Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Advice to the Minister for Health to inform decision-making around the design and delivery of urgent and emergency healthcare services in the HSE Mid West region of Ireland

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The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

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- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation**.**
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- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

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Expert Advisory Group (EAG):

Particular thanks are due to the Expert Advisory Group (EAG) listed in Appendix 1 and the individuals within the organisations listed below who provided advice and information.

The findings set out in this advice document represent the interpretation by HIQA of the available information and do not necessarily reflect the opinion of all members of the EAG.

Organisations that assisted HIQA in providing information, in writing or through meetings, included:

The Economic and Social Research Institute (ESRI), whom HIQA would like to thank for its regional projections for future demand and bed capacity requirements for public acute hospitals that have constituted a key input to HIQA's advice.

HIQA would also like to thank the Department of Health and the Integrated Information Service and Acute Business Information Unit in the Health Service Executive (HSE) for the provision of, and assistance in interpreting, relevant data and metrics.

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EAG	Expert Advisory Group
ED	Emergency Department
ESRI	Economic and Social Research Institute
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
MAU	Medical Assessment Unit
UHL	University Hospital Limerick

Executive Summary

Background

University Hospital Limerick (UHL) is part of HSE Mid West, which provides health and social care services in Clare, Limerick, and North Tipperary. Overcrowding at UHL has been a source of major public concern for a number of years. There has been significant investment in HSE Mid West in recent years to alleviate hospital overcrowding and improve services for patients. This has included efforts to increase staffing and expand infrastructure to increase bed capacity at UHL. Despite this investment, overcrowding persists at the hospital.

In mid-2024, the Minister for Health asked HIQA to conduct an independent review to inform decision-making around the design and delivery of urgent and emergency healthcare services in HSE Mid West. As part of this request, HIQA was asked to consider the case for a second emergency department (ED) in the region. To progress this work, HIQA took a programmatic approach spanning a number of different areas to inform the overall advice that has been provided to the Minister for Health. These included:

- international evidence reviews to identify measures to alleviate ED overcrowding and the requirements for the provision of an ED service
- a review of policy developments between 2000 and 2024 that have impacted current service configuration, design and delivery in the Mid West
- regulatory inspection of the healthcare services in the Mid West, building on the ongoing programme of monitoring of services in the region against the *National Standards for Safer Better Healthcare*
- a review of data relating to capacity and service activity performance to understand the situation in the Mid West and how it compares with other health regions
- a stakeholder engagement exercise, including a public consultation, to seek the view of both people in the Mid West, and other interested parties regionally and nationally.

HIQA worked with the Economic and Social Research Institute (ESRI) to understand projected changes in the demand for urgent and emergency care and inpatient capacity in the region up to 2040. HIQA used the ESRI's regional projections to

inform its advice on potential options for the necessary expansion of urgent and emergency healthcare services and inpatient capacity in the Mid West, to meet an expected increase in demand.

All of the work conducted by HIQA has been supported by an Expert Advisory Group convened to provide input and advice throughout this review process. Furthermore, through our regulatory inspections, this review has also considered the findings and recommendations of the Report of the Investigation of UHL by Chief Justice Frank Clarke.

Key findings from this review

Urgent and emergency healthcare services in the Mid West were reconfigured in 2009, with the closure of three smaller EDs at Ennis, Nenagh and St John's Hospitals, and the centralisation of ED care within a single site at UHL in Dooradoyle. At that time, it was determined that an extra 267 inpatient beds would be needed at the Dooradoyle site, along with further reconfiguration and refurbishment of the site (including a new or refurbished ED), to support this change in service design and delivery. These extra beds were intended to ensure the hospital's inpatient capacity could manage the expected increased volume of ED attendances and admissions generated by the reconfiguration. However, the reconfiguration coincided with an economic crash in Ireland, which led to public finances being severely constrained. Reconfiguration of healthcare services in the Mid West therefore occurred without the provision of the additional bed and ED capacity that had been identified as necessary for UHL. Since 2021, additional capacity has been added and more is expected to come into use this year.

A common theme identified in HIQA's extensive consultation process was a desire for change and reform in the region to enable the delivery of safe and effective healthcare. Members of the public who participated in this consultation perceived the current issues at UHL as an urgent and emergency care problem. In contrast, staffing groups and other interested parties predominantly cited overall inpatient bed capacity issues in the Mid West as the key cause of overcrowding and the need for this issue to be addressed in the first instance. In summary, HIQA's consultation process highlighted divergent views on how best to address the issue of ED and hospital overcrowding at UHL.

The key finding from data analysis conducted to inform this review is that the number of inpatient beds at UHL remains significantly lower than other Model 4[1] hospitals nationally when compared to the number of ED presentations. While there has been investment in bed capacity at UHL in recent years, demand for healthcare services in the region has also grown in line with demographic changes.

HIQA's data analysis indicates that the total volume of emergency care presentations in the Mid West is similar to that in other regions on a per head of population basis. However, the single ED configuration for the region is different. It is noted that the pattern of urgent and emergency care service usage in HSE Mid West differs from other health regions with a higher proportion of this care provided by local injury units. The overall acuity of patients who attend the ED at UHL was found to be higher than for other EDs around the country, likely due to these service usage differences.

Despite these challenges, findings from HIQA's regulatory monitoring programme point to areas of improvement and incremental progress in achieving better levels of compliance against the *National Standards for Safer Better Healthcare* between the years of 2022-2025. However, there is continued use of surge capacity with a substantial number of patients receiving care on trolleys in the ED and inpatient areas of the hospital. Within this context, patient safety risks will persist until the demand-capacity gap is resolved.

What is the key problem causing overcrowding in UHL?

The key problem is that there are not enough inpatient beds in the Mid West to meet current demand for those patients requiring admission through the ED who present with more serious or complex care needs, or those with an undifferentiated healthcare condition. An undifferentiated healthcare condition is one where diagnosis is not known prior to a patient going to hospital, and where they require the ready

[1] As defined by HSE, a **Model 2** hospital provides the majority of hospital activity including extended day surgery, selected acute medicine, local injury units, a large range of diagnostic services, (including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray), specialist rehabilitation medicine and palliative care.
A **Model 3** hospital admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine and critical care services.
A **Model 4** hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis (24/7) and an Emergency Department that may include a Clinical Decision Unit on site.

availability of a comprehensive range of services onsite to safely manage their possible care needs.

The current situation caused by the demand-capacity gap at UHL and across HSE Mid West, presents a risk to patient safety. The Mid West has the lowest number of inpatient beds relative to the number of people who attend the ED. It also has the highest number of ED attendances of any Model 4 hospital. This demand-capacity deficit will only be partially addressed by current investment and commitments to increase inpatient beds in the Model 4 and Model 2 hospitals. Further ED and inpatient bed capacity is required in the short and longer term, in a setting or settings that can treat patients with undifferentiated conditions, to mitigate the risk to patient safety. The planning for these beds needs to commence now.

What is needed to address the problem?

Current ongoing investment at UHL is due to provide an additional 128 inpatient beds by the end of 2025, with a further 96 beds in planning. Immediate delivery of all 224 of these beds would be expected to bring UHL up to parity with current bed numbers in other Model 4 hospitals, relative to demand. However, the timeline for 96 of these beds is now estimated to be 2029, by which time demand for acute capacity will have increased further in line with demographic change. With the recent notification of the potential delay in the provision of these 96 beds for planning reasons to 2029, there is a need to urgently re-evaluate the proposal for additional Model 4 and Model 2 inpatient beds as set out in the Acute Hospital Inpatient Capacity Expansion Plan 2024-2031. This re-evaluation should consider whether use of these Model 2 beds can be further optimised to support patient flow across the Mid West, and consider if the overall number of proposed Model 4 beds can be increased in the timeframe or if a greater proportion of the committed-to beds can be provided in a more acute setting, such as UHL, in an attempt to address near-term capacity deficits.

ESRI analyses to inform future service needs project ever-growing demand for services in the Mid West to 2040. Using a range of scenarios, the ESRI has projected that the number of inpatient beds in the region will need to increase from between 299 (+36%) and 593 (+71%) beds compared with 2023 capacity levels. The delivery of the planned additional capacity within the Acute Hospital Inpatient Capacity Expansion Plan 2024-2031 has the potential to address the projections within the low-pressure scenario. Investment in additional inpatient capacity would be required to address the requirements as set out by the ESRI in the other scenarios considered.

Ensuring flexibility and ongoing evaluation of decision-making

Given that the ESRI projections span a wide range in terms of additional beds required, it will be important to ensure that decisions made around the future design and delivery of urgent and emergency healthcare services enable flexibility in how services are planned and developed. It is essential that there is ongoing monitoring of actual demand for services relative to the ESRI capacity projections, to support timely decision making. There will be a need for systematic and regular evaluation of the impact of early investment to determine the longer-term requirements.

When reflecting on how to provide the additional capacity to meet the future ESRI projections, HIQA considered the configuration of healthcare services in the Mid West and how these services could be optimised to support current and future health needs for the people of the region. It is critical that management and operational arrangements at UHL, and in the wider HSE Mid West health region, continue to ensure the effective and efficient use of available resources to support the safe delivery of healthcare services in the region.

Recent investments and further developments in planning to grow capacity at UHL on the Dooradoyle site are welcome and should be expedited where possible. These interventions however will not fully address current deficits in inpatient beds and further action is now required to provide additional inpatient bed capacity in the Mid West. Given this, the decisions arising from this review should aim to deliver the necessary inpatient bed capacity within the shortest possible timeframe to mitigate potential patient safety risks arising from the demand-capacity mismatch.

Potential options for the provision of additional inpatient bed capacity in HSE Mid West

HIQA has identified three potential options for Ministerial consideration on how best to address current inpatient bed capacity deficits in the Mid West, as well as providing the additional inpatient bed capacity in line with the ESRI projections for the period up to 2040. Each option presents benefits and potential implementation challenges. The three options identified are:

- Option A – Expand capacity at UHL on the Dooradoyle site.
- Option B – Extend the UHL hospital campus to comprise the existing Dooradoyle site and another site, in close proximity to UHL, to support the delivery of healthcare services under a single governance and shared resourcing model.
- Option C – Develop a Model 3 hospital in the HSE Mid West, providing a second ED for the region.

The following advice outlines the potential benefits and possible implementation challenges associated with each option. Some of these benefits and challenges are readily quantifiable, whereas others are more difficult to assess, requiring further consideration of national policy, capital infrastructural investment and planning. What is clear is that there is a significant deficit of inpatient beds that could only be safely provided in a Model 3 or Model 4 setting, intensified by ever-growing demand for healthcare services in the Mid West. This deficit is markedly higher than that of other Model 4 hospitals in terms of inpatient beds, and the volume of emergency activity is also the highest of the Model 4 hospitals. Furthermore, the acuity of patients presenting to UHL is the highest of the Model 4 hospitals.

HIQA is of the view that Options A or B will likely yield the required inpatient bed capacity in the Mid West within a shorter timeframe, to address the immediate risk to patient safety. As part of this review, HIQA was provided with a document commissioned by HSE Estates and prepared by an external architectural firm titled *UHL Campus Built Infrastructure Capacity Study – July 2025*. In summary, the document suggests that from a feasibility perspective, it may be possible to further develop the UHL site at Dooradoyle on a four-phase basis over a 20-year period to add significant additional inpatient bed capacity. Option C offers the potential to meet the longer-term bed requirements, but would be least capable of addressing immediate capacity deficits, and would likely have the longest lead time.

Given recent experiences in the Irish health sector, there would be a long lead time to develop a Model 3 hospital in terms of planning, designing, building and commissioning. The associated costs would also be very significant, as evidenced by recent experiences in building the National Children's Hospital and projected costs for the new National Maternity Hospital. The potential displacement effect on other capital projects in the Mid West and across the country would also need to be factored in. An important consideration if Option C were determined as a desired potential longer-term option to further increase inpatient bed capacity in the Mid West is the context of the safety issues arising from current deficits in capacity. There is still a pressing need from a safety perspective to deliver additional inpatient bed capacity in the short term to ensure that current risks to patient safety are addressed. Options A or B, or a variation of same, would offer the potential to provide this capacity in a shorter timeframe than Option C. In the context of addressing ongoing risks, they may be more appropriate near-term options than Option C.

Other considerations of relevance and next steps

HIQA acknowledges that plans for how future healthcare services are provided in the Mid West will need to reflect relevant policy developments, and how these may interact with potential changes to service delivery outlined under each option. Relevant policy areas are referenced within this advice document, including Sláintecare, the National Maternity Strategy, the National Cancer Strategy, the National Trauma Strategy and plans for elective hospitals. This document also identifies other considerations or interventions that should be progressed alongside the option(s) chosen to add inpatient bed capacity across the Mid West. The considerations include ensuring effective clinical and managerial leadership and governance oversight at the UHL and HSE Mid West level; adopting a system-wide approach across both hospital and community services to realise the benefits of additional bed capacity; further development of pre-hospital emergency care services; enhancing community care and general practice services; responding to the ESRI projections for increased demand for long-term residential care; and using technology to support healthcare decision-making and service delivery across the Mid West.

In working to progress any of the options outlined above, it is recommended that a comprehensive strategic plan for the incremental reconfiguration and investment in healthcare services in the Mid West is developed. This should incorporate the objective of addressing the safety concerns which prompted this review, while having regard to the future demographic and policy considerations. This plan would benefit from a full infrastructural assessment with costings and timelines, and a clear consideration of workforce requirements, reporting lines and overall governance arrangements. Ensuring that the people of the Mid West are fully engaged with the delivery of such a plan will also be crucial; ongoing communication and engagement will be necessary to support this process in improving healthcare services and growing public confidence in them.

1 Introduction

Overcrowding at the emergency department (ED) and wider hospital at University Hospital Limerick (UHL) has represented a very serious cause of public concern in recent years. In 2024, the report of the Health Service Executive (HSE)-commissioned review by former Chief Justice Frank Clarke amplified the need to address safety concerns arising from overcrowding on a sustained basis. UHL has been subject to several external interventions aimed at supporting its internal capability to manage the demand-capacity mismatch and resulting overcrowding at the hospital. Significant investment and resourcing is underway to increase bed capacity across the HSE Mid West.

In mid-2024, the then Minister for Health asked the Health Information and Quality Authority (HIQA) to conduct a review to inform decision-making around the design and delivery of urgent and emergency healthcare services in the Mid West. The terms of reference for the review have been published on the HIQA website and are listed in Appendix 2 of this document. As part of this review, HIQA was requested to consider the case for a second ED within the Mid West, in the context of population changes and ongoing demand for urgent and emergency healthcare services and inpatient care at UHL. In conducting this review, HIQA was also requested to consider the recommendations of a HSE-commissioned review by former Chief Justice Frank Clarke into the circumstances surrounding the death of Aoife Johnston from sepsis at UHL in December 2022.

To progress this work, HIQA took a programmatic approach spanning a number of different areas to inform the overall advice that has been provided to the Minister for Health. These included:

- international evidence reviews to identify measures to alleviate ED overcrowding and the requirements for the provision of an ED service
- a review of policy developments between 2000 and 2024 that have impacted current service configuration, design and delivery in the Mid West
- regulatory inspection of the healthcare services in the Mid West, building on the ongoing programme of monitoring of services in the region against the *National Standards for Safer Better Healthcare*
- a review of data relating to capacity and service activity performance to understand the situation in the Mid West and how it compares with other health regions

- a stakeholder engagement exercise, including a public consultation, to seek the view of both people in the Mid West, and other interested parties regionally and nationally.

HIQA worked with the Economic and Social Research Institute (ESRI) to understand projected changes in the demand for urgent and emergency care and inpatient capacity in the region up to 2040. HIQA used the ESRI's regional projections to inform its advice on potential options for the necessary expansion of urgent and emergency healthcare services and inpatient capacity in the Mid West, to meet an expected increase in demand.

All of the work conducted by HIQA has been supported by an Expert Advisory Group convened to provide input and advice throughout this review process. Furthermore, through our regulatory inspections, this review has also considered the findings and recommendations of the Report of the Investigation of UHL by Chief Justice Frank Clarke.

For clarity, within this advice document, the term 'HSE Mid West' specifically refers to the HSE Mid West health region. This is one of the six health regions created by the HSE. HSE Mid West provides health and social care services in Clare, Limerick, and North Tipperary. The HSE Mid West health region, or 'Mid West' as it is referred to in this document, is distinct from the Mid West Region of Ireland, which covers the geographical area of counties Limerick, Clare and Tipperary.

2 Key findings from the Mid West Review

This section of the advice document presents a summary of the key findings and outputs of HIQA's review. The totality of outputs from this work has been considered to establish the core issues leading to ED and hospital overcrowding at UHL and to inform the advice.

Overcrowding is a common problem across hospitals providing urgent and emergency care nationally and internationally. However, relative to other Model 4 hospitals in Ireland, the issue is more prominent in UHL. Overcrowding within the ED and at wider hospital level in UHL is a result of the mismatch between available inpatient beds, and demand for urgent and emergency healthcare services and inpatient care. For example, between 2016 and 2024, UHL consistently recorded the highest ratio of ED presentations to inpatient beds among the Model 4 hospitals in Ireland, with its occupancy rate exceeding 100% in four of the six years from 2019 to 2024. Available data from 2025 suggests that this trend continues. This demand-capacity gap is greatest for the cohort of people who are acutely unwell and require

admission for inpatient care, people requiring complex care, or those with an undifferentiated condition (when a diagnosis is not known prior to attending hospital, and where the patient therefore requires a comprehensive range of available services onsite to safely manage their possible care needs).

This HIQA review has identified three options that may be deployed to address the gap between the available supply of and demand for the required type of inpatient bed capacity in HSE Mid West. Each option presents potential challenges or implementation risks. The options are provided to support the Minister for Health in making an informed decision on the configuration and design of urgent and emergency healthcare services in the Mid West. In line with the terms of reference for this review, one of the options included considers the provision of a second ED.

A key finding from this analysis is that the Mid West is already in a position of significant disadvantage compared with other health regions in terms of bed capacity relative to demand for healthcare services. Furthermore, the projected demographic changes for the HSE Mid West indicate that demand for urgent and emergency healthcare services and inpatient care will grow steadily over time, meaning that the provision of extra bed capacity in the Mid West will need to keep pace with this growth. The combination of the current need and projected future demand underlines the need for both immediate action and appropriate planning for the future. This is an important consideration to inform the Ministerial decision about the design and delivery of urgent and emergency healthcare services in the Mid West.

2.1 Historical context

In 2009, the reconfiguration of healthcare services in the Mid West led to the centralisation of the region's urgent and emergency healthcare services. Since that date, urgent and emergency care in the region has been primarily provided by the ED in the Mid Western Regional Hospital, Limerick (now known as UHL, a Model 4 hospital), and through injury units and medical assessment units (MAUs) in Ennis, Nenagh and St John's hospitals (all Model 2 hospitals). During the recession that occurred in Ireland after the 2008 financial crisis, the HSE budget was reduced, with a 22% decrease in budget observed between 2008 and 2013. As a consequence, a national moratorium on public service staff recruitment and promotion was rolled out in 2009, which applied to the publicly-provided and funded health service. This measure was intended to end in 2010, but instead continued up until 2015. Annual capital public health expenditure for infrastructure for the Acute Hospitals Programme also fell by 24% from 2007 to 2016. All these national measures impacted on staffing and infrastructure expenditure in the Mid West. Against this backdrop, the proposed additional bed capacity in the Mid West (which included an

estimated requirement of 267 inpatient beds at UHL), and the development of capability in Model 2 hospitals to support the centralisation of urgent and emergency care at UHL, was not provided.

More recent measures that have been implemented to partly address the deficits in bed capacity at UHL have included:

- capital funding of €24m for a new ED in UHL that opened in 2017.
- the provision of an extra 98 beds in 2020/2021 (bringing the inpatient bed complement in UHL at that time to 530 beds).
- additional capital and recurring revenue funding and resourcing for hospitals in the Mid West. This includes:
    - an additional €160m in capital funding, supporting initiatives including the addition of beds to the UHL site at Dooradoyle, and procurement of permanent step-down transition and rehabilitation beds in County Clare.
    - €79m in recurring revenue funding, supporting initiatives including the extension of a Framework for Safe Nurse Staffing and Skill Mix to all wards in UHL, the extension of opening hours in the region's MAUs, and the development of general practitioner (GP) and Advanced Nurse Practitioner roles in the ED.
    - Government's commitment, as per the Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031, to add a further 268 Model 4 inpatient beds in UHL and 114 Model 2 inpatient beds (48 inpatient beds in Ennis General Hospital, 24 inpatient beds in Nenagh General Hospital and 42 inpatient beds in St John's Hospital) in the HSE Mid West by 2031.

In 2024, UHL staffing levels were comparable to other Model 4 hospitals (relative to hospital activity) across the following high-level categories: medical and dental; nursing and midwifery; and health and social care professions. As these high-level categories do not fully reflect the complexity of the staffing profile, differences may exist in terms of skill mix and the relative ratio of senior decision-makers.

2.2 Findings on utilisation of capacity in the Mid West region

The delivery of public healthcare in Ireland has recently been restructured. Since March 2024, it is organised into six health regions. Across these six regions, there are, at the time of writing this advice document:

- nine Model 4 hospitals
- seventeen Model 3 hospitals
- eleven hospitals designated as Model 2 hospitals
- four paediatric hospitals.

Within these hospitals, there are 29 EDs and 15 injury units.

The Mid West has lower total per capita bed capacity compared with the rest of Ireland (2.2 versus 2.5 beds per 1,000 population), a situation that is further exacerbated by relatively low private hospital bed capacity in the region. Additionally, compared with the other health regions, a higher proportion of acute inpatient bed capacity in the HSE Mid West is in Model 2 hospitals, which do not have the capability to manage undifferentiated emergency presentations through an ED.

According to data available to HIQA from 2024, per capita use of hospital-based urgent and emergency care in the Mid West is broadly in line with the rest of Ireland. However, the distribution across the ED, MAUs and injury units differs significantly due to the centralised structure and considerable utilisation of the injury units and MAUs in the Mid West. Per capita, ED presentation rates are lower and injury unit presentation rates are higher in the Mid West than in the rest of Ireland.

Despite this, UHL recorded among the highest volume of presentations nationally in 2024 (n=87,195), alongside Cork University Hospital. Between 2016 and 2024, UHL had a consistently higher number of ED presentations relative to bed capacity than other Model 4 hospitals. From January to July 2025, ED presentations at UHL were 10% higher than the same period in 2024; the largest rise among Model 4 hospitals. The average increase across the other eight Model 4 hospitals was 4%. Furthermore, HIQA's analysis found that patients presenting to the ED in UHL are more often assessed as higher-acuity cases (Manchester Triage Score 2 and 3) compared with presentations at other EDs. The high volume of urgent and emergency care delivered through MAUs and injury units in the Mid West likely contributes to this lower proportion of low triage score presentations at UHL's ED.

Estimated annual inpatient occupancy rates are high across all Model 4 hospitals, with inpatient occupancy rates frequently exceeding 100% between 2019 and 2024. In this period, occupancy rates exceeded 100% in four of the six years at UHL. While there is no agreed-upon threshold for an "optimal" occupancy rate, there is evidence to suggest that levels below 85% better enable effective use of beds in terms of management of elective and emergency workloads. Occupancy rates below 85% also reduce the potential safety risks of invoking surge capacity in response to a mismatch between emergency and elective demands. High occupancy rates at UHL are contributing to a continued state of escalation, use of surge capacity, and pressure on bed utilisation at the hospital. For example, a higher proportion of admitted patients are accommodated on trolleys in UHL compared with other Model 4 hospitals. The Frank Clarke review amplified the safety risks of this constant cycle of escalation and the use of multiple overflow areas.

2.3 Other relevant regulatory, consultation and data findings

A range of interventions have been deployed nationally and internationally to address challenges around ED overcrowding and patient flow in acute hospitals. These include effective systems for managing ED input, throughput and output. HIQA's review of the international literature identified multiple interventions that have been shown to have a positive effect on ED overcrowding, with a number of these already rolled out at UHL and in the wider HSE Mid West.

Over the three-year period between 2022 to 2025, through the monitoring of compliance with the *National Standards for Safer Better Healthcare*, HIQA has seen that measures put in place by HSE Mid West to respond to the demand for urgent and emergency healthcare services and inpatient beds have led to improvements. These include improved operational efficiencies, increased surge capacity across HSE Mid West and more efficient patient flow at UHL. Incremental process improvements and operational efficiencies were also observed in leadership, governance and management at UHL. The inspection of UHL's ED in January 2025 found further operational and process improvements. At that time, compared to previous inspections, there was a decrease in the number of additional trolleys in the ED that were located outside of designated treatment areas and that were being used to accommodate admitted patients. While improvements were noted, there is a need to continue to reduce the patient safety risks arising from the demand-capacity gap and resulting capacity constraints at UHL. The patient safety risks at UHL will continue until the inpatient capacity deficits are addressed. Given demographic projections, there is a need to act now; otherwise, the gap between available beds

and demand will continue to grow, which will further disadvantage the people of the Mid West.

While having sufficient bed capacity to admit patients is a requirement of urgent and emergency care, HIQA's review identified several factors specific to UHL and the Mid West that are relevant to the consideration of requirements for the safe and effective delivery of urgent and emergency care. These are outlined below.

- For those patients discharged to nursing homes, there was no evidence of a longer length of stay at UHL relative to other Model 4 hospitals.
- The time between ED registration and discharge in the UHL ED was in line with that seen in other Model 4 hospitals nationally. Of note, this time is likely influenced by the relatively high rate of referral from the ED to acute assessment units at UHL, which is considered a discharge in the data source.
- UHL experiences a higher conversion rate from ED presentation to inpatient admission, although it is in line with what would be expected given the higher acuity of ED presentations and having regard to the profile of patients in terms of age and sex.
- UHL consistently has the highest proportion of inpatient discharges that are admitted through emergency pathways relative to other Model 4 hospitals. As a consequence, in 2024, UHL reported the second-lowest percentage of inpatient bed days used for elective care (9.3%), following Tallaght University Hospital (7%).
- Relative to other Model 4 hospitals, between 2012 and 2024 emergency admissions to UHL consistently had the lowest average length of stay (UHL 2012-2024 range: 4.8 to 5.9 days). It is also noted that the proportion of emergency admissions with a length of stay of one day or less was also highest at UHL from 2017-2024 (range: 33% to 43%).
- Overall, GP attendance rates among the Mid West population are in line with those in the rest of the country, but there is evidence that some people seek GP care outside their area of residence. Relative to the other health regions, the Mid West has similar GP care availability. However, there are differences across the region. For example, South Limerick City has high numbers of GPs relative to the population size, whereas East Limerick has low numbers of GPs. East Clare has the lowest number of

GPs on a regional population basis and is estimated to have the highest number of consultations per GP in the country.

- Overall, the population demographics of the Mid West are comparable to the rest of the country. Population growth between 2016 and 2022 in the Mid West was slightly lower than the national average (7.3% vs 8.1%); however, population growth in those aged 75 years and older was higher than the national average (29.6% vs 27.0%). The proportion of the Mid West population living in the country's top 10% most deprived areas, as assessed by the HP Deprivation Index, was 11.3% in 2022. This is the third highest of the six health regions and is higher than the national average. As with all health regions, there are pockets of very high deprivation in HSE Mid West.
- Residents of Clare, Limerick, or Tipperary accounted for 91% of urgent and emergency care presentations across the four Mid West hospitals. This figure includes ED and acute assessment unit presentations at UHL, and injury unit and MAU presentations at the Model 2 hospitals. For these analyses, Tipperary is reported as a single county and could not be disaggregated into North and South. Data on the county of residence of people who presented to EDs, injury units, or MAUs outside the Mid West were not available for analysis.
- Current health information systems have provided data to inform this review. These data are primarily collected for operational management purposes rather than for such analyses. Differences in systems and how data is collected present limitations in terms of the ability to track a patient's journey through the healthcare system. The full implementation of an individual health identifier and national health information standards to reduce variation and improve data reliability may help to address this issue, by enabling more accurate tracking of patient pathways and resource use. Additionally, in the absence of routine small-area coding, the inclusion of health region of residence as a standard variable in datasets would support service planning, while recognising that boundaries may change over time.

Feedback from stakeholders received as part of this review indicated that people had differing perceptions of the causes of the problems in the region, which led to differing solutions proposed to improve future healthcare service provision. In general, patients and families who engaged with HIQA perceived the current issues at UHL to be an urgent and emergency care problem, with many suggesting that

another ED would alleviate problems in the region. Healthcare professional groups attributed the problems to wider hospital overcrowding and capacity challenges, rather than an emergency care issue, although there were differing views on the future design and delivery of urgent and emergency healthcare services for the Mid West. Some expressed concern around the safety of decentralising urgent and emergency care, citing the potential difficulties posed in sustainably staffing multiple services in the same region. Across all stakeholders, there was a consistent view that there is a lack of sufficient acute inpatient bed capacity to manage demand for healthcare services in the Mid West, especially for patients with more serious urgent or emergency care needs.

2.4 Economic and Social Research Institute capacity projections

The Economic and Social Research Institute (ESRI) Capacity Review for the Mid West has identified that demand for healthcare services in the region will increase due to demographic changes. This means that significant further investment — beyond the beds already committed to for UHL and across HSE Mid West — is required to keep pace with the short and longer-term healthcare demand requirements across the region in the majority of scenarios considered by ESRI.

The ESRI identified that, compared to 2023 bed numbers, between 299 (+36%) and 593 (+71%) additional inpatient beds and 38 (+17%) and 73 (+33%) day beds will be required to meet future healthcare demand for the Mid West up to 2040. This range reflects several different assumptions on factors such as population growth, healthy ageing, occupancy rates and four healthcare delivery scenarios — progress, status quo, low-pressure and high-pressure scenarios. Of note, only the "progress" scenario assumes an 85% occupancy rate, the level beyond which the risk of bed shortages is often considered to rise.

- The "progress" scenario in the ESRI analysis assumes central population projections, an 85% occupancy rate, moderate healthy ageing, and a reduction in length of stay for both elective and emergency inpatients. It also incorporates the impact of care model changes and other policy interventions. This scenario projects a need for an additional 444 (+53%) inpatient beds and 41 (+19%) day beds in the Mid West.
- The "status quo" scenario assumes central population projections and 2023 inpatient occupancy rates; no healthy ageing or additional demand assumptions are applied. This scenario projects a need for an additional 412 (+50%) inpatient beds and 66 (+30%) day beds in the Mid West.

- The "low-pressure" scenario also assumes the central population projection and 2023 inpatient occupancy rates, but demand evolves in line with more optimistic healthy ageing effects. This scenario projects a need for an additional 299 (+36%) inpatient beds and 38 (+17%) day beds in the Mid West.
- The "high-pressure" scenario assumes that demand evolves in line with higher projected population growth (defined by higher net immigration) and no healthy ageing. This scenario also incorporates the low-clearance waiting list management assumption and assumes a lower inpatient occupancy rate for inpatients (90%) achieved by 2040. This scenario projects a need for an additional 593 (+71%) inpatient beds and 73 (+33%) day beds in the Mid West.

Planning and investment to reach the projected additional bed capacity (in the range of 299 to 593 inpatient beds and 38 to 73 day beds) requirements up to 2040 needs to commence now. Plans are in place to complete the addition of 128 beds at UHL by the end 2025. A further 96 beds are intended for the site, but are subject to a planning appeal. HIQA has been informed by the HSE that if the plan for these 96 beds progresses through this planning appeal, it is expected that they would be available for use in early 2029. In this context, the potential for augmenting capacity in the interim should be explored as a matter of urgency.

The call for immediate action acknowledges the lead-in times for major infrastructure projects and the continuous growth in demand for healthcare services in the Mid West. It is essential that any reconfiguration of urgent and emergency healthcare services in the Mid West, which occurs following this review, is appropriately resourced to support the implementation and restructuring process and to ensure that past occurrences of under resourcing in the Mid West are not repeated.

2.5 Co-dependencies to inform decision-making around the design and delivery of urgent and emergency healthcare services in the Mid West

Planning for urgent and emergency healthcare services in the Mid West cannot be undertaken without consideration of the interdependencies with other healthcare services. EDs cannot operate effectively in isolation from the other services within a hospital setting, so an integrated whole-system approach is necessary for the optimal delivery of urgent and emergency healthcare services in the Mid West. This will require the consideration of the following national health policies, strategies and

programmes when increasing bed capacity and configuring healthcare services to support the delivery of safe, high-quality healthcare across the Mid West. This includes, but is not limited to:

- Policies affecting configuration and design of services, such as:
  - The National Maternity Strategy: Creating a Better Future Together 2016-2026
  - Securing the Future of Smaller Hospitals: A Framework for Development
  - the Strategic Plan for Critical Care, which is aligned with the National Critical Care Clinical Programme
  - Sláintecare, including the development of elective and primary care capacity
  - The future plans for development of long-term capacity for Ireland, having regard to the ESRI projections for long-term care
  - Project Ireland 2040: National Planning Framework
  - Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031
  - Framework for Ambulatory Care on the Acute Floor
  - the National Clinical Programmes
  - National Virtual Ward Programme.
- Policies aimed at centralisation of complex work, such as the:
  - National Trauma Strategy for Ireland
  - National Cancer Strategy 2017-2026
  - National Review of Adult Specialist Cardiac Services in Ireland.
- Policies aimed at staffing, such as the:
  - Public Only Consultant Contract 2023
  - Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland 2018
  - Framework for Safe Nurse Staffing and Skill Mix in Emergency Departments
  - Health and Social Care Professions (HSCP) Advanced Practice Framework.

Considerations specific to the Mid West that will further inform the strategic plans and the Ministerial decision on the design and delivery of urgent and emergency healthcare services in the region include:

- the policy decision to relocate the maternity services currently provided at the University Maternity Hospital Limerick, Ennis Road, to the UHL Dooradoyle

site. HIQA understands through engagement with the Department of Health that Limerick remains a priority site for the co-location of maternity services alongside an acute hospital, in keeping with government policy in this area.

- the designation of UHL as a cancer centre, including the future expansion requirements consistent with this designation – such as in the areas of surgery, oncology and radiotherapy capacity.
- establishment of the national trauma system and the specific proposals for the Mid West in this context.
- plans for the future development of long-term care in the Mid West.
- the new undergraduate medical programme in University of Limerick, with the first programme due to begin in September 2026.
- the impact of the public-only consultant contract on the future distribution of patients across public and private hospitals.
- the need for a future impact assessment of the new private hospital that came online in September 2025.

Noting the key findings from HIQA's review, the advice for the Minister for Health provided below outlines the options for future healthcare service configuration in HSE Mid West to meet capacity projections up to 2040.

3. Advice for the Minister for Health

In framing the advice to the Minister for Health, HIQA believes it would firstly be valuable to clearly define the problem in the Mid West that needs to be addressed following consideration of this review. Taking full account of the preceding analysis, the below statement provides a clear summary of the target for intervention following this review.

Over the past number of years, UHL has been providing services in the context of a significant deficit in inpatient capacity. The Model 2 hospitals in the Mid West provide an important service, including through their acceptance of transfers from UHL where a patient's condition allows. These Model 2 services do not have the capability to safely manage the cohort of patients for whom the greatest gap between demand and capacity in the region exists. Current planned investment will address some, but not all of the deficit in bed capacity at UHL, and demand is growing over time. A policy decision is therefore required to address the safety concerns arising from the problem of insufficient bed capacity, and to determine how best to configure services to manage the totality of demand for urgent and emergency healthcare services and inpatient care for undifferentiated patients in the Mid West.

3.1 Advice relating to the current situation in the region, and expected benefits from current investment

Investment is ongoing in the Mid West to provide additional inpatient bed capacity and other necessary resources. The implementation of plans in place to add additional beds at UHL since quarter 4 of 2024 includes the following developments:

- a 16-bed rapid build ward opened in December 2024
- a second 16-bed ward due to open in winter 2025
- 96 beds scheduled to open in quarter 3 of 2025
- a second 96-bed block originally planned for late 2027, which is now planned for early 2029 (subject to the planning appeal process at time of writing this advice document).

Current ongoing investment at UHL is due to provide an additional 128 inpatient beds by the end of 2025, with a further 96 beds in planning. Immediate delivery of all 224 of these beds would be expected to bring UHL up to parity with current bed numbers in other Model 4 hospitals, relative to demand. However, the timeline for 96 of these beds is now estimated to be 2029, by which time demand for acute capacity will have increased further in line with demographic change. With the recent notification of the potential delay in the provision of these 96 beds, there is a

need to urgently re-evaluate the proposal for additional Model 4 and Model 2 inpatient beds for the Mid West as set out in the Acute Hospital Inpatient Capacity Expansion Plan 2024-2031. This re-evaluation should consider whether use of these Model 2 beds can be further optimised to support patient flow across the Mid West, and consider if the overall number of proposed Model 4 beds can be increased in the timeframe, or if a greater proportion of the beds committed-to can be provided in a more acute setting such as UHL, in an attempt to address near-term capacity deficits.

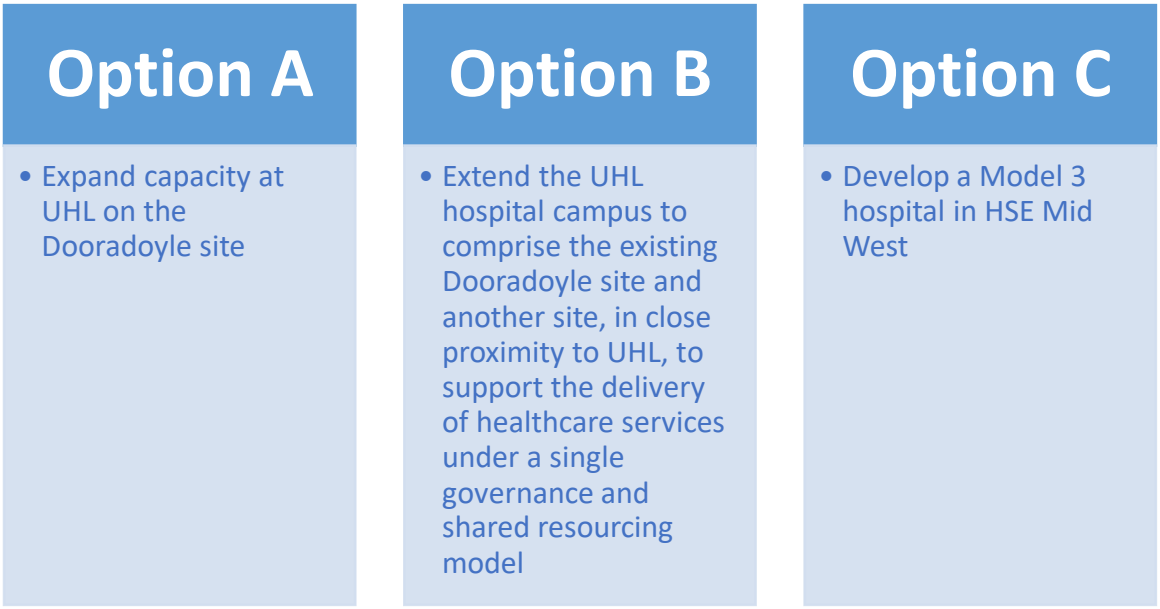
ESRI analyses to inform future service needs project ever-growing demand for services in the Mid West to 2040. Using a range of scenarios, the ESRI has projected that the number of inpatient beds in the region will need to increase from between 299 (+36%) and 593 (+71%) beds compared with 2023 capacity levels. The delivery of the planned additional capacity within the Acute Hospital Inpatient Capacity Expansion Plan 2024-2031 has the potential to address the projections within the low-pressure scenario. Investment in additional inpatient capacity would be required to address the requirements as set out by ESRI in the other scenarios considered. Therefore, there is a need to plan now for the development of further acute capacity. The optimisation of current capacity across all of the hospitals and the use of other public and private facilities should form part of this planning. While the deficit remains, there will be a corresponding risk to patient safety that will need to be mitigated.

3.2 Options to increase emergency department and inpatient bed capacity in the Mid West from now to 2040

The current situation caused by the demand-capacity gap at UHL and across HSE Mid West presents a risk to patient safety that is only partially addressed by the current investment and commitments to increase inpatient beds in the Model 4 and Model 2 hospitals. Further ED and inpatient bed capacity is required in the short and longer term, in a setting or settings that can treat patients with undifferentiated conditions, to mitigate the risk to patient safety.

Through this review, HIQA has identified three possible options (see Figure 1) that have the potential to address this ongoing patient safety risk as a consequence of continued projected inpatient bed capacity deficits in the Mid West.

Figure 1. Options to increase inpatient bed capacity in HSE Mid West



Options A and B seek to address capacity issues within a Model 4 construct, while Option C represents a fundamental change in the overall design and configuration of healthcare service delivery in the Mid West. Further adaptation may be necessary to account for all relevant factors when deciding the most appropriate way to provide additional bed capacity now and in the short and longer term. The three options are presented and discussed under three criteria:

- **Mitigation of current risks** – this criterion refers to how each option could mitigate the risk(s) associated with the mismatch between the current demand for urgent and emergency healthcare services and inpatient care, and bed capacity in UHL and across the wider Mid West.
- **Feasibility and key dependencies** – this criterion refers to the potential feasibility of each option from a resource perspective. It also considers key external dependencies to support the timely delivery and integration of additional bed capacity in the Mid West.
- **Potential acceptability to key stakeholders** – this criterion considers the potential acceptability of the option to key stakeholders, based on those stakeholders who engaged with HIQA.

All three options present relative benefits and challenges that need to be considered by the Minister for Health. A detailed analysis of the infrastructure will also need to be undertaken to determine the feasibility of the preferred option.

This should include evaluation of the capital and other relevant costs associated with the option. Such an appraisal is outside HIQA's expertise, and will also need to consider current or planned capital requirements for other regions.

Option A

Option A: Expand Capacity at UHL on the Dooradoyle site

This option involves adding all of the required additional bed capacity, including ancillary services, to the current UHL site at Dooradoyle, with one ED continuing to provide urgent and emergency healthcare services in the Mid West. The potential to further divert some elective care from UHL to Model 2 hospitals in the Mid West, alongside the provision of additional stepdown capacity to replace privately-purchased capacity (which is imminently set to revert to long-term residential care accommodation), should be considered within this option.

Mitigation of current risks

Capacity: Three of the ESRI scenarios will require additional inpatient capacity over and above that already committed to for the Mid West in the Inpatient Capacity Expansion Plan 2024-2031. If from an infrastructural perspective, this further increase in inpatient bed numbers is achievable on the current Dooradoyle site, it will increase bed capacity to meet demand up to 2040. It is notable that over recent years, UHL has demonstrated its efficiency in the ability to roll out additional bed capacity at the Dooradoyle site, with over 100 beds delivered since 2021, and another 128 beds expected by the end of 2025.

By expanding the current Model 4 bed capacity at UHL on the Dooradoyle site, Option A has the potential to provide economies of scale. The servicing of the additional beds in UHL would require the commensurate scaling up of ancillary services, such as radiology, laboratory and critical care services at UHL. The scaling up of ancillary services is needed to ensure the safe and effective delivery of the range of healthcare services provided in a large Model 4 hospital.

Attendances to ED: According to ESRI projections, HSE Mid West can expect an increase in attendance for urgent and emergency care in the range of 16% and 23% between 2023 and 2040, which will increase the volume of people attending the ED in UHL and the region's three injury units. Unless inpatient bed capacity at UHL increases in parallel with this rise in ED attendances, overcrowding at UHL will continue. Data available to HIQA shows that demand for urgent and emergency

healthcare services and inpatient care continues to outpace available bed capacity at UHL. As a result, it is imperative that the risk to patient safety continues to be managed to support the delivery of high-quality safe healthcare services, while the additional bed capacity is being developed and commissioned at UHL. This should include the mitigation of any actual and potential harm and safety risks to people using services, especially those who require admission and inpatient care.

Feasibility and key dependencies

Infrastructural considerations: As part of this review, HIQA was provided with a document commissioned by HSE Estates and prepared by an external architectural firm titled *UHL Campus Built Infrastructure Capacity Study – July 2025*. In summary, the document suggests that from a feasibility perspective, it may be possible to further develop the UHL site at Dooradoyle on a four-phase basis over a 20-year period to add significant additional inpatient bed capacity. The document also outlines the provision to add or expand required ancillary services, including but not limited to the pharmacy, catering department, radiology, oncology, pathology, mortuary, clinical support and car parking capacity. The document suggests that the number of additional beds which could be added to the current Model 4 (UHL) site over and above the 224 beds referenced earlier would meet the targets as set out in all ESRI projections for inpatient capacity to 2040.

Such an expansion in the Dooradoyle site capacity presumes that each required phase of development proceeds to time and can secure necessary planning from the local authorities. At the time of writing, the second 96-bedded block currently planned for construction on the UHL site at Dooradoyle remains subject to an appeal placed with An Coimisiún Pleanála. Therefore, each of the three options presented in this advice document should be considered in the context of potential delays associated with planning decisions, as the potential for delay has already been demonstrated. A risk analysis of whether all potential capacity outlined in this document would be fully available for use over the next 15 to 20 years up to 2040 and beyond should inform the decision-making process.

Through HIQA's analysis, it has been identified that much of the extra emergency capacity required for the Mid West cannot be met by services that can be safely provided by Model 2 hospitals. It may be possible to accommodate some of the extra bed capacity required at these sites through the reconfiguration of some services in line with national policy, for example the new HSE surgical hub for the Mid West. However, taking account of the ESRI projections and the options in this advice document there is a requirement to revisit Government's plans to invest and expand Model 4 and Model 2 inpatient bed capacity in the HSE Mid West up to 2031.

The revision should consider the proportion of beds committed to Model 2 hospitals, with the greater of the overall balance provided to Model 3 or 4 settings in the region as suggested in this advice document. The potential to further divert some elective care from the Model 4 (UHL) site to Model 2 hospitals in the Mid West to release Model 4 inpatient beds in UHL for non-elective and inpatient activity should also form part of future plans. The provision of additional step down facilities should also form part of the assessment to address Central Statistics Office projections for growth in the number and proportion of the population aged over 65. With Option A, consideration should also be given to whether some of the ambulatory care provided at UHL could be relocated to and expanded at Model 2 hospital sites.

As referenced previously, the ESRI has estimated that the number of urgent and emergency care presentations at hospitals in the Mid West will increase by between 16% and 23% between 2023 and 2040. Such an increase in presentations would need to be accommodated by the ED at UHL and supporting injury units. As such, the physical footprint of the ED in UHL would likely need additional infrastructural investment and space. This investment would need to be accommodated, along with the interventions to increase bed capacity. So, an assessment of Option A will need to include the infrastructural investment required to expand UHL's ED over the reference period to ensure the provision of the highest standards of emergency care. The capital cost associated with all of the options outlined in this document will need to be assessed, and such an analysis falls outside of HIQA's specific expertise. While there are many different potential factors that may contribute to the relative cost of each option, it is likely based upon recent experiences of construction in the Irish health service that Option A may represent the least costly of the all of the options presented, whereas Option C would likely be most costly.

The future-proofing of service configuration and capacity in the Mid West beyond 2040 is important in the evaluation of this option. This should be considered both from a service design and infrastructural perspective. While this HIQA review considers the ESRI projected demand and capacity requirements for the Mid West up to 2040, the time lag that exists in the approval, design and delivery process for the provision of infrastructure must be noted. It will therefore be important to ensure that decisions today also have regard for implications over a longer period. Given the constraints with the Dooradoyle site, it is likely that if demand projections for inpatient bed capacity continue beyond 2040 on a similar trajectory to the beds projected in the four ESRI scenarios (with resource utilisation patterns and models of care remaining similar), the current Dooradoyle site will not be able to upscale to accommodate the higher numbers of beds estimated. Should Option A be chosen, there may be merit from a risk-management perspective to explore the availability in

the short term of an adjacent site to expand or decant specific services away from the Dooradoyle site. Such a site could be deployed should service demand exceed most medium-term projections made for the Mid West, or at the very least be used in the longer term in contemplation of eventual growth or unanticipated extra development required at the Dooradoyle site.

Notwithstanding the significant level of disruption that might result from a 20-year construction project at UHL on the Dooradoyle site, Option A results in continuity of to the current urgent and emergency healthcare service configuration, whereby emergency care for the Mid West is provided in one ED (UHL) supported by MAUs and injury units. The level of change, adjustment and service disruption associated with Option A, especially during the construction and operational phases, would need to be identified at the outset. Measures would be required to manage and lessen the disruption to service and care delivery, and to support staff and people in the Mid West to adjust to any change and disruption to service delivery.

Governance, organisational structure and care processes: With Option A, service configuration and arrangements for the organisation and delivery of urgent and emergency healthcare services in the Mid West would remain unchanged. That is, centralised with one ED in UHL and supported by MAUs and injury units in Model 2 hospitals. This continuation of the current configuration would further support the specialisation and standardisation of urgent and emergency care and the delivery of key national policies for tertiary and quaternary services such as cancer, cardiac and trauma services. An expansion of bed capacity at UHL on the Dooradoyle site has the potential to be impactful in terms of meeting the demand for inpatient care and treatment. Such an expansion would leverage the gains, process improvements and operational efficiencies achieved over the past three years because of targeted interventions and increased resourcing in UHL. It would also leverage current business agility; the coordinated continuum of clinical services for unscheduled and scheduled care; existing corporate and clinical governance structures; and defined work patterns that include well-established clinician rosters, communication structures, and resource flows.

The continued centralisation of emergency care delivery at UHL, and the HSE Mid West configuration of one Model 4 hospital, with no Model 3 hospital, could present a service resilience risk for the Mid West should unplanned disruption to services occur at UHL. This risk should be evaluated and UHL's resilience strengthened by developing appropriate contingency plans that support the maintenance of healthcare services. Those living at greater distances from UHL would also continue to have long travel times and higher travel costs.

Relatively long travel times have the potential to disproportionately impact on the accessibility of emergency care services for some of the population in the Mid West. This could also impact on patient experiences and likely continue to result in increased demands on pre-hospital emergency care services.

Workforce considerations: Workforce planning and recruitment are crucial to ensuring that any additional beds at UHL on the Dooradoyle site are fully commissioned. This will also strengthen services, such as critical care, laboratory and radiology to ensure the safe and effective delivery of the range of healthcare services. Expanding UHL on the Dooradoyle site provides an opportunity to continue ongoing recruitment efforts at UHL, and increase employment opportunities at the site, which may support staff recruitment and retention.

The continued centralisation of urgent and emergency healthcare services in UHL has the potential to more readily enable certain healthcare professionals to maintain and enhance their clinical competence. This would involve the provision of continued education, training, and development opportunities, which is relevant given the establishment of the new undergraduate medical programme in University of Limerick. Option A would need to be bolstered by improved staffing and resilience in primary, community and pre-hospital emergency care services, particularly in those geographic areas with known shortfalls in GP numbers, and in areas with greatest travel distances to acute healthcare services.

Potential acceptability to key stakeholders

The findings of HIQA's stakeholder consultation process indicate that Option A may not be perceived to represent the adequate level of reform expected by those stakeholders in the Mid West who believe that a Model 3 hospital for the region represents the preferred option. Based on stakeholder engagement meetings carried out as part of HIQA's review, Option A may be acceptable to a number of healthcare professional groups and stakeholders who favoured solutions that focused on increasing inpatient bed capacity, while maintaining centralised urgent and emergency healthcare services. This view is informed by safety considerations that a decentralised urgent and emergency care model would dilute such healthcare services in the Mid West, which could have a negative impact on patient safety. Maintaining the current configuration was also favoured by some stakeholders who expressed concerns about significant challenges in terms of securing staff with the necessary skills and expertise on a sustained basis, to support the effective and viable operation of a model 3 hospital in addition to a model 4 hospital. Having adequate and appropriately-skilled staff was a commonly-shared view among all stakeholders.

If Option A is chosen, it will be important to set out clearly in the public domain the key safety considerations in support of this option. It will be necessary to set out clearly the roadmap for implementation of the additional bed capacity and the expected impact on access for urgent and emergency healthcare services. In the event that the Model 2 hospitals are leveraged to support ambulatory and elective access, the merits of local access to such services will need to be highlighted.

Option B

Option B: Extend the UHL hospital campus to comprise the existing Dooradoyle site and another site, in close proximity to UHL, to support the delivery of healthcare services under a single governance and shared resourcing model

Option B proposes the development of a two-site hospital campus across two locations in Limerick (one at the existing Dooradoyle site and another location close to the Dooradoyle site), under a single integrated operational governance and management structure, with the continuation of a single ED in UHL on the existing Dooradoyle site.

Mitigation of current risks

Capacity: An extended two-site hospital campus configuration will allow for the planning and on-boarding of additional inpatient beds in a range of between 299 and 593 as per the ESRI projections up to 2040. This will result in a hospital campus comprising an approximate range of between 837 and 1,131 inpatient beds. Depending on the overall span of the hospital campus, it could potentially enable the scaling up of inpatient bed capacity beyond 1,131 beds to meet growing population healthcare needs beyond 2040. The campus would also provide the agility to further develop healthcare services and therapies such as outpatient facilities to meet the Mid West's future healthcare needs. Option B might also more readily enable the planned co-location of maternity services at UHL.

Attendances to ED: As with Option A, while the additional bed capacity is being developed and commissioned, there is a risk that with the anticipated increase in attendances for urgent and emergency healthcare services of between 16% and 23%, demand for these services and inpatient care at UHL will continue to outpace bed capacity. Given the reliance on the external dependencies such as the identification of a suitable site, planning permission requirements and the timelines involved in a new build on a second site, this will need to be further evaluated in considering the risks associated with this option. Such risks will need to be managed

effectively to support the delivery of high-quality, safe care and to address any actual and potential harms to people using urgent and emergency healthcare services, especially those that may require admission and inpatient care.

Resources and feasibility issues

The feasibility of Option B is dependent upon both infrastructural considerations and the potential to scale up in a timely way to meet growing demand for urgent and emergency healthcare services and inpatient care in UHL in the longer term. An extended hospital campus would require sufficient investment at an infrastructural, process and operational level to ensure the effective and efficient integration and delivery of safe, high-quality services, including urgent and emergency healthcare. Significant investment would also be needed to support and enable optimum interoperability, to facilitate the effective integration and coordination of healthcare services, to enhance efficiencies, to ensure sufficient resourcing and to optimise healthcare delivery across the extended hospital campus.

Infrastructure considerations: A suitable, accessible site, adjacent or near the Dooradoyle site would have to be quickly identified to enable the extension and expansion of the hospital campus across two healthcare sites. The capital cost of developing an extended hospital campus will be significant. However, based on the information available on the construction of new hospitals in recent times, the cost associated with establishing a two-site hospital campus would likely be lower than the cost of building a Model 3 hospital (as per Option C).

Managing and delivering multiple capital projects occurring concurrently may also present a challenge. Concurrent projects will need to be comprehensively and efficiently managed in the short and medium term. It is noted that pre-existing ancillary services already in place at the Dooradoyle site would in many instances, not need to be replicated at the new site. Furthermore, a green field site could provide greater flexibility from a design and build perspective, compared to the complexity of adding capacity to a pre-existing hospital site such as UHL, while the delivery of healthcare services continues. The policy considerations in terms of alignment or co-location of specific services for clinical safety reasons will also need to be considered, including but not limited to maternity, cancer and trauma services.

HIQA is of the view that, should Option B be chosen, acknowledging the recent capital investment in and high infrastructural standard of the ED and Critical Care block, UHL should continue to deliver tertiary services with the ED, critical care and complex surgical services remaining on the Dooradoyle site. Therefore, it is suggested that other elements of healthcare service provision currently at UHL,

including specific elective and ambulatory services, could be relocated to the adjacent site. The risks in terms of planning authority decisions will need to be examined as part of the site assessment and overall assessment of the feasibility of Option B. HIQA understands that, at present, no site has been identified or acquired in the region that might be deemed suitable for Option B. A suitable site will need to be identified quickly if this option is to be considered. Any delay in identifying a site will need to be carefully weighed up against the need to keep pace with growing demand for urgent and emergency healthcare services and inpatient care in the Mid West.

The level of change that will come with an extended two-site hospital campus will need to be recognised and managed efficiently to ensure the successful integration of healthcare services across an extended hospital campus structure. Staff and people in the Mid West would need to be supported to adapt to the restructured and configured services, and new ways of working. With Option B, there would be no change to the current configuration and delivery of urgent and emergency healthcare services — one ED (at UHL), supported by MAUs and injury units. Nevertheless, the level of service disruption and adjustment needed from an infrastructural and human resource perspective due to Option B would need to be determined and actions implemented to support staff to adapt to the extended structure.

Governance, organisational structure and care processes: With Option B, the current operational governance structures and management arrangements in place at UHL would apply across the extended hospital campus. The two-site hospital campus would function under a single governance and shared resourcing model. The organisational structures and care processes would have to be updated to support this option and the integration of services across the expanded two-site hospital campus structure.

Option B would provide an opportunity for greater flexibility, allowing for the consideration of alternate service configurations with respect to national policy considerations including cardiac, elective surgery, maternity, cancer and trauma. In the current configuration, scheduled and unscheduled healthcare services compete for resources including diagnostic capacity and inpatient beds at UHL. Option B provides an opportunity to explore the segregation and decanting of healthcare services to a second adjacent site to UHL. For example, at University Hospital Galway (a Model 4 hospital which spans two sites) a range of healthcare services, including outpatient services, elective care, and specialised care are delivered on the extended hospital campus location at Merlin Park Hospital.

Consideration could also be given to an alternate model of scheduled healthcare delivery, where some elective care is provided on the second site. Option B could present an opportunity to ring-fence capacity for specific elective procedures and create a degree of separation that may mitigate competing clinical priorities. This is broadly consistent with current government policy in terms of the development of surgical hubs, but there would need to be further consideration of the scope of elective activity to be delivered on the adjacent site. Specifically, the degree of segregation that could be achieved across the extended two-site hospital campus would need to be determined in line with the overall policy context for tertiary services, policy on configuration of emergency and elective services, and consideration of clinical priorities, space and demand. A key benefit of Option B is that it provides for flexibility over time to change the way that the healthcare services in HSE Mid West are configured, with some scope to adapt and develop to accommodate future healthcare needs.

A well-defined integrated operational governance and management structure will be essential to ensure efficiencies in the delivery of high-quality, safe healthcare services across a two-site hospital campus. This structure would need to contain clearly-defined and delegated responsibilities and accountabilities, which include clear on-the-ground operational management arrangements. Strong, clinical and managerial leadership and clear, effective communication and collaboration will be required at all levels across the multiple constituents of the two-site hospital campus. As per Option A, the continued centralised configuration of urgent and emergency healthcare services would potentially impact on the accessibility of emergency services for some of the population in the Mid West.

Workforce considerations: The effectiveness of delivering healthcare services across a two-site hospital campus would depend on the ability to efficiently distribute resources across the two sites. As with Option A, workforce planning and recruitment will be crucial to ensuring the bed capacity needed can be operated across an extended hospital campus structure. Option B would require an appropriate uplift in staff to support optimal delivery of safe, high-quality healthcare and to ensure adequate staffing levels to maintain sustainable clinical rosters 24/7 across the two-site hospital campus. Sharing and distributing staff resources across the entire campus configuration may be beneficial in terms of access to tertiary and specialist staffing and expertise.

The implications for staff and the overall pathways of care arising from a reorganisation of healthcare services within an extended campus, as suggested in Option B, would need careful consideration and planning. Measures would be

required to alleviate staff concerns, manage staff expectations and support appropriate staff recruitment and retention. Like Option A, the continued centralisation of urgent and emergency healthcare services in UHL would support healthcare professionals to maintain and enhance their clinical competence; providing continued education, training, and career development opportunities.

Potential acceptability to key stakeholders

Option B maintains the continued centralised configuration of ED services in the Mid West. As outlined through the consultation process, this configuration may not be favourable to some stakeholders in the Mid West, particularly for those people living longer distances from Limerick city and those who favour the development of a Model 3 hospital. However, because Option B represents more significant change in terms of organisation and delivery of services and possibilities for future potential expansion than Option A, there is a possibility that people may perceive Option B as more likely to succeed and therefore more acceptable. Should there be a decision to establish a two-site hospital campus, time and effort should be taken to listen to and address any queries or concerns raised related to the continued centralisation of urgent and emergency healthcare services at UHL.

As per Option A, based on stakeholder feedback, Option B may be acceptable to those health professional groups and stakeholders who favoured solutions focused on increasing inpatient bed capacity while maintaining centralised urgent and emergency care services in UHL. While there was no overall consensus among healthcare professional groups with whom HIQA met on the future design and delivery of urgent and emergency healthcare services for the Mid West, HIQA was informed that the development of an extended two-site hospital campus, broadly in line with this option, was internally supported by a number of clinical and management staff in HSE Mid West.

Option C

Option C: Develop a Model 3 hospital in the Mid West

This option involves the development of a second ED in the Mid West, through the development of a Model 3 hospital.

Considering the growing demand for urgent and emergency healthcare services in the Mid West and projected capacity demand up to 2040, the potential for the provision of a second ED in the region is an alternative to the current configuration. As with Options A and B, there are potential benefits and challenges associated with choosing this option.

Based on the appraisal of international evidence carried out as part of this review, the commissioning of a second ED in the Mid West would require a facility with the range of healthcare services and specialties commensurate with a Model 3 hospital. A Model 3 hospital provides acute and emergency surgery and medicine, and critical care 24/7. It has an on-site emergency department and high-dependency unit, and strong links with the local Model 4 (tertiary referral) hospital to enable the transfer of patients requiring critical care. There are dependencies with the development of a Model 3 hospital to support the delivery of viable and safe healthcare. For example, establishing and operating a new ED requires the coexistence of other essential healthcare services, such as critical care services, 24/7 emergency surgical services, 24/7 access to diagnostics, and a sustainable on-call roster. There would be a need to meet certain minimum requirements to establish viable clinical services in each of the clinical specialties, as has been determined by the HSE National Clinical Programmes. In establishing a Model 3 hospital, these standards must be met in full for a safe service to be properly commissioned. Relevant National Clinical Programmes would include, but are not limited to:

- acute medicine
- anaesthesia
- cardiology
- critical care
- emergency medicine
- paediatrics and neonatology
- stroke
- surgery
- trauma and orthopaedic surgery
- interventional radiology.

In terms of the clinical requirements to support an ED service, HIQA's review of international standards on the requirements for an ED found that there was broad agreement on the requirement for timely access to a number of key support services. These included access to intensive care services, laboratory services, medical imaging, mental health services and operating theatres with the associated support services and staff. Pharmacy and social work services were also noted in some reports as essential support services.

In the evaluation of this Option, HIQA has not considered where such a service might be best located geographically within the Mid West region. This is because decision-making in this regard requires a further level of analysis that would only be appropriate if and when a Ministerial decision to progress this option has been

taken. However, the following analysis applies to either the expansion of pre-existing Model 2 hospital sites in the region, or the development of an entirely new standalone Model 3 hospital in the region.

Mitigation of current risks

Capacity: The planning, investment and resourcing of a Model 3 hospital should take account of the ESRI's projected demand for healthcare services and inpatient capacity requirement of 299 to 593 beds in the Mid West up to 2040. It should be cognisant of and have the ability to scale up to meet further increases in demand and requirements for healthcare services in the region beyond 2040. Consideration of this option might require decanting of some services from UHL - with decommissioning of older infrastructure in that hospital. This in turn might support greater sustainability of the Model 3 hospital in terms of workload volumes and staffing rosters.

Within Option C, HIQA does not believe that there would be justification for a second Model 4 hospital in the Mid West. Based on the projected bed numbers, the likely demand for many services would still not be sufficient to justify two tertiary services (Model 4 hospitals) in the Mid West. Furthermore, the development of a new Model 4 hospital may have an adverse impact on service sustainability from a staffing and skill mix perspective in both the pre-existing Model 4 and the new hospital.

Attendances to ED: Option C proposes the organisation and delivery of emergency care in the Mid West across two EDs — the existing ED in UHL at Dooradoyle and a new ED in a Model 3 hospital. The ESRI projections indicated that future demand for urgent and emergency care will increase by between 16% and 23% between 2023 and 2040, which includes attendances to ED and supporting injury units. A potential benefit of a second ED in the region would be the distribution of ED presentations across two locations. This may help to absorb peaks in demand for urgent and emergency healthcare services. A second ED could improve geographical distribution of ED attendances in the region and improve accessibility.

Furthermore, the division of services that would result from the development of a Model 3 hospital with an ED has the potential to mitigate possible risks around the resilience (in the event of service disruption at a particular site) of urgent and emergency care services in the Mid West. This is relevant in the context of requirements placed upon the health service by the European Union Critical Entities Resilience Directive, for which HIQA has recently been assigned as a Competent Authority.

Resources and key dependencies

Developing a Model 3 hospital represents the greatest amount of change to current healthcare service configuration in the Mid West. Option C would require substantial investment to ensure the infrastructure, operational structures and processes are in place to support the delivery of a range of medical specialties and the efficient and effective functioning of a Model 3 hospital. The feasibility of this option needs to be carefully considered by the Minister for Health, with particular focus on key determining factors which will impact the viability of this option, including the significant capital cost, time to deliver and workforce considerations associated with it. Given the level of mismatch between demand and capacity and the fact that the Mid West has significantly fewer beds than other regions, it would also be necessary to address the current capacity deficit in addition to planning for a model 3 hospital.

Infrastructure considerations: A determination would need to be made to establish if a Model 3 hospital could be commissioned at the site of an existing healthcare service in the Mid West, or whether a new site and build is required. Consideration should be given to the accessibility, planning requirements and capability of a physical site to enable future expansion and capacity growth to meet future demand for healthcare services in the Mid West beyond 2040.

Based on the available information at the current time, Option C is likely the most expensive of the options, and the development, building and commissioning of a new Model 3 hospital will require significant investment and incur high capital costs. The resourcing, planning and investment to support the delivery of the range of medical specialties consistent with a hospital of this type will be significant. Furthermore, the recently-published national projections by the ESRI may place significant demands on the health capital programme nationally. As a result, there may be significant potential for competition in securing the resources needed to progress such a project, given the likelihood of other large-scale infrastructure projects progressing in parallel across the country.

A feasibility assessment of creating a Model 3 hospital will critically hinge upon an evaluation as to whether the planning, construction and commissioning can proceed rapidly enough to meet the current pressing and projected increase in demand for healthcare services and bed capacity in the Mid West. The potential for delay associated with this option, given recent experiences of the development of new hospitals in the State, needs to be carefully considered and risk assessed. This represents a substantial risk to the potential overall success of this option, in providing much-needed capacity at a rate that is adequate to keep pace with projected ever-growing demand for services in the region. As a consequence,

immediate measures to provide capacity in the short term would also need to be considered, as in reality Option C represents a longer-term option only and will not enable capacity to quickly catch up with demand.

HIQA acknowledges that as part of the stakeholder engagement process in this review, Clare County Council proactively informed HIQA that it would be supportive of efforts to provide for an expanded or new hospital in Clare. It should be noted that HIQA did not actively seek such an assurance from other local authorities for development in their areas. The Department of Health and HSE will need to engage appropriately with planning authorities on the potential for developing a new hospital or expanding and extending an existing hospital in the Mid West.

Finally, the future-proofing of service configuration and capacity in the Mid West beyond 2040 is significant in the evaluation of this option. A Model 3 hospital would provide the opportunity to support any increase in healthcare needs in the Mid West in the longer term. A key dependency is the identification of a suitable location, ideally accessible and with adequate space for expansion to accommodate longer-term healthcare needs to advance the development of a Model 3 hospital.

Governance, organisational structure and care processes: Effective, integrated operational governance arrangements, organisational structures and care processes would be required to ensure and assure the quality of healthcare services delivered at the Model 3 hospital. The restructuring and reconfiguration of healthcare services in the Mid West that would result from the commissioning of a Model 3 hospital will be significant and will need time to build, commission, consolidate and embed.

A second ED in a Model 3 hospital would decentralise urgent and emergency healthcare services across two locations in the Mid West, which depending on the location, could improve equity of access from a geographical perspective. However, the decentralisation and division of urgent and emergency healthcare services does not align with the centralised model of care set out in the National Clinical Programme for Emergency Medicine. Care processes and pathways between UHL and a Model 3 hospital would have to be developed to optimise efficiencies in the allocation of resources and patient outcomes. A key consideration is whether the Model 3 hospital can maintain sufficient clinical activity to ensure effective and sustainable rostering practices and to support clinicians to maintain clinical skills and competence.

Workforce considerations: Given the clinical requirements for a Model 3 hospital, a key determining factor impacting the feasibility of Option C would be the

availability of a skilled healthcare workforce. The recruitment and retention of adequate staff with the right competence and skills is crucial to the optimum and safe delivery of high-quality healthcare services and the functioning and sustainable delivery of 24/7 healthcare services in a Model 3 hospital. These challenges have previously been well defined around medical staffing by the HSE National Doctors Training and Planning Office. This office has previously identified problems with recruitment for non-consultant hospital doctors to fill training positions in some Model 3 hospitals, with a resultant reliance on staff who were in non-training positions to fulfil services needed. While acknowledging the important role such medical staff provide, this is not an optimal situation for services from a quality or sustainability perspective.

The potential challenge with standing up and sustaining the workforce requirement for a standalone Model 3 hospital is significant, and should not be underestimated. Moreover, there is no recent precedent in the public healthcare system in Ireland of an entirely new facility with the full range of services being stood up in this way, with the requirement to be staffed at this scale and magnitude. Given the challenges in attracting staff to health services outside of the main urban areas in Ireland in particular, it is not certain how quickly or successfully this might be achieved in a sustainable way.

In addition, the potential implications for the existing Model 4 in terms of attracting and retaining staff will need to be assessed. There is potential for competition for resources between the two sites, which may have an adverse impact for both. The need for duplication of some clinical services already in place in the Mid West to ensure service viability in standing up Option C, means that it likely that the scale of required resourcing for Option C will be higher than Options A or B.

Potential acceptability to key stakeholders

Depending on the location of the Model 3 hospital, Option C would be more aligned with the expressed views and the opinions of some of the people and patient representative bodies who engaged in the stakeholder consultation process. If established successfully, this option would have the potential to improve accessibility to urgent and emergency healthcare services, particularly for those people living closer to the Model 3 hospital than to UHL.

This option may however be less acceptable in time, if the timeline required to deliver the Model 3 hospital is comparable with other recent examples within the State for the delivery of public hospitals. Furthermore, it does not align with the views of some of the professional groups and stakeholders with whom HIQA

engaged, who favoured maintaining centralised urgent and emergency care services in the region. Among these stakeholders, some concern was expressed that splitting out urgent and emergency care and other clinical services across two hospitals may have a negative impact on the clinical services provided, albeit this view was not universally expressed. Some stakeholders had particular concerns around safely staffing and sustaining a skilled workforce at a Model 3 service.

If this option is chosen without the establishment of parallel measures to support additional capacity in the short to medium term, the likely mismatch between demand for services and the time taken for new capacity to be realised could result in an unfavourable opinion of this option over time in the region.

4. Other areas of consideration or required intervention, which should be addressed alongside the chosen option(s)

Interventions needed both immediately and in the short term that should coincide with the commissioning of future additional inpatient bed capacity in the Mid West include:

Leadership, governance and management: Patient experiences at UHL and published reports, including the Frank Clarke report, clearly established the risks posed when the mismatch between urgent and emergency healthcare service demand and inpatient capacity manifests in ED and hospital overcrowding. Overcrowding leads to operational inefficiencies, is a strain on resources and negatively impacts patient outcomes and experiences. At hospital level, the focus on adherence to policies and procedures that promote and ensure safety mechanisms, including the implementation of the Emergency Medicine Early Warning System, should be continued and prioritised. It is imperative that the gains in operational efficiencies and the interventions implemented continue to optimise patient flow and improve internal capability in UHL. This will ensure there is robust corporate and clinical leadership and governance, effective operational grip and that the healthcare service is responsive in meeting the demand for urgent and emergency healthcare services and inpatient care. Maintaining strong, effective clinical and managerial leadership and governance at health region level will be fundamental to ensuring access to and the safe delivery of high-quality urgent and emergency healthcare services across the region.

System-wide approach: There is an urgent requirement to consider options for strengthening the immediate capacity up to 2029 through additional ambulatory care and step down capacity using the Model 2 capacity, private acute and sub-acute

capacity. HIQA also notes that significant additional requirements have been identified by the ESRI relating to long and short-term residential care beds, home support, GPs and GP nurses at the national level. While region-specific ESRI estimates have not, as yet, been published at the time of writing, these will need to be factored into resourcing estimates to ensure that the benefits of inpatient bed capacity investment in the region are fully realised.

For example, the ESRI projects that national demand for long-term residential care beds for older people will increase by at least 60% from 2022 to 2040. This increase in demand for residential care for older people is driven by substantial gains in life expectancy over recent decades. Approximately 80% of long-term residential care beds for older people is provided by the voluntary and private sector. If the projected growth in long-term residential care requirements to 2040 is not addressed, this may increase demand on inpatient capacity by potentially resulting in a rise in avoidable admissions and an upturn in delayed discharge of care. Similarly, a deficit in meeting the increased requirements for short-term residential care beds, home support, GPs and GP nurses will negatively impact appropriate provision of care and intensify demands on inpatient capacity.

There are also other factors that may impact the availability and demand for healthcare services, including the impact of:

- Any changes or variations in bed availability for step down services in the community, which currently support patient flow from UHL and other hospitals in HSE Mid West.
- The additional bed capacity of 150 beds in the new private hospital (Bon Secours Hospital Limerick), which became operational in September 2025.
- The new HSE surgical hub, which is due to be operational in Limerick by the end of 2026.

These developments have the potential to positively impact healthcare services in the Mid West, but their overall impact on demand for and utilisation of urgent and emergency healthcare services and inpatient care in UHL will need to be closely monitored by the HSE.

Pre-hospital emergency care services: Further investment, resourcing and development of pre-hospital emergency care services in the Mid West is needed. This will also assist the enhancement of existing and development of new initiatives that reduce conveyances to UHL's ED and support hospital admission avoidance to have an impact on ED attendances and demand for inpatient care in UHL.

Enhanced community care and general practice services: There is a need to continue to reform primary healthcare services in the Mid West in line with Sláintecare, to ensure services are sufficient for current and projected healthcare requirements in the region. GP services across the Mid West will need to be strengthened to ensure sufficient access and reduce risks to the delivery of these services. A particular focus is required on those areas less-well served by GPs. The ESRI has determined that Ireland needs between 943 and 1,211 additional full-time GPs by 2040, a projected increase of 23-30% to meet the demands of the country's growing and ageing population. Within this context, targeted investments and supports will be needed to improve GP numbers, especially in underserved areas in the Mid West such as East Clare, East Limerick and Ballina Community Health Networks.

Further resourcing and development of the Integrated Care for Older People Service, specifically the Integrated Care Programme for Older Persons (ICPOP) and the Integrated Model of Care for the Prevention and Management of Chronic Diseases will also be needed. Prioritising older persons and chronic disease pathways will support the delivery of care as close to the people requiring such care as possible. Continued investment and resourcing will be needed to bolster community services to meet growing demands associated with demographic changes that contribute to higher levels of admission to and delayed transfer from acute hospital settings.

Continued investment in workforce: There is a need to continue investment and resourcing to support the commissioning of additional bed capacity. Adequate staff resourcing of the acute, primary, community and pre-hospital emergency care services in the Mid West will need to be continued. A comprehensive workforce plan for the Mid West that reflects the changing nature of healthcare services will need to be developed and implemented to operate the additional bed capacity planned up to 2029 and beyond. The workforce plan should consider all professions and disciplines and should address any existing resourcing deficits while developing strategies to improve staff recruitment and retention in the Mid West. Incremental investment will ensure that healthcare services in HSE Mid West operate at a level of capacity that keeps ahead of projected population demands up to 2040 and beyond. A corresponding increase in human resources and other interventions is needed to ensure the full commissioning of all additional beds and to make a meaningful impact on the overcrowding situation in UHL both in the short and longer term.

Further refurbish and optimise healthcare services in HSE Mid West: There is a need to modernise and refurbish certain parts of UHL (for example, Nightingale wards) to bring the hospital fully up to modern infrastructural best practice standards. Tailored solutions with adequate investment are needed to support bi-directional flow across

healthcare services in HSE Mid West. Potential solutions include the effective use of Model 2 hospital sites and the extension of admission avoidance pathways, including the further expansion of medical assessment units and injury units in Model 2 hospitals, and elective and ambulatory care across all hospital sites in the Mid West. The optimising of ambulatory care should be in line with the *Framework for Ambulatory Care on the Acute Floor.* A continued focus on the regional delivery of diagnostics and laboratory services will need to be maintained to ensure timely access to these services to assist clinical decision-making in all hospitals in the Mid West.

Information systems, technology and new service delivery models: The need for improved health information systems has been recognised in many reports over the past two decades. HIQA has previously provided recommendations on reforming Ireland's national health information system and the need to implement these changes is further underscored by this review of the design and delivery of urgent and emergency healthcare services in the Mid West. Although some improvements have been made, there is an urgent need to integrate health information systems and standardise the data that are collected across HSE Mid West and at the wider health-system level. Technology could be used more to enhance healthcare decision-making and service delivery across the Mid West. For example, a more targeted use of telemedicine, the potential for further virtual ward initiatives, and an integrated community hub will enable the appropriate management of patients in hospitals across the Mid West and optimise bi-directional patient flow by supporting the intra-hospital transfer of patients. The full implementation and roll out of individual health identifiers and a shared health record will improve data reliability and enable more accurate tracking of patient pathways, outcomes and resource use.

5. Monitoring and evaluation of the impact of the interventions in the Mid West

Implementation of the advice contained within this document would benefit from the development of a published strategic plan that clearly details what is intended to be delivered in a time-bound way in the Mid West. Such a plan should identify the short, medium and long-term objectives and operational direction for the design and delivery of scheduled and unscheduled care in the Mid West, including urgent and emergency healthcare services. This should be considered in the context of the population demographics of the Mid West, taking cognisance of the ageing population, expected population growth, areas of social deprivation and projected inpatient bed requirements. The strategic plan should detail how the increase in bed capacity and changes to healthcare service reconfiguration arising from the Minister

for Health's decision will be achieved. It should reflect government policy, best practice standards and infrastructural considerations. A comprehensive, costed implementation plan would need to be developed to support plans to ensure the optimal design and delivery of urgent and emergency healthcare services in the Mid West.

Between now and 2029, HSE Mid West should measure and evaluate the impact that any additional bed capacity in the Mid West has on meeting the demand for urgent and emergency healthcare services and inpatient care. There is an urgent need to improve the ability to track a patient's journey through the healthcare system. This will support service planning and management and enable the more effective evaluation of healthcare services. This is coupled with a need to ensure the availability of consistent, reliable measures to evaluate primary care, ED and hospital services, considering both hospital performance, access and process data and patient-related outcome measures. The monitoring and evaluation should be broad in approach and should include metrics that measure patient outcomes, service management and support the safe, quality and timely delivery of healthcare that includes the entire patient pathway from pre-admission to discharge.

Taking account of relevant findings and recommendations from HIQA's recent Statutory Review at Children's Health Ireland, regardless of which option is chosen, the HSE must ensure that when planning major organisational changes; governance structures, processes and overall readiness for the changes are assessed from the outset. This assessment should evaluate management capacity and change management expertise to support both the transition and continued delivery of healthcare services during the period of adjustment. Planning should go beyond reporting structures to include how existing operational governance structures and management arrangements should adapt to the changes. This is essential to ensure that high-quality, safe healthcare services are maintained and delivered optimally during the time of transition.

Whichever option is chosen as the mechanism to increase inpatient capacity in the Mid West, the Department of Health and HSE will need to conduct an interim review to assess the impact of any investment and any change to underlying assumptions. These include demographic and other dependencies like health policy considerations, such as private off-site practice, the maternity, cancer and trauma strategies and infrastructural planning beyond 2029. The review might also consider projected changes in Ireland's population and long-term demographic trends over the next 40 years that have recently been published by the Department of Finance. Additionally, given certain assumptions about migration, fertility and mortality rates, the

potentially impact of these projections for healthcare services should also be considered. This interim review should take place no later than 2029, which HIQA understands to be the intended date at which the Irish Government plans to next undertake a substantive appraisal of overall capital expenditure programmes.

6. Conclusion

The number of presentations to the ED and the lack of sufficient acute inpatient bed capacity to meet demand for urgent and emergency healthcare services and inpatient care are key drivers of ED and hospital overcrowding at UHL. Several interventions over recent years have led to some improvements in operational and managerial processes at the hospital, including an increase in acute and critical care capacity. Notwithstanding this, there are significant deficits in inpatient bed capacity when compared with other Model 4 hospitals, particularly in light of the volume of activity at UHL. As a result, overcrowding in the ED and wider hospital persists and this represents an ongoing risk to patient safety.

The inpatient bed deficit cannot be addressed through a change in the structure or allocation of the beds currently available in the Mid West. Any increase in bed capacity in HSE Mid West must be achieved through the addition of new beds, with a focus on the provision of extra capacity in a setting capable of safely treating patients who are acutely unwell, require complex care or present with an undifferentiated condition. There is also a requirement to meet the needs of those patients requiring elective procedures in a timely fashion. The recommended new beds are in addition to the 128 beds already committed to be opened at UHL by the end of 2025. These 128 beds will not be sufficient to address all of the current or projected deficits in inpatient bed capacity in UHL and HSE Mid West.

The ESRI projections for the Mid West up to 2040 suggest that demand for healthcare services in the region will continue to grow year-on-year. At the current time, and notwithstanding recent investment in UHL and the Mid West, a deficit in Model 4 inpatient beds results in a scenario where patient safety risk persists. This safety issue will not be fully addressed until the demand-capacity gap is closed. Given this, the decisions about increasing capacity and improving healthcare delivery arising from this review should aim to deliver the necessary inpatient bed capacity within the shortest possible timeframe and in the safest way from the perspective of patient care. The planned bed capacity will bring UHL closer to addressing inpatient bed deficits. The second 96-bedded block currently planned for construction on the UHL site at Dooradoyle remains subject to an appeal placed with An Coimisiún Pleanála and likely won't be operational until 2029 should it be approved.

Taking account of the ESRI projections and the options in this advice document, there is a requirement to urgently re-evaluate the Government's plans to invest and expand Model 4 and Model 2 inpatient bed capacity in the HSE Mid West up to 2031. The re-evaluation should consider if the overall number of proposed Model 4 beds can be increased in the timeframe, or if a greater proportion of the beds committed to can be provided in a more acute setting such as UHL, in an attempt to address near-term capacity deficits. The potential to further divert some elective care from the Model 4 (UHL) site to Model 2 hospitals in the Mid West in an effort to release Model 4 inpatient beds in UHL for non-elective and inpatient activity, should form part of future plans. The provision of additional step down facilities should also form part of the assessment to address the Central Statistics Office projections for ageing.

This advice document presents three options for the Minister for Health to consider in deciding upon the design and delivery of urgent and emergency healthcare services and increasing inpatient bed capacity in the Mid West. The options represent variations on the optimal future configuration of healthcare services in the Mid West to provide additional inpatient bed capacity, in order to enable safe and effective care for the people of the region. All options will result in an increase in inpatient beds, but how that is achieved and to what level is dependent on the specific considerations and features set out under each option. Further adaptation and considerations may be necessary to account for all relevant factors when deciding the most appropriate way to provide the projected inpatient bed capacity in the Mid West now and in the short, medium and longer term up to 2040. Work carried out as part of this review, which included several work stream inputs and support from an External Advisory Group, was not conclusive in terms of directing this advice to one singular option.

Each of the options has merits in terms of addressing the capacity challenges. There are risks with each option and we have considered potential risk mitigations. A key driver for this review is patient safety; specifically, the safety risks associated with the significant mismatch between current capacity and demand in comparison with other Model 4 hospitals. In the interest of addressing patient safety concerns in the shortest possible timeframe, HIQA is of the view that Options A or B presented in this document are likely to yield the required bed capacity more quickly than Option C. It is also advised that a degree of flexibility is required in the planning for the addition of bed capacity, particularly given the potential wide range of required beds projected by the ESRI for the Mid West over the next 15 years.

Given recent experiences in the Irish health sector, there would be a long lead time to develop a Model 3 hospital in terms of planning, designing, building and

commissioning. The associated costs would also be very significant, as evidenced by recent experiences in building the National Children's Hospital and projected costs for the new National Maternity Hospital. The potential displacement effect on other capital projects in the Mid West and across the country would also need to be factored in. There is still a pressing need from a safety perspective to deliver additional inpatient bed capacity in the short term to ensure that current risks to patient safety are addressed. Options A or B, or a variation of same, would offer the potential to provide this capacity in a shorter timeframe than Option C. In the context of addressing ongoing risks, they may therefore be more appropriate near-term options than Option C. If it is decided that Option C represents the preferred longer-term option, then measures to further build inpatient bed capacity in the Mid West in the short term that align with Options A or B will still need to progress in order to mitigate the immediate risk to patient safety.

This review has confirmed that decision-making on how best to proceed in enhancing healthcare services in the Mid West through additional investment is complex. Key to considerations of the best solution is a judgment on how likely each option can provide the required inpatient bed capacity within a timeframe that keeps pace with the increasing demand for healthcare services in the Mid West.

Given the feedback provided to HIQA as part of the review's consultation process, it is also evident that measures to enhance public confidence in the healthcare services in UHL and the HSE Mid West will need to be continued and strengthened. As part of the decision-making arising from the advice contained in this document, proactive engagement with the population in the Mid West is essential to build trust and confidence in healthcare services, and consensus around the decision made to improve healthcare services in the region. This may also help to address the potential hesitancy to attend UHL for emergency care reported by the stakeholders who engaged with HIQA. Any decisions relating to this advice should be supported by a communications strategy to clearly communicate with the local population, help alleviate concerns and support the implementation of interventions to increase bed capacity in the Mid West.

Appendix 1 Membership of the Expert Advisory Group

Maria Bridgeman*	Integrated Healthcare Area Manager, Limerick City and North Tipperary, HSE
Sandra Broderick	Regional Executive Officer, Mid West health region, HSE
Prof John Browne	Professor of Epidemiology & Public Health, University College Cork
Prof Sara Burke†	Associate Professor and the Director of the Centre for Health Policy and Management, Trinity College Dublin
Ian Carter	Mid West Integrated Healthcare Area Manager, Acute and Older Person Services, HSE
Dr Sheelah Connolly	Senior Research Officer and Joint Research Area Coordinator for Health and Quality of Life Research, Economic and Social Research Institute (ESRI)
Margaret Costello*	Head of Service, Primary Care, HSE Mid West Community Healthcare
Prof Gary Courtney	Clinical Lead, National Clinical Programme for Acute Medicine, HSE
Dr Gino De Angelis†	Manager, Clinical Research, Canada's Drug Agency (L'Agence des medicaments du Canada)
Dr Michael Dockery	Clinical Lead, National Clinical Programme for Anaesthesia, HSE
Sean Egan	Director of Healthcare Regulation, HIQA
Dr Des Fitzgerald	Consultant in Emergency Medicine, University Hospital Waterford *Nominated by:* National Clinical Programme for Emergency Medicine
Patrick Glackin	Area Director, Nursing and Midwifery Planning and Development (Mid West, West and North), HSE
Prof Liam Glynn	Professor of General Practice, University of Limerick *Nominated by:* Irish College of General Practitioners
Janet Grene■	Honorary Secretary, University of Limerick Hospitals Group Patient Council

Dr David Hanlon	National Clinical Advisor and Group Lead Primary Care, HSE
John Hannifin♦	Chairperson, University of Limerick Hospitals Group Patient Council
Dr Patricia Harrington	Deputy Director, Health Technology Assessment, HIQA
Dr Martina Healy	Clinical Lead, National Clinical Programme for Critical Care, HSE
Dr Orla Healy	National Clinical Director of Quality and Patient Safety, HSE
Dr Terence Hennessy❖	Regional Clinical Lead for Strategy and Development for Mid West, HSE
Joe Hoare	Assistant National Director, Capital & Estates Mid West, HSE
Dr Graham Hughes	Clinical Lead, National Clinical Programme for Older People, HSE
Dr Paul Kavanagh	Consultant in Public Health Medicine, National Health Intelligence Unit, HSE
Ruth Kilcawley	Assistant National Lead of Health & Social Care Professions, HSE
Sinead Lardner	National Lead for Safe Nurse Staffing & Skill Mix, HSE
Dr Margie Lynch*	Medical Director, ShannonDoc *Nominated by:* Irish College of General Practitioners
Dr Mai Mannix	Regional Director of Public Health, Public Health Mid West, HSE
Dr Ciara Martin	National Clinical Advisor and Group Lead for Children and Young People, HSE
Prof Peter McCarthy	Consultant Radiologist, Former Dean of the Faculty of Radiologists and Radiation Oncologists
Claire McMahon*	Clinical Quality and Nurse Manager, ShannonDoc
Dr David Menzies	Deputy Clinical Director (Emergency Care), National Ambulance Services and Consultant in Emergency Medicine
Niall Murray	General Manager, National Ambulance Services Operations, Mid West Region

Kate O'Flaherty	Director of the National Patient Safety Office, Department of Health
Michelle O'Neill	Deputy Director, Health Technology Assessment, HIQA
Anne O'Shea Clarke	Patient representative, SAGE Advocacy
Dr Catherine Peters	Mid West Clinical Regional Director, HSE
Dr Máirín Ryan (Chair)	Director of Health Technology Assessment and Deputy Chief Executive Officer, HIQA
Prof Eamonn Rogers	Co-Lead of the National Clinical Programme for Surgery, HSE
Grace Rothwell	National Director for Access and Integration, HSE
Dr Nigel Salter	Consultant in Emergency Medicine, St. Vincent's Hospital *Nominated by:* Irish Association for Emergency Medicine
Mr Keith Synnott	National Clinical Lead for Trauma Services, HSE and Consultant Orthopaedic Surgeon at the Mater Misericordiae Hospital
Dr Conor Teljeur	Chief Scientist, Health Technology Assessment, HIQA
Dr Kieran Walsh	Deputy Director, Health Technology Assessment, HIQA
Patricia Whelehan	Assistant National Director, Older Person Services, National Office Access and Integration, HSE *Nominated by*: Director of Community Services, HSE
Jo Williams	Patient representative, Patients for Patient Safety Ireland

*Alternate nominee for programme; ■EAG member from 23 January 2025; ♦EAG member until 23 January 2025; †EAG member from 18 February 2025; ◦EAG member from 7 April 2025.

Conflicts of Interest

None reported.

Appendix 2 Terms of Reference for this review

The following terms of reference have been determined for the conduct of the review and agreed with the Minister for Health:

1. To review the current relevant national and international evidence — to ensure an evidence-based rationale to inform the potential future configuration of comparable urgent and emergency healthcare services.

2. To establish an Expert Advisory Group — which contains patient representatives and operational, clinical and nursing expertise to inform HIQA's overall approach in the conduct of this review.

3. To consult and engage with key stakeholders in the region and nationally — through the implementation of an extensive stakeholder engagement plan with key interested parties, including patients and healthcare professionals in the region and nationally.

4. To engage with the relevant clinical community in the region and nationally to inform clinical considerations — through the establishment of a Clinical Advisory Forum with relevant clinical and nursing representatives including, but not limited to, emergency medicine, acute medicine, surgery, anaesthetics, paediatrics, the National Ambulance Service and local general practitioners (GPs) to inform the review.

5. To monitor compliance with the *National Standards for Safer Better Healthcare*, in accordance with Section 8(1)(c) of the Health Act 2007, as amended. Such an analysis will build upon the prior body of monitoring work HIQA has conducted at UHL and seek to identify any further areas of progress achieved in working to meet the requirement of the national standards. This will seek to evaluate the potential impact and benefits of process improvement and operational effectiveness initiatives on available capacity across the UL Hospitals Group, having regard to national and international evidence on this issue. This is consistent with the focus in the Health Service Capacity Review (2018) whereby a proportion of the capacity requirement was imputed from expected efficiencies, but where it was also agreed that such work needed to be timed against the backdrop of delivering on a maximum 85% bed occupancy rate.

6. Utilising appropriate specialist expertise external to HIQA, to review health service capacity in the HSE Mid West. The outputs from this work will be considered along with the other work streams to inform key considerations and assumptions around best practice in the design and delivery of population needs

relating to urgent and emergency care, aligned to current and project population numbers.

7. To consider the findings and recommendations of the Report of the Independent Investigation at UHL by Mr Frank Clarke.

8. To give advice to the Minister on appropriate course(s) of action — to ensure optimal quality and safety in the delivery of future urgent and emergency care services for the population of the HSE Mid West, informed by evaluation of all of the above factors. In the interests of wider service improvement, national recommendations may be made where HIQA considers it appropriate.

A protocol outlining the programmatic approach to this review details how the terms of reference are addressed through seven distinct work streams. An Expert Advisory Group (EAG), comprising representation from a range of different stakeholder organisations including patient and public representation; healthcare providers, managers and policy makers; as well as clinical and methodological experts, was convened in November 2024 to provide expert input to the review. The recommendations of former Chief Justice Frank Clarke were considered through the work of the review where relevant.

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