: data analytics and evaluation; (iv) behavioural economics: behavioural/implementation research and data analytics; and (v) financing/expenditure projections: modelling, data analytics, and evidence synthesis.

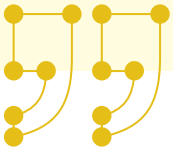
3.3.2 Transparency and quality of evidence

Our analysis found that transparency is strongest in structured evaluations and evidence products that followed recognised reporting standards. An example is the HTA of Spinal Muscular Atrophy (HIQA, 2023), which applied evidence synthesis, economic modelling, and data analytics in a transparent and well-documented manner. This document provided a clear methodology, public reporting, and a plain language summary that enhanced accessibility. However, many strategy or framework documents lacked detailed information on how evidence was produced (Department of Health, 2019b; Department of Health and Office of the Chief Nurse, 2018; Obesity Policy Implementation Oversight Group Reformulation Sub-Group, 2021), making it difficult to assess the robustness of their evidence base. Interviews echoed this inconsistency, noting the absence of established standards for what constitutes an effective health policy-making system and process. There was also an emphasis on the need for clearer guidance on best practices for public consultations so that diverse perspectives are systematically considered. Additionally, concerns were raised about the lack of guiding principles for commissioning external evaluations.

> *We need better ways to ensure that evidence is consistent, … evidence needs are more transparently identified and prioritised, and that evidence is consistently used when developing policies.* (Interview 2)

It is worth noting that in some sensitive policy areas, commissioning research can attract attention from stakeholders or interest groups before decisions are made. In these cases, some work may need to stay confidential or unpublished because of the nature of the policy process, rather than any lack of transparency.

In addition to transparency, the broader concept of open science is increasingly recognised as a cornerstone of an effective and trustworthy evidence support system.



In addition to transparency, the broader concept of open science is increasingly recognised as a cornerstone of an effective and trustworthy evidence support system. Open science refers to making scientific research openly accessible, with minimal delay, to maximise public benefit and scrutiny.

While some documents in the review demonstrated these principles, such as the HTA on Spinal Muscular Atrophy (HIQA, 2023), which published a registered protocol, applied PRISMA standards, and offered a plain-language summary, many did not. Across documents, there was limited detail on whether the underlying evidence, such as data and evidence syntheses, was publicly accessible, reproducible, or aligned with open science principles. These gaps may limit stakeholders' ability, including researchers and the public, to verify, replicate, or build on existing work, and may reduce trust in policy decisions. Taken together, the document review and interviews suggest that, although some areas of health policy-making are transparent about how evidence is used, application is inconsistent. Strengthening transparency around public consultation processes and the commissioning of evaluations, as well as integrating open science practices, would enhance trust and reinforce the evidence-informed support system, while promoting the reuse of valuable research.

Our analysis revealed varied approaches to quality assurance, with some documents, such as structured assessments (e.g. HTAs) and formal evidence products (e.g. national clinical guidelines), demonstrating a strong attention to evidence quality. For example, the HTA of Spinal Muscular Atrophy (HIQA, 2023) applied recognised standards, including PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) and CHEC (Consensus on Health Economic Criteria). By comparison, the Healthy Ireland Survey (IPSOS B&A, 2023) outlined data quality and validation processes to support the reliability of their findings (e.g. sampling frames, response rates, cleaning rules, and consistency checks), which are distinct from the methodological appraisal of research evidence forms such as systematic reviews or evaluations. The *Manual for Developing National Clinical Guidelines* (Department of Health, 2019a) set out the use of robust appraisal frameworks, such as GRADE (certainty of evidence) and AGREE II (guideline quality), in the development of clinical guidelines. In contrast, other documents, including *Smile agus Sláinte* (Department of Health, 2019c) and the *Women's Health Action Plan* (Women's Health Taskforce, 2022), cited evidence but did not describe how its quality was appraised. This may reflect their focus on high-level strategies or operational frameworks rather than detailed appraisal of evidence, but it limits transparency into the robustness of the evidence used.

Interview findings echoed this variability. Participants reported mixed experiences with commissioned evidence, highlighting quality concerns regarding some consultancy outputs and a lack of internal expertise to oversee or assess them. This gap in procurement expertise underscores a broader challenge in quality assurance for evidence production. For instance, a consultancy company was engaged to examine a particular topic, but the Department of Health ensured close collaboration, ongoing input, and verification, which required significant effort to ensure that the final product met high standards rather than relying solely on the consultancy's quality controls. Some participants suggested that evidence from reliable sources diminished their perceived need for critical analysis, which could lead to unchallenged assumptions:

> *"So in many respects there is an inherent trust because we aren't a research institute. We don't critically evaluate the evidence that comes in."* (Interview 7)

One interviewee questioned the value of claiming that something underwent peer review as a marker of quality, suggesting that the term could create a "veneer of integrity" if the feedback from reviewers is not meaningfully addressed or selectively implemented. This observation reflects broader concerns raised by the Global Evidence Commission regarding the need for robust quality assurance processes. These include using frameworks such as PRISMA and GRADE (as demonstrated in the HTA of Spinal Muscular Atrophy) (HIQA, 2023), and the Assessing the Methodological Quality of Systematic Reviews (AMSTAR) or Risk of Bias tool (RoB 2). In practice, quality should be assured by applying appropriate tools e.g. AMSTAR 2 for systematic reviews, RoB 2 for randomised trials, ROBINS-I for non-randomised studies, GRADE for certainty of bodies of evidence, and AGREE II for guidelines, paired with transparent reporting standards (e.g. PRISMA; CHEERS (Consolidated Health Economic Evaluation Reporting Standards) for economic evaluations) and open science practices (protocols, shared code/data where permissible). Peer review alone is not a substitute for these explicit, replicable methods.

3.3.3 Requesting research evidence

Our analysis revealed a broad range of practices for requesting evidence in health policy-making, ranging from minimal to high levels of structure, transparency, and collaboration. Some processes were formalised and well documented, while others were more ad hoc and unclear in their approach. The document review indicated that certain national bodies consistently commission evidence in a structured manner. For example, the NSAC commissions HTAs from HIQA, drawing on HIQA's expertise to inform screening programme decisions (NSAC, 2022b; HIQA, 2023). The NCEC, under ministerial direction, also commissions clinical guidelines (NCEC, 2022), with internal subcommittees overseeing the process. These represent more institutionalised approaches aligned with national priorities and demonstrate clear governance structures.

Other documents emphasised more collaborative arrangements involving Government Departments, academic institutions, and international partners. One example is the Department of Health, in collaboration with the WHO, commissioning research to map essential public health functions (World Health Organization, 2023a). In another instance, the Department of Health, the HSE, and the HRB commissioned research to inform the development of a model for population-based funding for health (Johnston *et al.* 2021), which was later referenced in related analysis by O'Malley *et al.* (2023). Some research was procured through open tenders, such as in the evaluation of advanced nursing and midwifery practice (Department of Health, 2019b). In other cases, consultancy firms (e.g. Crowe Ireland, Mazars) were engaged. However, the selection process and rationale were not always clearly detailed (Department of Health, 2023c; Crowe, 2023), thus limiting transparency around commissioning decisions.

Interviews confirmed this mixed picture. Requesting evidence was described as resource intensive, and timelines often proved constraining for policy-relevant outputs. Policy-makers expressed a need for trusted, timely, and relevant evidence to inform their decisions; however, the slow pace of academic research and rigid procurement structures created additional hurdles for producing responsive evidence. A lack of resources was also identified as a challenge. Depending on the type of evidence required, available resources, and the urgency of the timeline, policy-makers must decide whether to commission external research or attempt to conduct it in-house within their own units, which have limited capacity. Some interviewees expressed disappointment with the quality of evidence provided by consultancy firms, leading to a reluctance to engage with those companies again. This creates a dilemma: if research is not outsourced, policy-makers may lack the necessary evidence to inform decisions, but if it is outsourced and the resulting work is of poor quality, it represents a waste of taxpayers' money and may lead to suboptimal policy choices. One participant noted that procurement frameworks allowing access to research units within universities and specialised research centres offer a more reliable solution, as these institutions possess deeper subject matter expertise and can deliver more relevant, high-quality outputs, making them *"invaluable to ensure a useful project"* (Interview 14) that meets policy needs.

Overall, the findings suggest that while practices for requesting evidence differ in their formality, improving consistency, transparency, and governance in this area would enhance the quality and timeliness of policy-relevant evidence, offering better value for money.

3.4 Interface

This section examines the interface between evidence producers and users, where brokering and connection between demand and supply take place. The Department of Health currently lacks a formal interface mechanism to (i) surface and triage emerging policy questions, (ii) match each question to the right mix of evidence forms and response pathways (e.g. rapid review, HTA, evaluation, modelling), and (iii) log, quality assure, and integrate outputs into briefings and decisions; in its absence, informal relationships shoulder much of this work.

While the documents provided limited detail on the interface, interviews offered richer insights into these processes, particularly the informal relationships, anticipatory engagement, and collaborative structures that support evidence use in practice. Three sub-themes were identified: (1) Structured collaboration between researchers and policy-makers; (2) Proactive engagement and relationship building at the interface; and (3) Limitations of informal systems and over-reliance on relationships.

3.4.1 Structured collaboration between researchers and policy-makers

Formal collaborative mechanisms, particularly advisory groups, have emerged as key routes for connecting evidence producers with decision-makers to ensure the relevance and uptake of evidence.

Formal collaborative mechanisms, particularly advisory groups, have emerged as key routes for connecting evidence producers with decision-makers to ensure the relevance and uptake of evidence. Institutionalised groups, such as the NSAC, NCEC, and the NIMC for Mental Health, facilitate ongoing dialogue and the co-production of knowledge. These groups integrate clinical expertise, policy input, and stakeholder voices to inform evidence-based decisions on issues such as screening, clinical guidelines, and mental health strategies (NSAC, 2022; NIMC, 2021; NCEC, 2022). Interviewees confirmed the value of structured engagements such as expert advisory groups, especially when they involve early scoping of policy questions, co-development of research protocols, and continuous participation in advisory groups throughout the evidence generation process. For example, policy units are often directly represented on expert groups, thus ensuring that they can hear discussions first hand and help shape the work's focus so that the emerging evidence is relevant and usable. These advisory groups play an important interface role, by clarifying questions, indicating appropriate forms of research evidence (e.g. data analytics, evaluation, modelling, evidence syntheses), and documenting how evidence informs options and recommendations.

> *"So the linking in with the Department will be initial scoping of the policy question, key deliverables, protocol. Then, they will always have a representative on the expert advisory group so they can see those meetings and hear those discussions."* (Interview 11)

In addition to these external advisory structures, some units within the Department of Health, such as the Strategic Research & Evaluation Unit, have a knowledge brokerage role, connecting their own research to policy priorities, commissioning or overseeing targeted research to address evidence gaps, and facilitating strategic collaborations between policy units and external partners such as the ESRI Joint Research Programme on Healthcare Reform and the Hippocrates Model for projecting healthcare demand, capacity and expenditure.

This role also extends to international engagement, linking the Department of Health to cross-country research and best practice through participation in the OECD Health Committee. The Unit was also involved in the decision to renew The Irish LongituDinal Study on Ageing (TILDA) project, negotiating the transfer of the existing data and new data to the CSO, which should support expanded and timelier access for policy, planning and research purposes.

3.4.2 Proactive engagement and relationship building at the interface

Participants consistently identified strong informal relationships between researchers and policy-makers as a key enabler of effective evidence use, despite structural challenges. These personal connections bridge gaps left by inadequate formal structures, facilitating direct communication, quicker knowledge exchange, and greater trust in evidence – benefits that formal processes alone cannot achieve.

Interviewees noted that these relationships become particularly influential in urgent policy situations, when decision-makers rely on trusted contacts for quick insights without bureaucratic delays. Throughout the COVID-19 pandemic, researchers gained unprecedented access to senior policy-makers, facilitating the swift translation of evidence into policy decisions. This experience demonstrated both the value and potential vulnerability of relationship-based evidence support systems that lack institutional backup, raising concerns about over-reliance on individual perspectives, which may reflect personal values and preferences and draw mainly on their own work or what they are already familiar with.

Those working at the interface between policy-makers and evidence suppliers described engaging in anticipatory efforts to connect policy-makers with relevant research, even when there was no immediate demand for particular evidence. They characterised this dynamic as an informal yet intentional process of 'percolating' information, sharing insights from ongoing grants, European Union (EU) projects, or other research initiatives that might align with emerging policy priorities. This approach reflects an understanding of the Department of Health's structure, priorities, and decision-making processes. By leveraging this knowledge, evidence suppliers can proactively identify research that could be useful and facilitate early engagement between policy-makers and researchers before formal requests are made.

Knowledge brokering activities included informal 'speed dating' sessions between researchers and policy teams, as well as early-stage meetings between evidence providers and decision-makers. These efforts were viewed as particularly beneficial for keeping policy-makers informed and ready to engage with evidence when urgent issues arise, rather than having to start from scratch when needs become pressing.

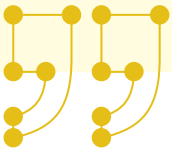
3.4.3 Limitations of informal systems and over-reliance on relationships

As stated previously, there is no formal interface mechanism to surface policy questions, connect them to the right evidence response, and embed findings into decision-making. While many mechanisms described above support effective evidence use, interviewees highlighted the fragility of systems that rely too heavily on informal networks lacking institutional foundations. Strong personal relationships between researchers and policy-makers enable quick exchanges and facilitate access to timely evidence. However, these connections are susceptible to staff turnover and are seldom backed by formal structures that can ensure continuity and institutional memory.

> *"The turnover in policy staff is huge, and it means we constantly have to rebuild relationships and reintroduce evidence processes."* (Interview 6)

Participants also described gaps in capacity and recognition at the interface level. Few dedicated roles exist to connect evidence supply and demand, and anticipatory engagement often relies on an individual's initiative rather than system design or established processes. While some outlined brokering meetings or shared research before formal requests, others focused more narrowly on reactive or commissioned work. This inconsistency highlights a broader lack of formal acknowledgement of the interface as a distinct part of the evidence support system that requires specific skills and resources.

The current reliance on informal systems risks duplication, variable access to support, and loss of learning across units, particularly for policy units without established research connections.



One example of an attempt to strengthen this space was the Department of Health's organisation of two 'Research and Policy' conferences that showcased academic research and brought policy-makers and researchers together. While welcomed, interviewees noted that such initiatives need to be sustained and supported by dedicated structures and staff in order to achieve a lasting impact. The current reliance on informal systems risks duplication, variable access to support, and loss of learning across units, particularly for policy units without established research connections.

3.5 Summary of findings across domains and sub-themes

Table 3.1. summarises the key strengths and challenges identified across the three RESSA domains: demand, supply, and interface, as described in more detail above under the sub-themes.

Table 3.1. Summary of strengths and challenges across the RESSA domains

Domain	Strengths	Challenges
Demand	• Strong commitment to evidence-informed policy-making across senior and operational levels • Alignment with strategic frameworks such as Sláintecare • Capacity building initiatives including training sessions • Evidence is routinely used to inform strategy and policy documents in key policy areas.	• Lack of consistent, transparent process for prioritising evidence needs • Variable capacity and technical capability across policy units • Limited operational clarity on how evidence is used in decision-making and on matching policy questions to the appropriate forms of research evidence and response pathways • Risk of duplication and missed priorities due to reliance on informal networks and insufficient coordination
Supply	• Production of a wide range of evidence types (e.g. data analysis, HTAs, evidence syntheses, behavioural research) • Well-established processes for generating evidence in high-priority areas • Collaborative partnerships and participation in national and international networks • Clear and timely outputs from key national agencies (e.g. HIQA, HRB) • COVID-19 pandemic experience showed latent capacity for rapid evidence synthesis and collaborative modelling during crisis situations.	• Fragmented evidence landscape and persistent data gaps (e.g. epidemiology and modelling) • Dispersed public health modelling expertise with no coordinating hub, limiting routine scenario analysis • Absence of a standing evidence synthesis hub leads to duplication and variable turnaround times • Uneven evaluation culture and resourcing; few rapid evaluation pathways • Inconsistent quality assurance processes and limited transparency in some areas • Limited strategic coordination of commissioned research across policy units and agencies
Interface	• When well-designed (diverse membership, transparent terms of reference, and explicit use of appraised evidence), advisory groups bring together diverse expertise, supporting shared understanding of complex issues (design quality varies across settings) • Examples of timely evidence-sharing during urgent policy needs (e.g. COVID-19) • Informal relationships that help connect researchers and policymakers in the absence of formal structures	• Absence of a formal interface mechanism to identify emerging policy questions, provide timely, demand-driven triage, match them to appropriate forms of evidence and response pathways, and ensure resulting evidence is logged, quality-assured, and integrated into briefing materials/decision-making processes • Roles and responsibilities for knowledge brokering remain unclear and unevenly resourced • Over-reliance on personal relationships that are vulnerable to staff turnover • Few formal mechanisms to support sustained cross-unit knowledge exchange and institutionalise knowledge transfer



4 Discussion



For clarity, this section is structured in five parts: (1) Key findings; (2) Findings in relation to other studies; (3) Strengths and limitations; (4) Implications for policy and practice; and (5) Implications for future research.

4.1 Key findings

This assessment of the evidence support system for health policy-making in Ireland highlights an institutional commitment to evidence-informed policy-making; however, it also exposes significant challenges in operationalising this commitment. Our findings indicate capacity challenges, a reliance on informal processes that limit the consistent use of evidence, and uneven implementation across units. By triangulating a document review and stakeholder interviews, we identified both strengths and key development opportunities across the RESSA domains of demand, supply, and interface. The RESSA framework helps identify what is working well in a country's evidence support system that should be systematised and scaled up, and what gaps should be addressed as a matter of priority (Global Evidence Commission, 2023). RESSA is best understood as a structured, evidence-informed starting point that identifies current strengths and gaps, and points to practical options for improvement, recognising that learning and iteration will always be needed as the system evolves.

The findings from our RESSA highlight a commitment to Evidence-informed policy-making (EIPM). This is evident in strategic documents such as the Department of Health's *Statement of Strategy 2023-2025* (Department of Health, 2023a) and in the establishment of structures such as the NCEC and NSAC to guide systematic evidence use. The Department of Health has a dedicated national research funding agency in the HRB, which, through initiatives such as the HRB Evidence Centre, the EfP Programme, and joint Research and Policy Conferences, has helped establish models of good practice that are being replicated across other Government Departments. Additionally, the Department of Health's collaboration with external agencies, such as HIQA and the ESRI, alongside internal units such as the Strategic Research & Evaluation Unit, further reinforces this commitment and advances progress towards institutionalising an evidence support system. Illustrative examples of these existing assets are summarised in Box A. These developments align with international calls to move beyond ad hoc arrangements towards a more formal and routine integration of evidence across policy cycles (OECD, 2020b). While initiatives such as IGEES and NSS help improve analytical capacity, the reliance on individual connections and relationships, as described by interviewees, as well as on ad hoc processes suggests fragility in the system. This reflects concerns outlined by the OECD (2023), which found that Ireland's overall policy system often relies on informal networks and fragmented coordination rather than institutionalised processes for evidence generation and use, thereby undermining long-term sustainability.

Box A: Illustrative examples of existing assets in the Department of Health's existing evidence support system (not exhaustive)



HIQA HTAs: transparent methods (e.g. PRISMA/ CHEERS; GRADE where appropriate), public reporting, and plain language summaries.



HRB Evidence Centre: structured, demand-driven evidence syntheses aligned with Department needs via annual business planning.



NSAC processes: systematic use of HIQA reviews and explicit criteria for national screening decisions.



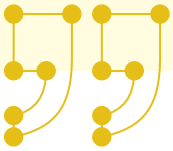
Embedded analytics (IGEES/NSS): placements and supports that expand data/ analytics capacity within policy units.

4.2 Findings in relation to other studies

There are RESSAs being conducted in 12 other countries (McMaster Health Forum, 2024); however, little has been published to date, which makes comparison with our findings difficult. The Global Evidence Commission provided an update in 2025 (Global Evidence Commission, 2025) and highlighted that while there are signs of building momentum, there is limited evidence of demand-side efforts to formalise and strengthen national and local evidence support systems. They noted that countries are rarely taking decisive action on the findings from RESSAs or committing to sustained, scaled-up versions of pilots such as ultra-rapid evidence support. Our findings align with the international literature, which indicates that while many countries demonstrate strategic commitments to evidence-informed policy-making, challenges persist in translating these commitments into practical action.

Common issues include the absence or weakness of formal systems for using evidence, unclear prioritisation mechanisms, underdeveloped roles for intermediaries working at the interface between demand for and supply of evidence, and limited capacity to use evidence among policy-makers (European Commission: Joint Research Centre, 2025).

Without investment in skills development, knowledge infrastructure, and leadership support, achieving the goals of evidence-informed policy will remain challenging.



These findings are reflected in a recent study by Calnan and McHugh (2024), which examined how senior decision-makers in Ireland's health service use evidence. They discovered that, while support for research use is high, numerous practical barriers persist. For example, many rely on personal relationships with researchers instead of formal systems and often find that research is neither timely nor meets their needs. The study also highlighted a lack of internal research capacity and a need for better coordination across the system. These issues closely align with what we found in our assessment, particularly regarding uneven implementation, variable skills, and the absence of formal roles that connect research to policy. Both studies suggest that a more integrated and well-supported system is needed, with clearer processes and structures for incorporating evidence into decision-making. While not a theme directly addressed in the interviews, the Global Evidence Commission (2022) has highlighted the importance of supporting policy-makers in matching different types of policy questions to the appropriate forms of evidence, such as data analytics, evaluations, and qualitative studies. Without investment in skills development, knowledge infrastructure, and leadership support, achieving the goals of evidence-informed policy will remain challenging. This is also a priority, as reflected in the Civil Service Renewal 2030 Strategy (Department of Public Expenditure and Reform, 2021), which pledges to develop an evidence-informed approach to decision-making by equipping the Civil Service with the requisite capacity and to review and invest in the sector's strategic policy infrastructure. The lack of systematic professional development, combined with dependence on informal learning or motivated individuals, undermines long-term capacity. A recommendation to integrate EIPM competencies into Ireland's PMDS framework and to provide more accessible training aligns with international recommendations. However, performance incentives must be supported by cultural change and leadership support (OECD, 2020b). Langer et al. (2016) found that interventions focusing solely on access to research evidence or skills development are unlikely to shift evidence use unless they are supported by broader organisational and behavioural change strategies that address culture, incentives, and decision-making structures in a coordinated manner.

The document review identified multiple forms of evidence in use, including routine data, evidence syntheses, qualitative studies, and behavioural research. Some evidence products adhered to recognised reporting standards (e.g. PRISMA for systematic reviews) and applied explicit appraisal tools e.g. GRADE for certainty of bodies of evidence; AMSTAR 2 for systematic reviews; RoB 2 for randomised trials), while others incorporated formal approaches to quality assessment and transparency.

However, variation in the quality and transparency of evidence was a recurring theme. While some documents demonstrated robust methods and clear referencing, others, including those commissioned from consultancy firms, provided limited detail on methodology or stakeholder input. Interviewees echoed these concerns, with several citing frustration at the variable quality of commissioned work and the lack of clear standards for evaluating evidence. It was sometimes unclear how deliberative processes, such as public consultation and stakeholder engagement, influenced final decisions. In some cases, the transparency of how feedback was used to inform policy was limited, raising questions about the depth and impact of these deliberative efforts. The OECD has emphasised the need for transparency in how stakeholder input is used in policy-making to enhance legitimacy and public trust (OECD, 2021), and to build a stronger evidence-based culture.

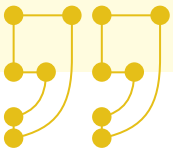
Despite progress in developing analytical capacity through the placement of IGEES and NSS staff, now embedded within the Department of Health's Research and Development and Health Analytics Division, and efforts to improve data flows, access to key datasets remains fragmented. This situation is expected to improve in the coming years with the introduction of the European Health Data Space Regulation (European Commission, 2025). Under this Regulation, EU Member States must, by 2029, make routine health data accessible in a secure format via a clear access request mechanism for secondary uses such as policy-making, research, and innovation. An EU co-funded project is currently underway, led by the Department of Health, to design and establish a designated Health Data Access Body to facilitate this process. This aligns with the Global Evidence Commission's (2022) emphasis on evidence-related global public goods and the importance of data infrastructure for effective evidence use. Additionally, the new Health Information Bill aims to enhance the collection, quality, use, and reuse of health information in Ireland by specifying an identity management system and establishing Digital Health Records for all patients in Ireland. This will also support Ireland's EU obligations for primary and secondary uses under the European Health Data Space Regulation, creating a more robust foundation for evidence-informed decisions.

Duplication and the lack of a centralised approach to managing commissioned research and existing evidence were discussed in the interviews. Participants highlighted the risk of repeating work and the challenges in accessing previous outputs. The Global Evidence Commission report (Global Commission on Evidence to Address Societal Challenges 2022) echoed this concern, highlighting substantial research waste globally due to poor coordination, duplication, and limited access to existing evidence. It recommended developing coordinated knowledge management systems, both nationally and internationally, to make evidence more visible, shareable, and easier to utilise.

The OECD has raised similar concerns, noting that many Government Departments do not maintain databases of commissioned research, thereby increasing the risk of duplication and underuse of existing evidence (OECD, 2020b). Having a central location to store and access commissioned research could help reduce duplication, improve transparency, and enhance the use of existing work while maximising return on investment in research.

Our findings show that the connection between evidence producers and policy-makers is active and largely based on personal relationships, although it lacks formal recognition and investment. Strong informal networks, personal initiative, and anticipatory brokering were identified as key enablers of evidence use, particularly in urgent or time-sensitive policy situations. Interviewees also noted that decision-making timelines can vary widely, from same-day responses to longer-term reforms. Urgent, deadline-driven tasks often take priority over more strategic, longer-term evidence work. This highlights the importance of having flexible systems that can respond quickly to immediate policy questions, while still supporting the slower, more sustained work of building an evidence base over time. Structured engagement mechanisms, such as expert advisory groups, also played a role in linking researchers and policy-makers from the outset of policy development processes. However, concerns were raised that these systems rely too heavily on individual personnel and are vulnerable when staff transition or roles change. The Global Evidence Commission report (2022) noted that intermediaries, those who translate, broker, and connect evidence with policy-making, are often under-recognised, inconsistently resourced, and rarely embedded in formal structures. Other studies have shown that collaborating with an evidence intermediary can help policy-makers develop skills in finding, appraising, and using evidence, which in turn can lead to more consistent engagement with evidence in policy-making (Haynes *et al.* 2018). Our findings align with this, particularly emphasising the dependence on informal relationships and individual initiative rather than institutionalised interface roles. Illustrative international examples of formalised interface mechanisms are presented in Box B. These international models highlight the importance of institutionalised structures and knowledge broker roles. In addition, initiatives such as the Research and Policy Conferences and the HRB's EfP Programme represent promising steps towards strengthening this interface, but further investment in dedicated intermediaries or knowledge brokering roles is essential in order to create sustainable connections between research and policy. The Department of Health's Strategic Research & Evaluation Unit plays a growing brokerage role in formalising these linkages and supporting structured collaboration, including through international engagement with cross-country research and best practice via the OECD Health Committee.

The importance of having flexible systems that can respond quickly to immediate policy questions, while still supporting the slower, more sustained work of building an evidence base over time



Box B: Examples of international formalised interface mechanisms

Canada:

National Collaborating Centre for Methods and Tools (NCCMT): A federally funded intermediary providing rapid reviews, online training, and evidence repositories. During the COVID-19 pandemic, it produced more than 40 reviews in response to federal and provincial policy needs (Husson *et al.* 2021).

Uganda:

Centre for Rapid Evidence Synthesis (ACRES): a knowledge brokering institution providing timely and responsive knowledge for equitable policy-making. Policy-makers report that its rapid evidence briefs influenced their decisions and increased confidence in policy choices (Mijumbi *et al.* 2014).

United Kingdom (UK):

Parliamentary Office of Science and Technology (POST) and What Works Centres. POST is a research and knowledge exchange service based in the UK Parliament that is widely regarded as a trusted and well-used source of evidence in parliamentary decision-making (Kenny *et al.* 2017). What Works Centres are a UK Government-endorsed network of knowledge brokering organisations, created in 2013, to help advance evidence-based policy and practice.

Overall, the findings show that the evidence support system has a strong foundation and a clear commitment to using evidence to inform policy-making. However, this commitment is not applied consistently across policy areas. Policy-makers want to use evidence, but they often do not have enough time or face other demands that make it hard to stay engaged. The quality and transparency of evidence use are improving in areas with formal evaluation processes, such as HTAs and clinical guidelines, but standards remain uneven across other types of commissioned research and strategic policy work.

Policy-makers want to use evidence, but they often do not have enough time or face other demands that make it hard to stay engaged.

In addition, while researchers and policy-makers work together, these connections can depend on personal connections rather than formal systems. In order to improve, the evidence support system should build on its strengths by formalising access to evidence, establishing consistent quality standards, and enhancing the interface between evidence and policy.

4.3 Strengths and limitations of the assessment

This report summarises an assessment of Ireland's health policy-making landscape, drawing on a review of publicly available documents and interviews with key stakeholders. A strength of the assessment is the combination of methods that blends a document review with interviews from key stakeholders. This approach enabled us to cross-check our findings and gain a better understanding of the strengths and areas for improvement. The interviews captured perspectives from a wide range of participants, including senior policy-makers, evidence producers, and those working at the interface between evidence and policy. A structured approach to analysing documents and interviews ensured that the findings were consistent, grounded in evidence, and aligned with international frameworks.

One limitation is that many documents did not indicate how evidence was prioritised, commissioned, or used in developing policy. This made it more difficult to assess the full system. While the interviews included senior policy-makers and those who supply evidence, they may not reflect the views of all relevant stakeholders, particularly those at operational levels. Finally, this report captures a moment in time, and subsequent developments may already be underway. Despite these limitations, the research offers important insights into the strengths, challenges, and opportunities for strengthening Ireland's evidence support system to inform system improvements.

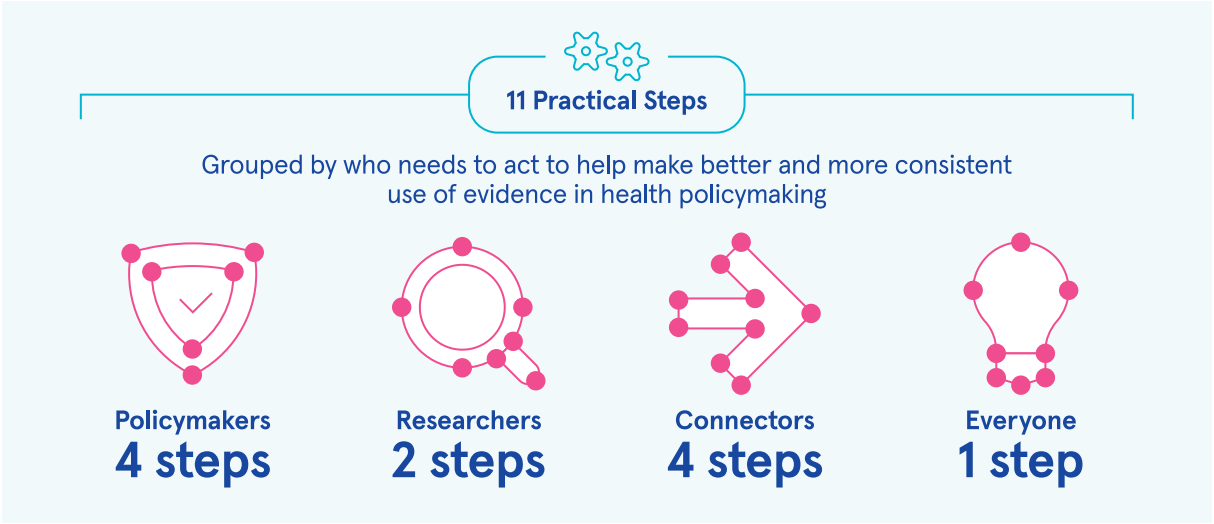
4.4 Implications for policy and practice

Based on the assessment findings, we identify 11 key elements that could strengthen Ireland's health evidence support system. The actions below are calibrated to the strength of our data. We use:

- "establish/develop" where findings directly support a system change
- "strengthen/expand" where triangulated evidence indicates a clear benefit
- "pilot/explore" where interview insights and international guidance suggest a promising option that should be tested and evaluated before scale-up.

This approach aligns with a staged model of institutionalising evidence-informed policy-making, which progresses from awareness, through development (piloting promising innovations), to assessment (scaling and embedding processes), and finally to maturation (where evidence use is routine and resilient) (Al Sabahi et al 2022).

The recommendations are grouped by the primary actors involved: policy-makers (within the Department of Health), researchers and evidence producers, and evidence intermediaries at the research policy interface. One recommendation requires shared, system-level ownership across these groups. The verb used in each recommendation (e.g. 'pilot', 'develop', 'establish', 'strengthen') signals the suggested level of commitment based on the strength of the evidence. The 'what this looks like in practice' examples are illustrative and are intended to support interpretation, not to prescribe a single approach.



Policy-makers

Recommendation 1. Prioritisation of Evidence Needs

Pilot a structured prioritisation approach in selected policy units for evidence requests, recognising that requests often exceed available capacity. Distinguish clearly between planned evidence needs and urgent, time-critical requests, and document the basis for decisions. This will make choices about which requests are progressed, deferred, or not pursued clear and defensible.

What this looks like in practice

One or two policy units test a simple shared process that:

- Records evidence requests and the question being asked
- Distinguishes planned needs from urgent requests
- Sets indicative timelines and outputs
- Documents prioritisation decisions (and why)

Recommendation 2. Capacity and Culture for Evidence Use

Strengthen capacity and culture by integrating evidence-informed policy-making competencies into performance and development processes, and by requiring or encouraging completion of foundational training for new policy staff.

What this looks like in practice

- Evidence-informed policy-making is reflected in existing performance and development conversations, for example, through discussion about how evidence was used in their policy-making.
- New policy staff are directed to a small set of agreed foundational learning resources on evidence-informed policy decisions.

Recommendation 3. Transparency and Accountability for Evidence Use

Develop transparency and accountability frameworks for evidence use by issuing guidance on how to document the role of evidence in policy decisions, and by supporting proportionate, periodic learning reviews of evidence use across policy areas.

What this looks like in practice

- Policy submissions and briefing materials include a short 'evidence considerations' section that explains how evidence informed both the options presented and the decision taken (including key uncertainties)
- Clear acknowledgement of evidence gaps or uncertainty where relevant
- Policy units periodically reflect on how evidence was used to inform a policy, with a focus on what worked well and what could be improved.

Recommendation 4. Knowledge Management and Repositories

Develop a central, accessible repository for commissioned research and evidence products to support reuse, reduce duplication, and enhance transparency about what evidence exists and how it was produced, including basic metadata (commissioner, date, scope, methods, status, access restrictions).

What this looks like in practice

- A basic, searchable inventory of commissioned work is maintained and accessible across policy units, supporting continuity and reducing duplication.
- Agreed protocols clarify when and how evidence products should be deposited, and who is responsible for maintaining the inventory.

Researchers and evidence producers

Recommendation 5. Quality Assurance and Standards

Improve consistency and transparency in evidence quality by providing clear, proportionate guidance on reporting, appraisal, and data governance standards across different forms of policy-relevant evidence.

What this looks like in practice

- Guidance clarifies quality expectations for different types of evidence used in policy-making (e.g. evaluations, modelling or qualitative studies), with illustrative examples of appropriate reporting or appraisal approaches (e.g. PRISMA for reporting reviews, GRADE for critical appraisal tools)
- Commissioners and evidence producers can agree on expectations at the outset, reducing late-stage disagreements about quality or scope.
- The guidance serves as a reference point, allowing flexibility when timelines or policy contexts require proportionate approaches.

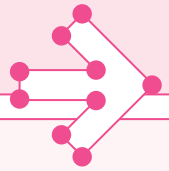
Recommendation 6. Rapid and Proportionate Research Approaches

Pilot rapid forms of research (e.g. rapid evaluations, rapid qualitative inquiry, rapid-cycle testing) using predefined templates, minimal datasets, and proportionate governance to complement rapid evidence reviews.

What this looks like in practice

- Alongside rapid evidence reviews, selected programmes incorporate other rapid evidence to answer context-specific or implementation questions.
- These approaches use proportionate methods and governance, delivering timely insights that inform policy decisions.

Evidence Intermediaries (connecting evidence and policy)



Recommendation 7. Flexible Procurement and Delivery Models

Pilot a lead contractor procurement model that enables an approved lead evidence unit to assemble the right mix of partners (HTA, evaluation, analytics, modelling) under pre-approved terms for urgent, complex briefs.

What this looks like in practice

- For urgent or complex policy questions, a pre-approved lead evidence organisation is commissioned to manage and integrate multiple strands of expertise (e.g. modelling, evaluation, synthesis) under a single contract, rather than having policy teams commission each component separately.
- The model works within existing procurement and governance arrangements while reducing delays and coordination burden for policy teams.
- Use is targeted and proportionate, reserved for briefs where speed, integration, or complexity would otherwise be difficult to manage.

Recommendation 8. Knowledge Broker Roles

Pilot embedded knowledge broker roles within key evidence-producing organisations, with clear responsibilities for policy liaison and performance metrics (timeliness, relevance, transparency). Separately, consolidate and institutionalise regular 'research and policy' forums with dedicated time for rapid matchmaking between policy-makers and researchers, and for shared learning across priority areas.

What this looks like in practice

- Within key evidence-producing organisations, named staff are responsible for policy liaison, supported by clear expectations regarding responsiveness, relevance, and transparency.
- These roles are recognised and resourced as part of normal business, reducing reliance on informal personal relationships and individual goodwill.
- Regular 'research and policy' forums provide structured opportunities for policy-makers and researchers to connect, exchange insights, and share learning, rather than relying on ad hoc contacts.

Recommendation 9. Rapid Response Evidence Services

Pilot a rapid response evidence service (target turnaround within 10 working days) for urgent policy needs, complementing existing planned evidence processes. The service would operate with clear triage criteria, agreed service expectations (e.g. timelines and outputs), and proportionate outputs that are logged for reuse.

What this looks like in practice

- Urgent policy questions are submitted through a defined route and triaged against agreed criteria. Where accepted, a short evidence output (e.g. a brief synthesis, data summary, or signposting to existing evidence) is produced within an agreed time frame and scope.
- Outputs are logged and shared where appropriate to reduce duplication and support institutional learning.

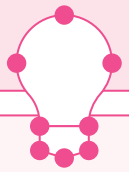
Recommendation 10. Evidence Synthesis Hub

Establish a standing Evidence Synthesis Hub with rapid activation protocols for health emergencies, and maintain an open catalogue of living reviews to support both routine and crisis evidence needs in prioritised areas.

What this looks like in practice

- A small number of priority policy areas are selected where evidence needs recur or change rapidly.
- For these areas, evidence syntheses are updated periodically or maintained in a 'living' format, rather than commissioned repeatedly from scratch.
- During urgent situations, rapid activation protocols enable existing synthesis capacity to be mobilised quickly, without bypassing quality or relying solely on informal networks.

System-level Shared Responsibility



Recommendation 11 requires joint ownership.

Recommendation 11. Analytical, Modelling, and Evaluation Capacity

Expand capability across key forms of research evidence, including modelling (epidemiological, health system, economic), evaluation, data analytics, and qualitative/behavioural/implementation research via fellowships, secondments, and academic-agency partnerships. Explore the feasibility of a coordinating function for public health modelling (e.g. a national modelling hub or equivalent).

What this looks like in practice

- Targeted fellowships, secondments, or partnership arrangements are used to address gaps in expertise or capacity, particularly for time-limited or high-priority needs.
- Options for more formal coordination of public health modelling are explored pragmatically, informed by an assessment of demand, feasibility, and added value.

Implementation and accountability

Finally, to ensure progress in implementing the actions above, leadership commitment within the Department of Health is essential. This could include, for example, convening an implementation group to take the actions forward, evaluate impacts, and share the learning with other Government Departments. Progress could be reviewed annually against agreed milestones. The WHO (2023b) has described the need for high-level leadership and commitment to champion evidence use, strengthen political support, and ensure that reforms are sustained over time. Collectively, these actions will build a more coherent, transparent, and resilient evidence support system, thus moving Ireland from episodic good practice to system-wide routine use of high-quality evidence.

4.5 Implications for future research

This RESSA identifies several priorities for future research. These include evaluating the design, uptake, and effects of a two-track evidence prioritisation protocol across policy units; assessing the added value of dedicated knowledge broker roles; evaluating the impact of capacity building initiatives on evidence use; and examining how quality assurance processes influence the credibility and use of evidence. Related system components that merit testing include a central repository, a rapid response evidence service, and an evidence synthesis hub. Where feasible, pragmatic evaluations alongside realist/process evaluations and mixed-methods approaches should be used. Protocols should be pre-registered and open science practices applied (sharing code/data where permissible). Primary outcomes could include timeliness, duplication rates, transparency, and decision uptake; secondary outcomes could include cost/resource use, staff experience, and equity of representation in deliberative inputs. Such research would enhance understanding of approaches to building a sustainable, evidence-informed system.



5 Conclusion

This assessment highlights both the progress made and the work still needed to strengthen Ireland's evidence support system for health policy-making. The Department of Health has taken important steps in recent years to expand analytical capacity, strengthen research and evaluation functions, and collaborate with national agencies. These efforts provide a foundation for further progress in embedding evidence use across the policy system. While there is a clear commitment to using evidence and examples of good practice, challenges remain in ensuring consistent application and embedding formal structures. Moving from reliance on informal networks to clearly governed processes, i.e. triaging questions, matching them to appropriate forms of research evidence, and logging/quality assurance/integration of outputs, will be critical. Strengthening coordination, building capacity, and investing in interface roles will be key to making evidence use more routine, transparent, and sustainable. If piloted and shown to be effective, measures such as a central repository, rapid response evidence services, an evidence synthesis hub, and embedded knowledge broker roles can help institutionalise good practice. Overall, there is an opportunity to build on existing foundations and develop a more integrated approach to evidence-informed decision-making that can withstand personnel changes and respond to both routine and urgent policy needs.



6 References

Academic Medical Centre of the University of Amsterdam (2021) *Methodological report: The development of the Irish Health System Performance Assessment Framework and its relation to the Health Information System*.

Al Sabahi S, Wilson MG, Lavis JN, El-Jardali F, Moat K, Vélez M. Examining and contextualizing approaches to establish policy support organizations – a critical interpretive synthesis. Int J Health Policy Manag. 2022;11(5):551–566. Doi:10.34172/ijhpm.2020.18.

Calnan S and McHugh S (2024) Experiences and perceptions of evidence use among senior health service decision-makers in Ireland: a qualitative study, *Evid. Policy* 20(2), pp. 163–183. Available from: https://doi.org/10.1332/174426421X16917571241005

Central Statistics Office (2025) Provisional Health Expenditure Estimates for 2024. Available from: https://www.cso.ie/en/releasesandpublications/ep/p-sha/systemofhealthaccounts2023/provisionalhealthexpenditureestimatesfor2024/ [Accessed 03 March 2025]

Crowe (2023) *Review of the National Sexual Health Strategy*. Dublin: Department of Health

Dalglish SL, Khalid H and McMahon SA (2020) Document analysis in health policy research: the READ approach, Health Policy Plan 35(10), pp. 1424–1431. Available from: https://doi.org/10.1093/heapol/czaa064

Department of Health (2019a) *How to develop a National Clinical Guideline: A manual for guideline developers*. Dublin: Government Ireland.

Department of Health (2019b) *A policy on the development of graduate to advanced nursing and midwifery practice*. Dublin: Government of Ireland.

Department of Health (2019c) *Smile Agus Sláinte – National Oral Health Policy*. Dublin: Government of Ireland.

Department of Health (2022b) *Business case for the implementation of Regional Health Areas*. Dublin: Government of Ireland

Department of Health (2023a) *Statement of Strategy 2023-2025*. Dublin: Government of Ireland.

Department of Health (2023b) *Statement of Priorities: Health & Social Care Research 2023-2025*. Dublin: Government of Ireland.

Department of Health (2023c) *National Open Disclosure Framework*. National Patient Safety Office. Dublin: Government of Ireland.

Department of Health (2023d) *National Drugs Strategy – Strategic Action Plan 2023-2024*. Dublin: Government of Ireland.

Department of Health (2024) *Policy proposals on adult safeguarding in the health and social care sector*. Dublin: Government of Ireland.

Department of Health and Healthy Ireland (2022a) *Healthy Ireland Outcomes Framework*. Dublin: Government of Ireland.

Department of Health and Office of the Chief Nurse (2018) *Framework for safe nurse staffing and skill mix in general and specialist medical and surgical care settings in adult hospitals in Ireland 2018: Final report and recommendations by the Taskforce on Staffing and Skill Mix for Nursing*. Dublin: Government of Ireland.

Department of Health and Health Service Executive (2022) *Implementation Plan 2022–2024: Sharing the Vision: A Mental Health Policy for Everyone*. Dublin: Government of Ireland.

Department of Health and HSE National Cancer Control Programme (2023) *National Skin Cancer Prevention Plan 2023–2026*. Dublin: Government of Ireland.

Department of Public Expenditure and Reform (2021) *Civil Service Renewal 2030 Strategy – Building on our strengths*. Dublin: Government of Ireland.

European Commission (2025) *European Health Data Space Regulation*. Available from: https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space-regulation-ehds_en#:~:text=On%205th%20March%202025%2C%20the,the%20transition%20phase%20towards%20application. [Accessed 03 March 2025]

European Commission: Joint Research Centre, Nakrošis V, Petraitė I, Bortkevičiūtė R and Vilpišauskas R, (2025) *Building capacity for evidence-informed policymaking in governance and public administration in a post-pandemic Europe – Country analysis, policy recommendations and implementation roadmap Lithuania*, Almeida M and Olajos-Szabo A. editor(s), Publications Office of the European Union, Luxembourg, 2025. Available from: https://data.europa.eu/doi/10.2760/0030376, JRC141125.

Global Commission on Evidence to Address Societal Challenges. *The Evidence Commission report: A wake-up call and path forward for decision-makers, evidence intermediaries, and impact-oriented evidence producers*. Hamilton: McMaster Health Forum, 2022.

Global Commission on Evidence to Address Societal Challenges. *Evidence Commission update 2023: Strengthening domestic evidence support systems, enhancing the global evidence architecture, and putting evidence at the centre of everyday life*. Hamilton: McMaster Health Forum, 2023.

Global Commission on Evidence to Address Societal Challenges. *Global Evidence Commission update 2025: Contributing to a step-change improvement in how we learn from others around the world, and not losing sight of ongoing opportunities*. Hamilton: McMaster Health Forum, 2025.

Haynes A, Rowbotham SJ, Redman S, et al. (2018) *What can we learn from interventions that aim to increase policy-makers' capacity to use research?* A realist scoping review. *Health res. Policy syst*. **16**, 31. Available from: https://doi.org/10.1186/s12961-018-0277-1

Health Information and Quality Authority (2022) *High level review of configuration and reform of Public Health systems in selected countries*. Dublin: Health Information and Quality Authority (HIQA).

Health Information and Quality Authority (2023) *Health Technology Assessment of the addition of spinal muscular atrophy (SMA) to the National Newborn Bloodspot Screening Programme*. Dublin: Health Information and Quality Authority (HIQA).

Husson H, Howarth C, Neil-Sztramko S and Dobbins M (2021). *The National Collaborating Centre for Methods and Tools (NCCMT): Supporting evidence-informed decision-making in public health in Canada. Canada communicable disease report = Releve des maladies transmissibles au Canada, 47(56), 292–296*. Available from: https://doi.org/10.14745/ccdr.v47i56a08

Ipsos B&A (2023) *Healthy Ireland Survey Summary Report 2023*. Dublin: Ipsos B&A.

Johnston B, Burke S, Kavanagh P, O'Sullivan C, Thomas S and Parker S (2021). *Moving beyond formulae: A review of international population-based resource allocation policy and implications for Ireland in an era of healthcare reform*. HRB Open Research, Vol. 4, p. 121.

Kenny C, Rose DC, Hobbs A, Tyler C and Blackstock J (2017) *The role of research in the UK Parliament, Volume One*. London: Houses of Parliament.

Langer L, Tripney J and Gough D (2016) *The Science of Using Science: Researching the use of research evidence in decision-making*. London: EPPI-Centre, UCL Institute of Education, University College London.

McMaster Health Forum (2024) RESSA Country Leads Group. Available from: https://www.mcmasterforum.org/networks/evidence-commission/about-us/who-we-are/ressa-country-leads-groupMcMaster [Accessed 3 April 2025].

Mijumbi RM, Oxman AD, Panisset U, *et al*. Feasibility of a rapid response mechanism to meet policy-makers' urgent needs for research evidence about health systems in a low income country: a case study. *Implement. Sci* **9**, 114 (2014). Available from: https://doi.org/10.1186/s13012-014-0114-z

Murphy R and Kelly A (2023a) *Acute hospital waiting lists and times: An umbrella review on the effectiveness of interventions to reduce waiting lists and times for elective care*. Waiting Lists Series: Report No. 2. Dublin: Government of Ireland.

Murphy R and Kelly A (2023b) *Acute hospital waiting lists and times: International comparisons and trends in Ireland to end 2021*. Waiting Lists Series: Report No. 3. Dublin: Government of Ireland.

Murphy R, Reidy J, Delaney L, Lunn P, Robertson D, Ryan H and Wood A. (2024) *The Better Letter Initiative: An evaluation of the impact of redesigned appointment SMS reminders on outpatient DNAs*. Research Services and Policy Unit, Department of Health. Dublin: Government of Ireland.

National Clinical Effectiveness Committee (2022) *National Clinical Effectiveness Committee Modus Operandi*. Dublin: Government of Ireland.

National Implementation and Monitoring Committee (NIMC) (2021) *Terms of Reference and Membership*. Dublin: Government of Ireland.

National Public Health Emergency Team (NPHET) COVID-19 Subgroup – Guidance and Evidence Synthesis (2020) *Overview of activities and next steps*. Dublin: Government of Ireland.

National Screening Advisory Committee (2022a) *Annual Report 2022*. Dublin: Government of Ireland.

National Screening Advisory Committee (2022b) *Criteria for appraising the viability, effectiveness and appropriateness of a screening programme*. Dublin: Government of Ireland.

Obesity Policy Implementation Oversight Group Reformulation Sub-Group (2021) *A roadmap for food product reformulation in Ireland*. Dublin: Government of Ireland.

Organisation for Economic Co-operation and Development (OECD) (2020a) *Mobilising evidence for good governance: Taking stock of principles and standards for policy design, implementation and evaluation*. OECD Public Governance Reviews. Paris: OECD Publishing. Available from: https://doi.org/10.1787/3f6f736b-en

Organisation for Economic Co-operation and Development (OECD) (2020b) *Building capacity for evidence-informed policymaking: Lessons from country experiences*. OECD Public Governance Reviews. Paris: OECD Publishing. Available from: https://doi.org/10.1787/86331250-en

Organisation for Economic Co-operation and Development (OECD) (2021) *Good practice principles for deliberative processes for public decision-making*. Available from: https://cop-demos.jrc.ec.europa.eu/resources/good-practice-principles-deliberative-processes-public-decision-making [Accessed 11 January 2025].

Organisation for Economic Co-operation and Development (OECD) (2023) *Strengthening policy development in the public sector in Ireland*. OECD Public Governance Reviews. Paris: OECD Publishing. Available from: https://doi.org/10.1787/6724d155-en

Oxman AD, Lavis JN, Lewin S, *et al*. (2009) SUPPORT Tools for evidence-informed health policymaking (STP) 1: What is evidence-informed policymaking?, *Health Res. Policy Syst.* 7(Suppl 1), S1. Available from: https://doi.org/10.1186/1478-4505-7-S1-S1

O'Malley C, McCarthy T, Hannigan A and Buckle N (2023) *Spending Review 2022 – Towards population-based funding for health: Model proposal.* Dublin: Government of Ireland.

Public Health Reform Expert Advisory Group (2023) *Report of the Public Health Reform Expert Advisory Group*. Dublin: Government of Ireland.

Whelan B, Tierney M and Burke NN *et al*. (2025) *A Rapid Evidence Support System Assessment (RESSA) of health policymaking in Ireland – A protocol.* HRB Open Research, 8, p. 70. Available from: https://doi.org/10.12688/hrbopenres.14167.1

Women's Health Taskforce, Department of Health (2022) *Women's voices and supporting evidence for the Women's Health Action Plan 2022–2023*. Dublin: Government of Ireland.

World Health Organization (2023a) *Essential Public Health Functions in Ireland: Perspectives to strengthen public health capacities and stewardship*. Geneva: World Health Organization.

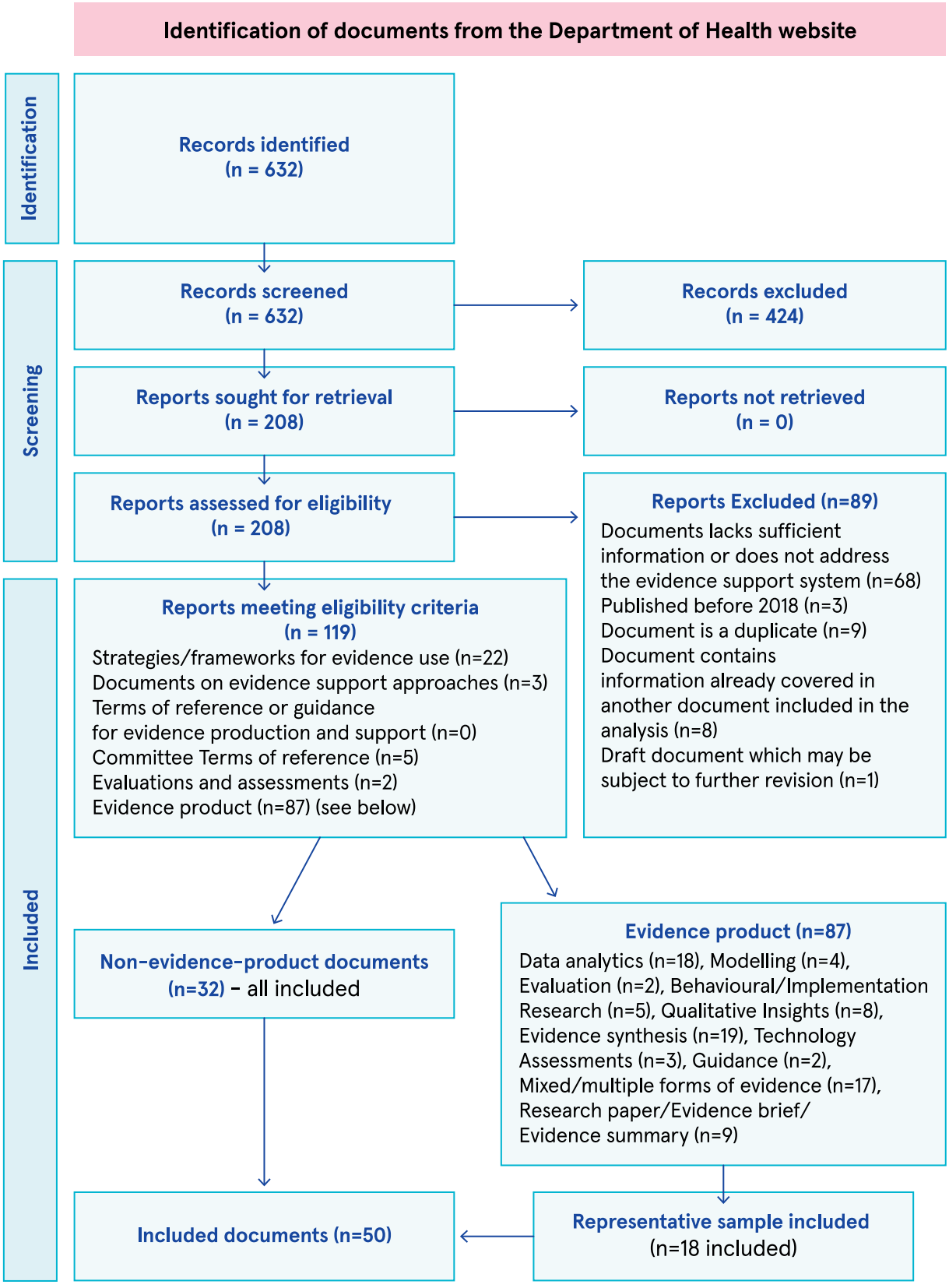
World Health Organization (2023b) *Supporting the routine use of evidence during the policy-making process: A WHO Checklist*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

Appendix A Document review

A1.1 Inclusion criteria for documents

1. Published in 2018 or later to capture changes since the launch of Sláintecare and developments during and after the COVID-19 pandemic.
2. Relevant to the evidence ecosystem, illustrating the demand, supply or interface of evidence in health policy-making. We excluded documents that lacked relevance to these criteria or were published prior to 2018.

A1.2 Selection process of the related documents



A1.3 Overview of documents included in the Review

Title	Type	Year	Source
National Drugs Strategy: Strategic Action Plan 2023-2024	Strategy/ framework for evidence use	2023	Department of Health
Framework for safe nurse staffing and skill mix in general and specialist medical and surgical care settings in Adult Hospitals in Ireland 2018. *Final Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing*	Strategy/ framework for evidence use	2018	Department of Health. Office of the Chief Nurse
A Policy on the Development of Graduate to Advanced Nursing and Midwifery Practice	Strategy/ framework for evidence use	2019	Department of Health
Smile Agus Sláinte – National Oral Health Policy	Strategy/ framework for evidence use	2019	Department of Health
Methodological report: The development of the Irish Health System Performance Assessment Framework and its relation to the Health Information System	Strategy/ framework for evidence use	2021	Academic Medical Centre of the University of Amsterdam (AMC)
Final Report: Performance accountability for the Irish health system	Strategy/ framework for evidence use	2021	Academic Medical Centre of the University of Amsterdam (AMC)
Implementation Plan 2022–2024 Sharing the Vision: A Mental Health Policy for Everyone	Strategy/ framework for evidence use	2022	Department of Health and HSE
Sharing the Vision: A Mental Health Policy for Everyone	Strategy/ framework for evidence use	2020	Department of Health

Title	Type	Year	Source
Change for the future – A Vision for Change 'refresh'	Strategy/ framework for evidence use	2019	Oversight group on mental health policy – Department of Health
Joint Committee on the Future of Mental Health Care – Final Report	Strategy/ framework for evidence use	2018	Joint Committee on the Future of Mental Health Care, House of the Oireachtas
National Skin Cancer Prevention Plan 2023-2026	Strategy/ framework for evidence use	2023	Department of Health and HSE National Cancer Control Programme
A Roadmap for Food Product Reformulation in Ireland	Strategy/ framework for evidence use	(2021)	Obesity Policy Implementation Oversight Group (OPIOG) Reformulation Sub-Group
Healthy Ireland Outcomes Framework	Strategy/ framework for evidence use	2022	Department of Health, Healthy Ireland
Healthy Ireland at Work *A National Framework for Healthy Workplaces in Ireland 2021–2025*	Strategy/ framework for evidence use	2021	Department of Health, Healthy Ireland
Organisational Reform *HSE Health Regions* *Implementation Plan*	Strategy/ framework for evidence use	2023	Government of Ireland and HSE
National Open Disclosure Framework (2023)	Strategy/ framework for evidence use	2023	National Patient Safety Office (Advocacy and Legislation) – Department of Health

Title	Type	Year	Source
Public Consultation *Policy Proposals on Adult Safeguarding in the Health and Social Care Sector*	Strategy/ framework for evidence use	2024	Department of Health
National Screening Advisory Committee Annual Report 2022	Strategy/ framework for evidence use	2022	National Screening Advisory Committee
Criteria for Appraising the Viability, Effectiveness and Appropriateness of a Screening Programme	Strategy/ framework for evidence use	2022	National Screening Advisory Committee
National Care Experience Programme *Strategy 2022-2024*	Strategy/ framework for evidence use	2022	National Care Experience Programme
The National Public Health Emergency Team (NPHET) COVID-19 Subgroup: Guidance and Evidence Synthesis	Committee terms of reference	2020	The National Public Health Emergency Team (NPHET) COVID-19 Subgroup – Guidance and Evidence Synthesis
National Implementation and Monitoring Committee (NIMC) Terms of Reference and Membership	Committee terms of reference	2021	National Implementation and Monitoring Committee (NIMC)
National Clinical Effectiveness Committee Modus Operandi	Committee terms of reference	2022	National Clinical Effectiveness Committee
Terms of Reference of the Strategic Advisory Forum to the Patient Advocacy Service	Committee terms of reference	2019	Department of Health

Title	Type	Year	Source
Standing Orders	Committee terms of reference	2019	National Screening Advisory Committee
Overview of activities and next steps	Documents on evidence support approaches	2020	National Public Health Emergency Team (NPHET) COVID- 19 Subgroup - Guidance and Evidence Synthesis
NCEC Implementation Guide and Toolkit.	Documents on evidence support approaches	2018	Department of Health
How to develop a National Clinical Guideline A manual for guideline developers	Documents on evidence support approaches	2019	Department of Health
Report of the Public Health Reform Expert Advisory Group	Evaluations and assessments	2023	Public Health Reform Expert Advisory Group
Essential Public Health Functions in Ireland: Perspectives to Strengthen Public Health Capacities and Stewardship	Evaluations and assessments	2023	World Health Organization (WHO)
The testing and results of an integrated nurse-led community virtual ward proof-of-concept	Evidence product - mixed/multiple forms of evidence	2021	Chief Nursing Officer's Office, Department of Health & Office of the Nursing and Midwifery Directorate, Health Service Executive
Mental health-related indicators for measuring performance and impact of mental health policy – An evidence Brief	Evidence product – evidence synthesis	2023	HRB

Title	Type	Year	Source
Healthy Ireland Survey 2023 Summary Report	Evidence product – data analytics	2023	Ipsos B&A
Evaluation of the Implementation of A Healthy Weight for Ireland 2016-2025 Obesity Policy and Action Plan	Evidence product –Evaluation	2022	UCC School of Public Health
Promoting workplace health and well-being through culture change – Evidence review	Evidence product – evidence synthesis	2021	HRB
Stakeholder Consultation to inform the development of the National Mental Health Promotion Plan	Evidence product – qualitative insights	2022	Alpha
Review of the National Sexual Health Strategy	Evidence product – evaluation	2023	Crowe
Stratification of clinical risk in pregnancy National Clinical Guideline No 23	Evidence product – guidance	2020	Childbirth Guideline Development Group
The Better Letter Initiative: An Evaluation of the Impact of Redesigned Appointment SMS Reminders on Outpatients DNAs	Evidence product	2024	Research Services & Policy Unit, Department of Health
Acute Hospital Waiting Lists and Times: An Umbrella Review on the Effectiveness of Interventions to Reduce Waiting Lists and Times for Elective Care Waiting Lists Series: Report No 2	Evidence product –evidence synthesis	2023	Research Services & Policy Unit, Department of Health
Towards Population-Based Funding for Health: Model Proposal	Evidence product	2023	IGEES staff in the Department of Health
Acute Hospital Waiting Lists and Times: International Comparisons and Trends in Ireland to end 2021 Waiting Lists Series: Report No 3	Evidence product	2023	Research Services & Policy Unit, Department of Health

Title	Type	Year	Source
Report - High level review of configuration and reform of Public Health systems in selected countries	Evidence product	2022	HIQA
Analysis of a public consultation survey to inform the work of the Public Health Reform Expert Advisory Group – Organisational Responses	Evidence product – qualitative insights	2023	HIQA
Business Case for the Implementation of Regional Health Areas (RHAs)	Evidence product – Modelling	2022	Department of Health
A Briefing on Women's Mental Health in Ireland	Evidence product – evidence brief	2020	National Women's Council of Ireland. Department of Health
Women's voices and supporting evidence for the Women's Health Action Plan 2022-2023	Evidence product – qualitative insights	2022	Women's Health Taskforce, Department of Health
Health technology assessment of the addition of spinal muscular atrophy (SMA) to the National Newborn Bloodspot Screening Programme	Evidence product	2023	HIQA
Department of Health Statement of Strategy 2023-2025	Strategy/ framework for evidence use	2023	Department of Health
Department of Health Statement of Priorities: Health & Social Care Research 2023-2025	Strategy/ framework for evidence use	2023	Department of Health

Appendix B Data extraction framework

Variable	Examples of questions	Extracted data	Original quote/exact data from the document/ page number
Document number and title			
Author/Source			
Publication date			
Document type			
Brief explanation of the document	What is the document about? What is the background and rationale for the document?		
Types and sources for the evidence. (Evidence supply)	What types of evidence are used? Where is the evidence from/who produced the evidence? Is there integration of the different forms of evidence?		
Evidence demand Who commissioned the research? What decision was informed by the evidence?	Who commissioned the research? What approach was used for finding/commissioning the research? What decision/policy was informed by the evidence?		
Quality of the evidence	How is the quality of the evidence evaluated?		
Transparency and accessibility	Is there transparency in what types of evidence were used? Can external stakeholders access the evidence that supports the decisions?		

Variable	Examples of questions	Extracted data	Original quote/exact data from the document/ page number
Committees and Advisory Groups	Were expert panels/advisory committees used to inform decision? Who were the members and how were they chosen? How was the group set up and operated? Was there a mix of subject knowledge, evidence methods and real-world experience?		
Any additional information/insights			

Appendix C Examples of questions in the interview guide

Evidence demand side	• If you consider the evidence support ecosystem (possibly show slide with this), what do you think works well and what could be improved? • What decisions are made and what types of evidence are used to inform decisions? • What sources of evidence are currently drawn upon (e.g. domestic data analytics and evaluations, evidence syntheses)? • What other sources of information are used (e.g. expert panels, deliberative processes, jurisdictional scans)? • Is there an organisation-wide commitment to using the best available evidence? How is this demonstrated? What are the enablers of this (culture, capacity)? What are the barriers? • Is there transparency in what types of evidence are used to make decisions? Can external stakeholders access information about the evidence that supports decisions? • Is there any tracking/evaluation of how effectively evidence is being used in policy-making? • Is there any engagement with other departments or external organisations to learn from their experiences with evidence-informed policy-making? Can you give any examples of improvements made as a result of these discussions? • Are expert panels or advisory committees used to inform decisions? • How are expert panels/advisory committees set up? (how is membership determined, how do you ensure a range of issue-specific knowledge/ lived experience and ability to appraise evidence)? • How are expert panels/advisory committees operated? (Declaration of conflict of interest; pre-circulation of a summary of the research; are recommendations from the panel backed by a summary of supporting evidence?; are recommendations adjusted as evidence/situation evolves?; and are recommendations of the panel/committee made public?) • Is there a dedicated science advisor who plays an evidence support role? • How is science advice/research communicated to policy-makers/public servants?

Evidence demand side	• Are there enablers in place to support policy-makers/public servants to use evidence: 1. Budget (for evidence infrastructure or licencing of journals, etc.; is the budget spread across the different forms of evidence?) 2. A knowledge management system so that people involved in making health policies can easily find and use the research available? 3. Codes of practice/guidelines/toolkits for using evidence to inform policy-making? 4. Information/training for public servants in how to find and use evidence, convene expert panels, etc? 5. Staff with the skill set to support evidence-informed policy-making? • Is there a process to check if using research is actually helping to make better health policies? • Is there a process to learn from what others are doing and to improve on how research is used? • Do you have the staff with the necessary skills to support the use of research in health policy-making? (Translating research findings – communicating them in a form that relates to what is needed and in concise and accessible language)? • Is there a career-path/opportunity for career progression for these staff? • Has there been a change since the COVID-19 pandemic in how you are using evidence? Has there been a change since the pandemic ended? • Is there a contingency plan for evidence support in the case of a new crisis?
Interface of supply and demand (evidence coordination)	• Are there research coordinators/entities who are responsible for coordinating evidence support in line with advisory and decision-making processes? • Tell me about your role in supporting evidence-informed policy-making? How do you engage with policy-makers?; how are the evidence needs of decision-makers and their advisors elicited and prioritised? How do you ensure the questions that need answers get to the people who can do the research to answer the questions? How do you decide if experts are needed and how do you choose them and what is their role?

Interface of supply and demand (evidence coordination)	• Are there evidence support units for each form of evidence? 1. Data analytics 2. Modelling 3. Evaluation 4. Behavioural/implementation research 5. Qualitative insights 6. Evidence synthesis 7. Technology assessment 8. Guidelines 9. Other (e.g. primary research studies) – please describe. • How do you choose the evidence and communicate this to policy-makers? • Are the questions typically complex and do they require the engagement of multiple forms of evidence? • Do you provide integrated responses that may draw on the eight forms of evidence as needed? Or include: 1. Jurisdictional scan (learning from evidence of other countries) 2. Evidence scan across all applicable forms of evidence (to capture best evidence) 3. Horizon scan (to leverage foresight work done nationally and globally) 4. Key informant interviews (to leverage rich experiences) 5. Deliberative processes (to engage citizens and stakeholders in collective problem-solving) • How is the quality of evidence assessed? • How is the evidence communicated to policy-makers? What works well and what does not work well? (Timely; concise and accessible language?) • How do you identify what new research is needed? • What commissioning/tendering approaches are used for new research? • Are there explicit efforts to combine global and local research evidence? • Is there a mechanism in place to share questions and findings across groups so that there isn't duplication? (collaboration and data sharing)

Interface of supply and demand (evidence coordination)	• Has there been a change since the COVID-19 pandemic in how you are producing/using/communicating evidence? (use of AI; collaboration and data sharing; emphasis on real-time data and evidence; interdisciplinary research; need for flexibility in policy-making; greater public engagement) • Is there a contingency plan for evidence support in the case of a new crisis? • If you consider the evidence support ecosystem (possibly show slide with this), what do you think works well and what could be improved?
Evidence supply side	• Are all forms of evidence covered by existing evidence support units? This includes data analytics, modelling, evaluation, behavioural/ implementation research, qualitative insights, evidence synthesis, technology assessment, guidelines. • Are there efforts to combine research findings from around the world with local studies to create a broader understanding, and are there systems in place to pinpoint areas where new research is needed, which could guide where to invest in future research? **Questions for evidence producing units:** • How do you decide the research topics and what evidence is needed? (Are they demand driven – aligned with decision-making at the Department of Health/HSE? • What systems or protocols are in place for managing requests for evidence within your organisation? • How do you track and prioritise these requests? • What mechanisms ensure that responses to evidence requests are accurate and timely? • Are there experts in particular research methods? • Is there collaboration between evidence methods experts, subject matter experts, and citizens engaged in your projects? • Are there standards for what constitutes 'good' research? How do you decide what type of research/evidence is needed for a particular issue? • What resources are available to staff for accessing internal and external evidence sources? • Is there an inventory/database of evidence that the organisation has gathered, or is there access to external sources of information?

Evidence supply side	• Are there any governance structures in place (e.g. policies and standards that guide the collection, storage, access, and use of data within the organisation?) Or systems for regularly auditing and evaluating how evidence is collected/used within the organisation – reviewing decision-making processes, assessing the impact of evidence-informed policies, and identifying areas for improvement? • How do you engage with external networks, both nationally and internationally, to share and learn about best practices in evidence use? • Can you describe a specific partnership or collaboration that has enhanced your evidence capabilities? • What mechanisms are in place to ensure that learning from external networks is integrated into your organisation? • Is there a mechanism in place to share questions and findings across groups/organisations so that there isn't duplication? • Has there been a change since the COVID-19 pandemic in how you are producing/using/communicating evidence? (Use of AI; collaboration and data sharing; emphasis on real-time data and evidence; interdisciplinary research; need for flexibility in policy-making; greater public engagement) • What are the facilitators to getting funding for your research? What are the barriers to getting funding for your research? • Tell me about using evidence syntheses in your work? • How important is it in the work that you do to include evidence synthesis studies? • What are the facilitators and barriers to including evidence synthesis studies in your work? Where do you search for evidence syntheses? • Where would you go if you needed to commission an evidence synthesis? • Do you know of any units that are providing ultra-rapid evidence support (drawing on existing evidence) or using a general contractor model (coordinators) to create flows of new evidence from the different evidence support units?
Additional interview insights	

Appendix D Rapid evidence support system assessment (RESSA) – Ireland Oversight Group membership

RESSA Ireland Oversight Group

Dr Mairéad O'Driscoll (Chair)
Chief Executive
Health Research Board (HRB)

Prof John Lavis
Department of Health Evidence and Impact (HEI), McMaster University, Canada
Director- World Health Organization (WHO) Collaborating Centre for Evidence-Informed Policy and
Co-Lead - Evidence Commission secretariat

Dr Kerry Waddell
Senior Scientific Lead for Evidence Support
McMaster Health Forum, McMaster University, Canada

Prof Mary Horgan
Interim Chief Medical Officer
Department of Health (DOH)

Dr John O' Neill
Principal Officer - Head of Research Policy and Innovation Unit
Department of Health (DOH)

Trudy Duffy
Principal Officer - Head of Evidence for Policy
Department of Further and Higher Education, Research, Innovation and Science (DFHERIS)

Fergal O'Leary
Evidence for Policy Unit
Department of Further and Higher Education, Research, Innovation and Science (DFHERIS)

Prof Declan Devane
Professor - Health Research Methodology and Deputy Dean of the College of Medicine, Nursing and Health Sciences, University of Galway
Director-Evidence Synthesis Ireland and Director - Cochrane Ireland

Dr Teresa Maguire (deputy Chair)
Director- Research Strategy and Funding, HRB

RESSA Ireland Project Team (ESI)

Dr Barbara Whelan
Research Fellow (RESSA Ireland Project)

Dr Marie Tierney
Postdoctoral Researcher (RESSA Ireland Process Evaluation)

Dr Paula Byrne
Research Fellow (RESSA Ireland Process Evaluation)

Dr Nikita Burke
Programme Manager - Evidence Synthesis Ireland and Cochrane Ireland

Dr KM Saif-Ur-Rahman
Senior Research Fellow - Evidence Synthesis Ireland and Cochrane Ireland

RESSA Support (HRB)

Dr Catherine Gill
Programme Manager, International Cooperation, Evaluation and Targeted Programmes, HRB

Dr Caitriona Creely
Head of International Cooperation, Evaluation and Targeted Programmes, HRB

Notes

Health Research Board
Grattan House,
67-72 Lower Mount Street,
Dublin 2,
D02 H638
Ireland

e hrb@hrb.ie
w www.hrb.ie