Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Expert Advisory Group Membership and Meeting Minutes

Contents

Acknowledgements

HIQA would like to thank the Expert Advisory Group who provided their time, advice and information in support of this review.

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.

2. First Meeting of the Expert Advisory Group

First meeting of the Expert Advisory Group

Evidence synthesis to inform the review of urgent and emergency healthcare services in the Health Service Executive Mid West health region

Monday 16 December 2024, 10am-11.45am (via Zoom)

Minutes

Expert Advisory Group Attendees:

Name	Initials	Details
Ms Maria Bridgeman	**MBr**	HSE Mid West Community Care
Ms Sandra Broderick	**SB**	HSE Mid West Regional Executive Officer
Mr Ian Carter	**IC**	HSE Mid West Acute and Older Person Services
Dr Sheelah Connolly	**SC**	Economic & Social Research Institute
Ms Margaret Costello	**MC**	HSE Mid West Community Care
Prof Garry Courtney	**GC**	HSE Acute Medicine National Clinical Programme
Dr Michael Dockery	**MD**	HSE Anaesthesia National Clinical Programme
Mr Sean Egan	**SE**	HIQA
Dr Des Fitzgerald	**DF**	HSE Emergency Medicine National Clinical Programme *Nominated by:* National Clinical Programme for Emergency Medicine
Dr Patrick Glackin	**PG**	Office of the Nursing and Midwifery Services Director (HSE)
Prof Liam Glynn	**LG**	Professor of General Practice, University of Limerick *Nominated by:* Irish College of General Practitioners
Dr David Hanlon	**DH**	HSE Primary Care National Clinical Programme
Mr John Hannifin	**JHa**	UL Hospitals Patient Council
Dr Patricia Harrington	**PH**	HIQA
Dr Orla Healy	**OH**	National Quality and Patient Safety Directorate (HSE)
Dr Martina Healy	**MH**	HSE Critical Care National Clinical Programme
Mr Joe Hoare	**JHo**	HSE Estates
Dr Graham Hughes	**GH**	HSE Older People National Clinical Programme
Dr Paul Kavanagh	**PK**	HSE National Health Intelligence Unit
Ms Ruth Kilcawley	**RK**	HSE Health and Social Care Professions
Ms Sinead Lardner	**SL**	Office of the Nursing and Midwifery Services Director (HSE)
Dr Margie Lynch	**ML**	Medical Director, ShannonDoc *Nominated by:* Irish College of General Practitioners
Dr Mai Mannix	**MM**	HSE Mid West Public Health

Dr Ciara Martin	**CM**	HSE Paediatrics and Neonatology National Clinical Programme
Prof Peter McCarthy	**PMcC**	Faculty of Radiologists and Radiation Oncologists
Dr. David Menzies	**DM**	National Ambulance Service
Mr. Niall Murray	**NM**	National Ambulance Service
Kate O'Flaherty	**KOF**	Department of Health
Ms Shelley O'Neill	**SON**	HIQA
Anne O'Shea Clarke	**AOSC**	SAGE Advocacy
Dr Catherine Peters	**CP**	HSE Mid West Clinical Regional Director
Prof Eamonn Rogers	**ER**	HSE Surgery National Clinical Programme
Ms Grace Rothwell	**GR**	HSE Director of Acute Operations
Dr Máirin Ryan	**MR**	HIQA
Dr Nigel Salter	**NS**	Consultant in Emergency Medicine, St. Vincent's Hospital *Nominated by:* Irish Association for Emergency Medicine
Mr Keith Synnott	**KS**	HSE Trauma and Orthopaedic Surgery National Clinical Programme
Dr Conor Teljeur	**CT**	HIQA
Ms. Patricia Whelehan	**PW**	Assistant National Director, Older Person Services, National Office Access and Integration, HSE *Nominated by*: Director of Community Services, HSE
Ms Jo Williams	**JW**	Patients for Patient Safety Ireland

In attendance:

Name	Initials	Details
Mr Martin Boudou	**MBo**	HIQA
Dr Louise Larkin	**LL**	HIQA
Ms Arielle Maher	**AM**	HIQA
Dr Cillian McDowell	**CMcD**	HIQA
Dr Michelle Norris	**MN**	HIQA
Mr John Tuffy	**JT**	HIQA
Dr Kieran Walsh	**KW**	HIQA

Apologies:

Name	Initials	Details
Professor John Browne	**JB**	University College Cork

1. Welcome from the Chair (Máirin Ryan)

MR opened the meeting and welcomed those in attendance at the meeting.

2. Apologies and introductions (MR)

Introductions were made and apologies noted.

3. Background to the request (KOF)

KOF provided an overview of the background to the request made by the Minister for Health to HIQA to conduct the review.

4. Group management and protocols

a. Confidentiality and Statements of Interest (MR)

MR thanked members of the EAG for the completion of conflict of interest forms and confidentiality statements. MR noted that this is a deliberative process and as such the work is confidential until it has been published on the HIQA website. MR requested that should any member of the EAG receive media queries, these should be forwarded to HIQA who will address same.

b. Terms of Reference of the Expert Advisory Group (MR)

The EAG Terms of Reference (ToR) were presented. No comments were made by the group.

5. Work programme

a. Work stream overview (LL)

LL provided an overview of the seven work streams in the Mid West Review programme of work, in line with the protocol for the evidence synthesis to inform the review of urgent and emergency healthcare services in the Health Service Executive Mid West health region. LL noted that work streams 1, 2, 3 and 4 are in progress.

b. Programme timelines (LL)

LL provided an overview of programme timelines, noting the deadline of end of May for completion of the work.

- The importance of defining urgent and emergency care in relation to the scope of the project was noted. The HIQA evaluation team responded highlighting they are using a working definition of emergency and urgent care as 'emergency care can be defined as lifesaving care and that urgent care can be defined as not immediately lifesaving care but very important to the health of the individual'.

c. HTA work stream 2: Background information – data (CMcD)

Cillian McDowell (CMcD) introduced the general plan for the data scoping work stream by HTA.

The following points and issues for consideration were raised by the EAG:

- A question was raised regarding the term "specific challenges to the UHL ED (emergency department)". It was noted that the data might not reveal "unique" challenges but instead demonstrate the degree or extent of the challenges faced. It was clarified that the degree or magnitude of the challenges will be considered in the analyses. It was also highlighted that the initial analysis is exploratory, aiming to provide a general overview of the current situation at UHL ED in comparison to other EDs nationwide. This approach seeks to address the extent of challenges specific to UHL ED.
- Consideration should be given to historical resourcing data, particularly from the past six years.
- Issues to consider were raised regarding the use of national datasets, such as the Patient Experience Time (PET) dataset. The importance of understanding the quality of these datasets was emphasised, including potential biases and inconsistencies over the analysis period. PK offered to meet with the evaluation team to discuss these challenges.
- Consideration should be given to investigating seasonal patterns across EDs and examining primary care access and vaccination rates, to identify potential regional differences. It could be useful to review preventative actions such as immunisation rates for flu and COVID-19 and resources for prevention.
- The importance of data related to community healthcare, such as General Practice (GP) services and nursing homes was emphasised. Staffing rates and vacancy rates in staffing of community services would be important to consider alongside numbers of GPs.
- Other suggested sources of potentially useful data included ambulance data, General Practice Out of Hours (GPOOH) data, home help hours, respite beds, and Model 1 and 2 capacity in the region and how it is used. It was further suggested that palliative care capacity and Community Intervention Teams/Outpatient Parenteral Antibiotic Therapy and direct access to urgent speciality care for example, Ophthalmology, Ear, Nose and Throat (ENT), dental, psychiatry, gynaecology, intellectual disability, should be considered. In addition, complaints data, state claims, and National Incident Management System (NIMS) data could also be considered.
- It was queried if it is possible to distinguish between GP walk-in/pop-up clinic referrals to ED versus standard GP referrals for ED referral. It was noted that there has been work done in Cork University Hospital on this and that GPOOH is another distinct service. As daytime General Practice

and GPOOH are based entirely on Electronic Medical Records (EMR), there is data available. The Irish College of General Practitioners (ICGP) has a Data Clinical Lead; a GP in the Mid West who can generate GP-based data. It was queried if the Mid West bed bureau tracks the number of beds requested by GPs.

- The analysis of scheduled care data should consider the specific regional characteristics of the Mid West.
- It was asked whether trolley data would be used to compare UHL ED with other hospitals. The evaluation team confirmed that trolley data will be examined, as it provides valuable insights into potential overcrowding at UHL ED.
- Exploring regional differences in staffing, particularly in terms of consultant numbers by specialty in various health regions, could help identify capacity gaps in certain specialties.
- Bed boarding should be considered as this may slow patient flow through the ED. It was noted that the NQAIS Clinical system might be useful as it includes targets and outliers and includes data on length of stay and bed use. The National Acute Medicine Programme has access to all hospitals' NQAIS Clinical data and comparative analyses.
- Three primary points for evaluating UHL ED were noted:
  - Inefficiencies
  - Strategies
  - Capacity
- It was queried if there is any measure of unmet need, that is, where people are not attending the ED when they should.
- The challenges in accessing information to inform the work streams was noted and it was advised that a relevant point of contact would be arranged for each work stream in UHL.

d. HTA work stream 1: Background information - policy (MN)

MN provided an overview of Work Stream 1. This included the methodological approach and progress to date.

The following points and issues for consideration were raised by the EAG:

- It was noted that the approach would not include examining how a single policy may impact the data.
- It was suggested the National Doctors Training and Planning report on staffing for Model 3 hospitals (available here) should be considered. It was further noted that the review of MAUs/IUs in 2023 would be relevant.
- The Royal College of Surgeons Ireland (RCSI) has a short-life working group on clinical governance in operation at the moment, which might be worth engaging with. It was stated that for community services, home

support is an important element in hospital avoidance and also for discharge.

e. ESRI: Capacity review (SC)

SC provided an overview of the ongoing ESRI Health services capacity review. The overview included:

- Overview of the capacity review work
- Hippocrates model
- Detail on the services included in the capacity review
- Caveats for regional analysis

The following points and issues for consideration were raised by the EAG:

- It was queried if it was possible to be informed of what assumptions were made as part of the work. It was confirmed that the work has input from the HSE and Department of Health (DoH) regarding such assumptions, and that it would be possible to share national information. It was also noted that health inequalities in the Mid West are based on CSO data.
- It was asked if the capacity review also included attendance at Model 2 hospitals. It is to be confirmed with the team in ESRI if that information is included.
- A query was raised as to whether the assumptions include trolley capacity. In response, it was confirmed that the analysis does not include trolley information.
- It was suggested that private hospital capacity (current and planned) could be considered. The National Treatment Purchase Fund activity in the private sector was noted.
- The challenge with capacity may be attributed to changes in healthcare expectations post-COVID, which has led to an increase in assessment, diagnoses and treatment. It was also noted the importance of key diagnostics such as computed tomography (CT) capacity and actual throughput. It was advised that CT and other testing capacity is being used for unnecessary tests and medicolegal concerns when there is a need to focus on sustainable/realistic medicine. There was some agreement on this point with it being noted that both process and capacity should be considered.

f. Healthcare regulation work stream: Stakeholder engagement (SE)

SE provided an update on Work Stream 4 (stakeholder engagement). This included an overview of the public engagement work which is ongoing.

The following points and issues for consideration were raised by the EAG:

- It was stated that, for EAG members who wish to link in and provide input, further engagement offline could be facilitated.
- EAG members highlighted that it would be helpful to be aware of which stakeholders were being engaged with, and also noted the importance of the staff voice being included in this work stream.
- A meeting will be arranged with SB regarding contact points for the HSE Mid West.
- It was queried if the stakeholder engagement would include inputs from all age groups including younger age groups. It was noted that input has already been received from some parents.
- It was further queried if and how individuals and advocacy groups can engage with the public engagement submission process, if the public engagement has been publicised and if consideration has been given to the inclusion of marginalised and minority communities. It was confirmed that the submission portal is available on the HIQA website and that it was publicised through local media in the Mid West.

6. Protocol (LL)

LL provided a high-level overview of the protocol and requested feedback from the EAG by COB on Friday 20 December 2024.

7. Meeting schedule (LL)

LL advised that the next EAG meeting will be in early February 2025 with the exact date TBC. Two further EAG meetings will be scheduled for April and early May 2025.

8. AOB

No AOB raised.

The meeting closed at 11.45

Actions arising from this meeting

No	Action	Responsibility
1	Arrange meeting between evaluation team and PK	CMcD
2	Circulate stakeholder engagement details	SE/JT/LL
3	Contact SB regarding contact points for the HSE Mid West	SE/LL
4	Follow up with GC for the 2023 LIU review link	MN

3. Second Meeting of the Expert Advisory Group

Second meeting of the Expert Advisory Group

Review of urgent and emergency healthcare services in the

Health Service Executive Mid West

Friday 07 February 2025, 11am-1pm (via Zoom)

Minutes

Expert Advisory Group Attendees:

Name	Initials	Details
Professor John Browne	**JB**	University College Cork
Ian Carter	**IC**	HSE Mid West Acute and Older Person Services
Margaret Costello*	**MC**	HSE Mid West Community Care
Prof Garry Courtney	**GC**	HSE Acute Medicine National Clinical Programme
Dr Michael Dockery	**MD**	HSE Anaesthesia National Clinical Programme
Sean Egan	**SE**	Director Healthcare Regulation HIQA
Dr Des Fitzgerald	**DF**	Consultant in Emergency Medicine, University Hospital Waterford *Nominated by:* National Clinical Programme for Emergency Medicine
Dr Patrick Glackin	**PG**	Office of the Nursing and Midwifery Services Director (HSE)
Prof Liam Glynn	**LG**	Professor of General Practice, University of Limerick *Nominated by:* Irish College of General Practitioners
Janet Grene	**JG**	UL Hospitals Patient Council
Dr David Hanlon	**DH**	HSE Primary Care National Clinical Programme
Dr Patricia Harrington	**PH**	Deputy Director Health Technology Assessment HIQA
Dr Orla Healy	**OH**	National Quality and Patient Safety Directorate (HSE)
Dr Martina Healy	**MH**	HSE Critical Care National Clinical Programme
Joe Hoare	**JHo**	HSE Estates
Dr Graham Hughes	**GH**	HSE Older People National Clinical Programme
Dr Paul Kavanagh	**PK**	HSE National Health Intelligence Unit
Ruth Kilcawley	**RK**	HSE Health and Social Care Professions
Sinead Lardner	**SL**	Office of the Nursing and Midwifery Services Director (HSE)
Dr Mai Mannix	**MM**	HSE Mid West Public Health
Dr Ciara Martin	**CM**	HSE Paediatrics and Neonatology National Clinical Programme
Dr David Menzies	**DM**	National Ambulance Service
Prof Peter McCarthy	**PMcC**	Faculty of Radiologists and Radiation Oncologists
Dr Claire McMahon	**CMcM**	ShannonDoc
Dr Niall Murray	**NM**	National Ambulance Service

Shelley O'Neill	**SON**	Deputy Director Health Technology Assessment HIQA
Anne O'Shea Clarke	**AOSC**	SAGE Advocacy
Dr Catherine Peters	**CP**	HSE Mid West Clinical Regional Director
Grace Rothwell	**GR**	HSE National Director for Access and Integration
Dr Máirin Ryan	**MR**	Director Health Technology Assessment HIQA
Dr Nigel Salter	**NS**	Consultant in Emergency Medicine, St. Vincent's Hospital *Nominated by:* Irish Association for Emergency Medicine
Mr Keith Synnott	**KS**	HSE Trauma and Orthopaedic Surgery National Clinical Programme
Dr Conor Teljeur	**CT**	Deputy Director Health Technology Assessment HIQA
Patricia Whelehan	**PW**	Assistant National Director, Older Person Services, National Office Access and Integration, HSE *Nominated by*: Director of Community Services, HSE
Jo Williams	**JW**	Patients for Patient Safety Ireland

*Alternate for Maria Bridgeman

Apologies:

Name	Initials	Details
Maria Bridgeman	**MBr**	HSE Mid West Community Care
Sandra Broderick	**SB**	HSE Mid West Regional Executive Officer
Dr Sheelah Connolly	**SC**	Economic & Social Research Institute
Kate O'Flaherty	**KOF**	Department of Health
Prof Eamonn Rogers	**ER**	HSE Surgery National Clinical Programme

Not attending as alternate:

Name	Initials	Details
Dr Margie Lynch	**ML**	Medical Director, ShannonDoc *Nominated by:* Irish College of General Practitioners

In attendance:

Name	Initials	Details
Dr Martin Boudou	**MBo**	HIQA
Dr Louise Larkin	**LL**	HIQA
Dr Arielle Maher	**AM**	HIQA
Dr Cillian McDowell	**CMcD**	HIQA
Dane Moriarty	**DMo**	HIQA
Dr Michelle Norris	**MN**	HIQA
John Tuffy	**JT**	HIQA
Dr Kieran Walsh	**KW**	HIQA

1. Welcome from the Chair (Máirin Ryan)

MR opened the meeting and welcomed those in attendance at the meeting.

2. Apologies and introductions (MR)

Introductions were made and apologies noted.

3. Minutes (MR)

- Minutes from the previous meeting were circulated and agreed by all.
- Actions from the previous meeting were noted as complete.

4. Group management and protocols

a. Confidentiality and Statements of Interest (MR)

- MR gave the opportunity for attendees to raise any new conflicts — none were raised.

5. Work programme

a. Work stream overview and timelines (LL)

- Tentative dates for the third and fourth EAG meetings were provided.

b. HTA Work Stream 1: Background information - policy (MN)

- MN presented an overview of Work Stream 1, noting that the draft report was circulated to the EAG in advance of the meeting.
- EAG responses to queries raised by the HIQA team and suggestions or comments from EAG members are summarised below, grouped by issue.
- Capacity and operational queries
    - Projects to increase capacity in the region have targeted acute inpatient bed capacity in the first instance. The first 96-bed block in UHL is due to open in summer 2025; building of a new surgical hub is to start in the coming weeks.
    - Fifty beds have been procured in the community nursing unit (CNU) in Nenagh; this unit is open and operational, with alternative access routes to urgent care now available.
    - Twenty-five rehab beds have been procured in Cahercalla Community Hospital, Co. Clare. These are specifically rehab (not step-down) beds with geriatrician and MDT support. Current demand for rehabilitation services remains low.
    - The extension of medical assessment units (MAUs) to operating 24/7 is planned. MAU opening hours have been extended to 12 midnight in Ennis and Nenagh, but uptake of these extended opening hours has been poor.
    - GP providers including out-of-hours (OOH) GP services were notified of the extended MAU hours. Local perceptions of staffing issues and or the

availability of laboratory and radiology support during the extended hours may have contributed to poor uptake. GP OOH services cannot refer for diagnostics and this may be a reason for low levels of MAU demand from this setting.
    - The extension of MAU hours to 24/7 is not recommended in the HSE Model of Care. Reasons for this approach included awareness of staffing and equipment limitations (e.g., lab testing, radiology). Without sufficient resources, 24-hour operations are deemed risky and impractical. It was noted that six consultant physicians would be required to operate an MAU 24/7. This is the recommended staffing level to operationalise an increase in hours of operation. Consideration should be given in the first instance to operating a 12 hr MAU 7/7 with radiology (including CT) and laboratory support to establish that the approach works before any further expansion occurs.
    - Concerns were raised over access to diagnostic and radiology services and the lack of integrated care programmes for children not only in terms of laboratory services, but also access to other services including radiography.
    - Clarification was provided in relation to the Sláintecare 2017 report, which outlined plans for five integrated care programmes; one of which, the programme for children, has not yet been developed.
- Primary care and geriatric support
    - There is a need to decrease dependency on transitional care funding and to ensure that all funding has appropriate clinical oversight. Currently, issues are arising where funding is available, but there are delays with it being deployed resulting in delayed discharges. This has been highlighted in Winter After Action Reviews and can contribute to congestion in hospitals during the winter period.
    - The work of community specialist teams was noted and it was stated that there is geriatric medicine cover available and funding in place for same.
    - Delays in patient transfer typically relate to legal (including assisted decision making, although there is legislation now for same) and funding issues rather than delays in assessment. Transitional care funding is an important surge measure used to manage patient flow including step down to contracted rehab beds. Challenges with funding may also result in patients returning to the acute care system, highlighting the need for a person-centred approach.
    - The Pay and Numbers Strategy resulted in vacant posts being lost, e.g., the social inclusion team lost two medical social worker posts for this reason.
    - RK offered an offline discussion regarding HSCP roles.
    - It was noted that the inpatient community specialist team for geriatric support resource is available at nursing homes.
    - Initiatives to support patient flow have been implemented and were noted. The data around primary care from 2010-2019 was noted, including 39 primary care teams with relevant data that can be shared with the group.
    - MC offered an offline discussion regarding Primary Care information.

- As of 31 December 2024, data show that 23.8m home support hours were delivered nationally; 58,546 people were in receipt of home support and there was a 7.4% increase in the number of hours delivered when compared to the same period last year.

- Governance and staffing - acute medical and medical assessment units
  - The Urgent and Emergency Care directorate oversees development and governance of MAUs. The designated clinical lead physician roles rotate every 2–3 years.
  - There are dedicated on-site lead consultant physicians in the AMU in UHL and the Model 2 JEN hospital MAUs.
  - The need for sufficient paediatric consultant posts was emphasised.
  - Funding is provided through Sláintecare and the health regions, with recent increases in funding and resources.
  - Capacity has been impacted by the closure of EDs in the region, recruitment freezes and decreases in budgetary allocations to acute hospitals.
  - It is important to collect and enable access to detailed data on staffing and bed capacity for planning purposes.
  - There is a need for better contextualisation of national policies at the local level.
  - Changes in the demography of the Mid West region including an ageing population may result in increased demand for services, with potential downstream effects on hospitals.
  - Phase 1 and 2 of the Framework for Safe Nurse Staffing and Skill Mix have been implemented in UHL and Model 2 hospitals, with 21 additional nurses allocated to UHL following the reassessment. The National Service Plan has been implemented for 2025, but there has been no increase in the budget for staffing increases. The Pay and Numbers strategy will likely impact the number of posts filled within the framework.
  - The Safe Nurse Staffing Framework does not include HSCP roles. Issues around resourcing of HSCP roles should also be considered.
  - The report should explore challenges in policy-making processes, and especially differences in processes to inform local versus national-level decision making and implementation.

c. HTA Work Stream 2: Background information – data (CMcD)

- The Department of Health and the HSE were thanked for providing access to data. The variations in data completeness across providers and over time was noted. It was highlighted that the data collected are not intended for the purposes they are being used for, so insights from the EAG are critical for interpretation.
- EAG responses to queries raised by the HIQA team and or suggestions or comments from EAG members are summarised below.

- It was noted by a member of the EAG that in UHL, total ED attendances in 2024 increased by 9% from 2023.
- Hospital length of stay (LOS) is only calculated from when a patient is admitted to a ward; as any time spent in the ED is excluded, these data underestimate the time spent by the patient in the hospital.
- High rates of admission with a LOS ≤one day raises questions around the severity of illness and the need for admission.
- A higher proportion of unplanned admissions may reflect a policy to deflect planned activity outside the region including to national centres, contributing to observed differences in the ratio of unplanned vs. planned care.
- The categorisation of beds may impact whether the time spent in the hospital is captured as part of any LOS analysis. The data do not distinguish if the patient is a boarder. Boarding refers to patients who have been admitted but are waiting for an inpatient bed.
- It was queried if the data included ED boarders and ward boarders. It was noted that overnight stays may be due to a lack of access to senior or specialist input to diagnose and treat. It was advised that there was no data to determine if a patient is a boarder or not.
- Discharges from the AMAU/ASAU are counted as hospital admissions and these are included in the estimates, but otherwise care provided entirely in the ED is excluded.
- It was suggested that 2024 UHL data for patients aged over 75 years should be included in the analysis.
- In the UK, demand for urgent care is increasing, while demand for emergency care remains steady.
- It was suggested that variables of interest should be standardised using key metrics of hospital capacity such as bed availability and or volume of presentations such as trolley count.
- There were queries if the data provides information on admissions that were avoidable.
- The indications for admissions that were under one day were also queried and whether or not this data could be compared to data for the other Model 4s.
- The general demography and health of the Mid West population could be examined to see if the age profile and general health differs in the Mid West compared to other regions.
- There are limitations with current data systems and congestion challenges nationally. It was suggested that using NQAIS clinical data for short stays and bed utilisation at UHL should be considered.
- Leadership and management are difficult to quantify based solely on data.
- There were further concerns raised about the limitations in current data systems and it was stressed that ED data needs further examination. In particular, it was noted that time spent in ED does not count towards length of stay for an admission. It was also stated that improved qualitative and quantitative measures

for overcrowding in the ED are needed and that better integration of data on patient flow, resource utilisation and patient outcomes would be useful.

- It was acknowledged that comparing Model 4 hospitals is imperfect due to the structural differences.
- It was stressed that same day emergency care, which provides same day specialist care for emergency patients, without admitting them to a hospital bed, would benefit healthcare delivery across the country and not just for the Mid West.
- Governance challenges and UHL's unique operational environment were noted. It was stated that AMAUs are functioning as extensions of EDs rather than for their intended role.
- A distinction was drawn between avoidable referrals and avoidable admissions.
- A population profile of the Mid West was shared and it was suggested that the paediatric population be excluded from data analysed as many of the Model 4s are adult only.
- It was recommended that any statistics used be reported relative to denominators such as the population served as much as possible so that inferences can be made about the extent to which UHL demand/flow is different from other model 4 hospitals.
- Consideration should be given to the proportion of the population in the Mid West seeking care outside the region. There is an absence of private hospitals in the region, while in other regions private capacity maybe a modifier of demand on public hospitals.

d. ESRI Work Stream 3: Capacity review (CT)

- The ESRI has informed HIQA that national projections have now been submitted to the Department of Health and HSE, with feedback on these national projections awaited before work can commence on regional projections.

e. Healthcare regulation Work Stream 4: Stakeholder engagement (SE)

- There were 1,221 submissions through the public consultation.
- Coding of the responses is now ongoing.
- Face-to-face engagements with stakeholders are also planned to capture more information from respondents.

f. Healthcare regulation Work Stream 5: Regulatory monitoring (SE)

- SE provided a brief update on the purpose of Work Stream 5. Information sources will include:
  - HIQA inspection reports
  - Further consultation with both GPs and the National Ambulance Service.

g. HTA Work Stream 6: International review (MN)

- This review will look at interventions that can impact on ED overcrowding.

- It was suggested to consider interventions which can be implemented during times of severe pressure in ED but that transferability from one country to another might not be possible.

6. Next steps (MR)
   - MR informed attendees that written feedback following today's meeting could be submitted by Friday 14 February 2025 and would be taken into consideration.
   - A briefing will be provided to the Minister of Health in February, with the report due to the Minister by the end of May 2025.
7. AOB
   - No other business was raised.

This meeting closed at 12:56

Actions arising from this meeting

No	Action	Responsibility	Status
1	Arrange offline discussion with RK regarding HSCP roles	LL	Complete
2	Arrange offline discussion with MC regarding Primary Care information	LL	Complete

4. Third Meeting of the Expert Advisory Group

Third meeting of the Expert Advisory Group

Review of urgent and emergency healthcare services in the

Health Service Executive Mid West

Monday 07 April 2025, 2-4.35pm (via Zoom)

Minutes

Expert Advisory Group Attendees:

Name	Initials	Details
Sandra Broderick	**SB**	Regional Executive Officer, Mid West health region, HSE
Prof Sara Burke	**SBu**	Associate Professor and the Director of the Centre for Health Policy and Management, Trinity College Dublin
Prof John Browne	**JB**	Professor of Epidemiology & Public Health, University College Cork
Ian Carter	**IC**	Mid West Integrated Healthcare Area Manager, Acute and Older Person Services, HSE
Margaret Costello*	**MC**	Head of Service, Primary Care, HSE Mid West Community Healthcare
Prof Garry Courtney	**GC**	Clinical Lead, Acute Medicine National Clinical Programme, HSE
Dr Gino De Angelis	**GDeA**	Manager, Clinical Research, Canada's Drug Agency
Dr Michael Dockery	**MD**	Clinical Lead, National Clinical Programme for Anaesthesia (NCPA), HSE
Dr Des Fitzgerald	**DF**	Consultant in Emergency Medicine, University Hospital Waterford *Nominated by:* National Clinical Programme for Emergency Medicine
Patrick Glackin	**PG**	Area Director, Nursing and Midwifery Planning and Development (NMPD) (Mid West, West and North), HSE
Janet Grene	**JG**	Honorary Secretary, University of Limerick Hospitals Group (ULHG) Patient Council
Dr David Hanlon	**DH**	National Clinical Advisor and Group Lead Primary Care, HSE
Dr Patricia Harrington	**PH**	Deputy Director, Health Technology Assessment, HIQA
Dr Orla Healy	**OH**	National Clinical Director of Quality and Patient Safety, HSE
Dr Martina Healy	**MH**	Clinical Lead, National Clinical Programme for Critical Care, HSE
Dr Terence Hennessy	**TH**	Regional Clinical Lead for Strategy and Development for HSE Mid West
Joe Hoare	**JH**	Assistant National Director, Capital & Estates Mid West, HSE
Dr Graham Hughes	**GH**	Clinical Lead, National Clinical Programme for Older People (NCPOP), HSE
Dr Paul Kavanagh	**PK**	Consultant in Public Health Medicine, National Health Intelligence Unit, HSE
Ruth Kilcawley	**RK**	Assistant National Lead of Health & Social Care Professions, HSE
Sinead Lardner	**SL**	National Lead for Safe Nurse Staffing & Skill Mix, HSE
Dr Margie Lynch*	**ML**	Medical Director, ShannonDoc *Nominated by:* Irish College of General Practitioners
Dr Mai Mannix	**MM**	Regional Director of Public Health, Public Health Mid West, HSE
Prof Peter McCarthy	**PMcC**	Former Dean of the Faculty of Radiologists and Radiation Oncologists

Dr David Menzies	**DM**	Deputy Clinical Director (Emergency Care), National Ambulance Services and Consultant in Emergency Medicine
Niall Murray	**NM**	General Manager, National Ambulance Services Operations, Mid West Region
Michelle O' Neill	**MON**	Deputy Director, Health Technology Assessment, HIQA
Anne O' Shea Clarke	**SOSC**	Patient representative, SAGE Advocacy
Dr Catherine Peters	**CP**	Mid West Clinical Regional Director, HSE
Prof Eamonn Rogers	**ER**	Co-Lead of the National Clinical Programme for Surgery (NCPS), HSE
Dr Máirín Ryan (Chair)	**MR**	Director of Health Technology Assessment and Deputy Chief Executive Officer, HIQA
Dr Nigel Salter	**NS**	Consultant in Emergency Medicine, St. Vincent's Hospital *Nominated by:* Irish Association for Emergency Medicine
Mr Keith Synnott	**KS**	National Clinical Lead for Trauma Services, HSE and Consultant Orthopaedic Surgeon at the Mater Misericordiae Hospital
Dr Conor Teljeur	**CT**	Chief Scientist, Health Technology Assessment, HIQA
Dr Kieran Walsh	**KW**	Deputy Director, Health Technology Assessment, HIQA
Patricia Whelehan	**PW**	Assistant National Director, Older Person Services, National Office Access and Integration, HSE *Nominated by*: Director of Community Services, HSE
Ms Jo Williams	**JW**	Patient representative, Patients for Patient Safety Ireland

*Alternate for Maria Bridgeman

Apologies:

Name	Initials	Details
Maria Bridgeman	**MBr**	HSE Mid West Community Care
Dr Sheelah Connolly	**SC**	Senior Research Officer and joint Research Area Coordinator for Health and Quality of Life research, Economic and Social Research Institute (ESRI)
Sean Egan	**SE**	Director of Healthcare Regulation, HIQA
Prof Liam Glynn	**LG**	Professor of General Practice, University of Limerick
Dr Ciara Martin	**CM**	National Clinical Advisor and Group Lead for Children and Young People, HSE
Kate O' Flaherty	**KOF**	Director of the National Patient Safety Office, Department of Health

In attendance:

Name	Initials	Details
Mr Martin Boudou	**MBo**	HIQA
Dr Louise Larkin	**LL**	HIQA
Dr Arielle Maher	**AM**	HIQA
Mr Dane Moriarty	**DM**	HIQA
Dr Cillian McDowell	**CMcD**	HIQA
Dr Michelle Norris	**MN**	HIQA
Dr Kirsty O'Brien	**KOB**	HIQA
Dr Lydia O'Sullivan	**LOS**	HIQA
Mr John Tuffy	**JT**	HIQA

1. Welcome from the Chair (Máirin Ryan)

- MR opened the meeting and welcomed those in attendance at the meeting.

- New members of the EAG (SBu, GDeA, TH) were welcomed.

2. Apologies and introductions (MR)

- Introductions were made and apologies noted.

3. Minutes (MR)

- Minutes from the previous meeting, which had been circulated in advance, were formally adopted having been agreed by all.
- Actions from the previous meeting were noted as complete.

4. Group management and protocols

a. Confidentiality and Statements of Interest (MR)

- MR gave the opportunity for attendees to raise any new conflicts — none were raised.

5. Work programme

a. Work stream overview and timelines (LL)

- Overview of the work programme and its work streams given to attendees.
- Attendees were informed that the fourth EAG has been postponed

b. ESRI Work Stream 3: Capacity review (CT)

- An update on the progress of the review was provided, noting that work on draft regional projections is ongoing.

c. HTA Work Stream 2: Background information – data (CMcD)

- CMcD presented an overview of Work Stream 2, noting that the draft report was circulated to the EAG in advance of the meeting.
- EAG responses to queries raised by the HIQA team and suggestions or comments from EAG members are summarised below, grouped by issue.
    - The quality of the report presented was acknowledged by members of the EAG.
    - Clarity was sought as to whether the presented data indicated that there are fewer high acuity presentations in UHL compared with other Model 4

hospitals. It was confirmed that a lower than expected number of high acuity triage scores (1 and 2) presented at UHL ED. It was noted that the different distribution of acuity scores may be influenced by the availability of local injury units (LIUs) in the region. Activity in the Mid West may be different to the rest of country and the relationship between regional context and triage scores was noted. Relative to other regions, higher admission rates at UHL and lack of access to specific diagnostics were raised.

- It was suggested that the negative media coverage may explain why there are fewer high-acuity presentations to UHL, with patients potentially opting to present at other hospitals outside of the Mid West.
- Clarity was also sought regarding hospital transfers to and from Model 2 hospitals in the Mid West and UHL. It was confirmed that the analysis demonstrated higher transfer rates from UHL compared with other Model 4 hospitals.
- There may be anomalies in how data are captured, making comparisons challenging. In UHL part of a patient's entire stay could be in the AMAU, with this contributing to the observed lower than average length of stay for UHL. A previously conducted study focusing on triage score analysis was noted.
- There may be an expectation that this review will present the mortality within the ED and the wards. It was suggested that mortality could be examined by linking HIPE and CSO data. Analysing data such as admission rate or triage scores by age groups, would be beneficial. A relevant academic article was shared. It was emphasised that despite data limitations, safety and mortality data could be considered.
- General data limitations regarding the data collection approach were noted, including the inability to link hospital (HIPE) and ED (PET) data. It was noted that while in-hospital mortality is documented in HIPE, there are questions around the accuracy of the PET ED mortality data; such an analysis may present an incomplete picture in the context of urgent and emergency care.
- Additional data variables and sources could be explored, for example analysing absenteeism rates by staff grades, and considering data from NQAIS clinical or patient experience surveys.
- It was also suggested that staff morale might be negatively impacted by this media coverage.

- The older profile of patients in the Mid West and potential lack of beds to meet requirements of older patients was noted. Further data for older patients in UHL prior to 2009 is available and can be shared by SB with the EAG. A recent publication on geriatric assessment in the ED in UHL was noted.
- Senior decision-making presence at UHL is viewed as operating well in the Mid West.
- There was agreement that the solution to the challenges in the Mid West is multi-faceted.

d. HTA Work Stream 6: Interventions review (MN) and Standards review (LOS)

- MN presented an overview of Work Stream 6a Interventions review, noting that the draft report was circulated to the EAG in advance of the meeting.
- EAG responses to queries raised by the HIQA team and suggestions or comments from EAG members are summarised below, grouped by issue.
  - There is a need for long-term evaluation of interventions. No interventions with negative outcomes were identified in the systematic review.
  - It was noted that there may be differences in the extent to which hospitals use trolleys to supplement capacity, which may pose challenges when using activity levels to inform appropriate bed numbers. It was also noted that a distinction should be made between scheduled and unscheduled care beds. It was suggested that increasing bed capacity could help reduce short-term pressures, but there is no evidence that it is effective in the long-term. In UHL, there are no obvious issues with patient waiting lists.
  - Virtual wards are in place at ULHG and work well. Virtual wards support services with a lack of outpatient capacity.
  - It was suggested there is a need to ensure adequate capacity and capability to monitor and evaluate the effectiveness of any interventions that are implemented.
  - While demand for ED attendances is generally predictable, it can be subject to substantial variability. This variability can lead to periods when demand is lower than expected and equally periods when demand exceeds capacity, contributing to overcrowding. Interventions should address the variability in demand.
  - Consideration should be given to the possibility that AMU/ASAU are under-utilised in Model 2 hospitals in the Mid West due to a lack of diagnostics

capacity. It was noted that NQAIS clinical could capture most of the data for AMU/ASAU.
    - It was suggested that it may be helpful to engage with the HSE regarding strategies to address data limitations.

- LO'S presented an overview of work stream 6b Standards review, noting that the draft report was circulated to the EAG in advance of the meeting.
- EAG responses to queries raised by the HIQA team and suggestions or comments from EAG members are summarised below, grouped by issue.
    - It was noted that the reported ED requirements for the different countries and regions should be considered within the context of their broader health systems.

e. Healthcare regulation Work Stream 4: Stakeholder engagement (JT)

- JT presented an overview of Work Stream 4 Stakeholder engagement.
- EAG responses to queries raised by the HIQA team and suggestions or comments from EAG members are summarised below, grouped by issue.
    - Feedback from stakeholders in Mid West was positive in terms of engagement from HIQA. Participants felt that they were listened to and their opinions were valued.
    - The report could be structured in consideration of the model of five types of public participation (that is, IAP2 Spectrum of Public Participation).
    - It was mentioned that GPs and their practices are changing and therefore hospital models need to change alongside this.
    - The perception differences between public and clinical staff were discussed. Public opinion is that ED overcrowding is an ED problem, whereas clinician views are that it is a hospital capacity issue.

f. Healthcare regulation Work Stream 5: Regulatory monitoring (JT)

- JT presented an update on work stream 5 Regulatory monitoring.

6. Next steps (MR)

- Date for final EAG meeting is to be confirmed.
- MR informed attendees that feedback following today's meeting could be submitted by Friday 11 April 2025 and would be taken into consideration.

7. AOB

- No other business was raised.

The meeting ended at 16:35.

Actions arising from this meeting

No	Action	Responsibility
1	Confirm the next EAG meeting date	LL

5. Fourth Meeting of the Expert Advisory Group

Fourth meeting of the Expert Advisory Group

Review of urgent and emergency healthcare services in the

Health Service Executive Mid West

Thursday 28 August 2025, 1-3pm (via Zoom)

Minutes

Expert Advisory Group Attendees:

Name	Initials	Details
Maria Bridgeman	**MB**	Integrated Healthcare Area Manager, Limerick City and North Tipperary, HSE
Sandra Broderick	**SB**	Regional Executive Officer, Mid-West health region, HSE
Prof John Browne	**JB**	Professor of Epidemiology & Public Health, University College Cork
Prof Sara Burke	**SBu**	Associate Professor and the Director of the Centre for Health Policy and Management, Trinity College Dublin
Ian Carter	**IC**	Mid-West Integrated Healthcare Area Manager, Acute and Older Person Services, HSE
Dr Sheelah Connolly	**SC**	Senior Research Officer and Joint Research Area Coordinator for Health and Quality of Life Research, Economic and Social Research Institute (ESRI)
Dr Gino De Angelis	**GDeA**	Manager, Clinical Research, Canada's Drug Agency
Sean Egan	**SE**	Director of Healthcare Regulation, HIQA
Dr Des Fitzgerald	**DF**	Consultant in Emergency Medicine, University Hospital Waterford. *Nominated by:* National Clinical Programme for Emergency Medicine
Patrick Glackin	**PG**	Area Director, Nursing and Midwifery Planning and Development (NMPD) (Mid West, West and North), HSE
Prof Liam Glynn	**LG**	Professor of General Practice, University of Limerick *Nominated by:* Irish College of General Practitioners
Janet Grene	**JG**	Honorary Secretary, University of Limerick Hospitals Group (ULHG) Patient Council
Dr David Hanlon	**DH**	National Clinical Advisor and Group Lead Primary Care, HSE
Dr Patricia Harrington	**PH**	Deputy Director, HTA, HIQA
Dr Martina Healy	**MH**	Clinical Lead, National Clinical Programme for Critical Care, HSE
Dr Terence Hennessy	**TH**	Regional Clinical Lead for Strategy and Development for HSE Mid-West
Joe Hoare	**JH**	Assistant National Director, Capital & Estates Mid-West, HSE
Dr Graham Hughes	**GH**	Clinical Lead, National Clinical Programme for Older People (NCPOP), HSE

Dr Paul Kavanagh	**PK**	Consultant in Public Health Medicine, National Health Intelligence Unit, HSE
Ruth Kilcawley	**RK**	Assistant National Lead of Health & Social Care Professions, HSE
Sinead Lardner	**SL**	National Lead for Safe Nurse Staffing & Skill Mix, HSE
Dr Mai Mannix	**MM**	Regional Director of Public Health, Public Health Mid-West, HSE
Prof Peter McCarthy	**PMcC**	Consultant Radiologist, Former Dean of the Faculty of Radiologists and Radiation Oncologists
Niall Murray	**NM**	General Manager, National Ambulance Services Operations, Mid-West Region
Kate O' Flaherty	**KOF**	Director of the National Patient Safety Office, Department of Health
Anne O' Shea Clarke	**SOSC**	Patient representative, SAGE Advocacy
Dr Catherine Peters	**CP**	Mid-West Clinical Regional Director, HSE
Prof Eamonn Rogers	**ER**	Co-Lead of the National Clinical Programme for Surgery (NCPS), HSE
Dr Máirín Ryan (Chair)	**MR**	Director of Health Technology Assessment and Deputy Chief Executive Officer, HIQA
Dr Nigel Salter	**NS**	Consultant in Emergency Medicine, St. Vincent's Hospital. Irish *Nominated by:* Association for Emergency Medicine
Dr Conor Teljeur	**CT**	Chief Scientist, Health Technology Assessment, HIQA
Dr Kieran Walsh	**KW**	Deputy Director, HTA, HIQA
Jo Williams	**JW**	Patient representative, Patients for Patient Safety Ireland

Apologies

Name	Initials	Details
Dr Orla Healy	**OH**	National Clinical Director of Quality and Patient Safety, HSE
Michelle O' Neill	**MON**	Deputy Director, Health Technology Assessment, HIQA
Patricia Whelehan	**PW**	Assistance National Director, Older Person Services, National Office Access and Integration, HSE *Nominated by:* Director of Community Services, HSE

Not attending as alternate

Name	Initials	Details
Dr Margie Lynch	**ML**	Medical Director, ShannonDoc *Nominated by:* Irish College of General Practitioners

In attendance

Name	Initials	Details
Martin Boudou	**MBo**	HIQA
Dr Louise Larkin	**LL**	HIQA

Denise Lawler	**DL**	HIQA
Dane Moriarty	**DMo**	HIQA
Dr Cillian McDowell	**CMcD**	HIQA
Maeve McGarry	**MMcG**	HIQA
Dr Michelle Norris	**MN**	HIQA
Dr Lydia O'Sullivan	**LOS**	HIQA
John Tuffy	**JT**	HIQA

1. Welcome from the Chair (Máirín Ryan)
   - MR opened the meeting and welcomed those in attendance.

2. Apologies and introductions (MR)
   - Introductions were made and apologies noted.

3. Minutes (MR)
   - Comments were sought in relation to the draft minutes from the previous meeting, which had been circulated in advance. MR noted that a minor clarification will be made to the minutes and that they will be re-circulated for final approval.
   - Actions from the previous meeting were noted as complete.

4. Group management and protocols

a. Confidentiality and Statements of Interest (MR)
   - MR gave attendees the opportunity to raise any new conflicts of interest. No new conflicts were raised.

5. Work programme

a. Work stream overview and timelines (LL)
   - LL provided an overview of the work programme and outlined the timelines for each work stream.

b. HTA Work stream 1: Background information – policy (MN)
   - MN presented changes made to the report. No further comment was received.

c. HTA Work stream 2: Background information – data (CMcD)
   - CMcD presented changes made to the report. No further comment was received.

d. HTA Work stream 6: Interventions review (MN) and Standards review (LOS)
   - MN presented changes made to the report. No further comment was received.
   - LOS presented changes made to the report. No further comment was received.

e. Healthcare regulation Work stream 4: Stakeholder engagement (JT)

- JT presented changes made to the report. No further comment was received.

f. Advice (SE)

SE provided an overview of the Advice.

A detailed discussion ensued with the following points noted:

- The current approach in the data report to displaying emergency department (ED) presentations at University Hospital Limerick (UHL) per capita may lead people to believe that UHL has fewer ED presentations than other Model 4 hospitals; when in absolute terms, it actually has a higher number of presentations than other Model 4 hospitals. It was suggested that presenting only the per capita figures without the absolute figures may be misleading. It was noted that the presentation of both the absolute and per capita data within the data report would be considered.
- Access to ED and ED overcrowding were recognised as distinct issues that should be addressed separately.
- A distinction was made between admissions to hospital and presentations to the ED.
- It was suggested that sociodemographic detail could be added to the problem statement, on the basis that deprivation in the Mid West may be influencing the high number of ED attendances.
- There was a discussion on some of the assumptions used in the ESRI projections for demand and bed capacity requirements for public acute hospitals. It was noted that the ESRI draft report on regional projections was made available to the HIQA Evaluation Team on a confidential basis. It is anticipated that the ESRI report will be publicly available in advance of publication of the HIQA report.
- The proposed additional 224 beds were not considered to be sufficient to bring the Mid West in line with other regions in the future, given that other regions are already in the process of increasing capacity, with provision of additional beds through the Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031. It was clarified that the 224 beds related to Model 4 beds at UHL only and did not include any Model 2 beds.
- An update was provided on the second 96-bed block at UHL; it was noted that this block would likely not be operational until Q1 2029.
- Expansion of diagnostic and laboratory services may be required as demand is not solely addressed by increased bed numbers. It was clarified that the intention of the wording in the Advice was to highlight that when providing additional

inpatient beds, there may be a requirement for a commensurate increase in supporting services, including diagnostics.

- It was clarified that the analysis of occupancy and length of stay in Model 4 hospitals included data on both adult and paediatric beds; CHI data were, however, excluded.
- It was stated that maternity services should ideally be co-located from a clinical perspective, in line with national policy. Implications of maternity service co-location at the UHL site for construction of further inpatient capacity were noted.
- There was a detailed discussion on the configuration of services in the Mid West and specifically the potential role, if any, for a Model 3 hospital or an additional Model 4 hospital and the challenges associated with same. Some EAG members expressed concern about development of a Model 3 hospital, with other EAG members being supportive of this as a potential option and noting that in the longer term there is the potential for this to be required in the region. Concerns were raised regarding the creation of a new Model 3 hospital, given the recognised national experience of staffing, clinical and operational challenges specifically in relation to critical care and emergency services in these hospitals. Concern was also expressed that addition of a second Model 4 hospital would dilute the focus of services in the region. There was no consensus amongst EAG members as to which singular option presented might represent the optimal approach.
- The potential to define the level of demand and or population size that would justify the development of an additional Model 3 or 4 hospital was raised. The changing population of the Mid West in the immediate and long-term future was emphasised, with the observation that recently-published Central Statistics Office (CSO) population projections suggested that the Mid West will have the largest increase in the country (11%). It was clarified by the HIQA Evaluation Team after the EAG meeting that in the CSO estimates, the Mid-West region (as distinct from the HSE Mid West) had projected growth below the national average in all modelled scenarios.
- An undergraduate medical programme is starting next year in the region, and it was noted that this should be factored into decision-making around future staffing. Moreover, it was noted that any decisions around the configuration of services in the region should take consideration of other new national policies.
- The need for careful consideration of the language for communicating the Advice was noted.
- It was highlighted that the dedication and commitment of the workforce in the Mid West should be emphasised in the report.

- The importance of future capacity planning was stressed.
- The importance of reflecting the ESRI's projection of a substantial increase in requirements for long-term care beds by 2040 was emphasised.

6. Next steps (MR)
   - MR outlined the next steps in the process.
   - Feedback on the reports is welcomed until 3 September 2025.
7. AOB
   - Attendees were thanked for their contribution to the programme of work.

The meeting ended at 15.00.

Actions arising from this meeting

No	Action	Responsibility
1	Consideration of the framing of the data in report	CT, CMcD
2	Advice to be reviewed	SE