Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

A summary of the key health system and policy recommendations and decisions that have impacted urgent and emergency healthcare services in the Health Service Executive Mid West health region (2000 to 2024)

Work stream 1 of the Review of urgent and emergency healthcare services in the Health Service Executive Mid West health region

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Conflicts of Interest

None reported.

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Plain language summary

Background

The HSE Mid West region covers Limerick, Clare and North Tipperary and is called the Mid West in this report. There are six hospitals in the Mid West: University Hospital Limerick (UHL), University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St John's Hospital. These hospitals work together and are called the University of Limerick Hospitals Group (ULHG). In 2024, the Minister for Health asked HIQA to look at how urgent and emergency healthcare is working in the Mid West. This report describes the main health system and policy recommendations and decisions that have affected urgent and emergency healthcare in this region, between 2000 and 2024.

Key findings

We gathered 80 different sources that provided information for this report. Some of the main recommendations and decisions found were about:

- *Reorganisation of the health services in the Mid West*
  This included reports from 2003 to 2008 which recommended closure of the 24/7 (24-hours a day, 7-days a week) emergency departments (EDs) in Ennis, Nenagh and St John's Hospitals. In 2009, the EDs were replaced with medical assessment units. These units provide assessment, diagnosis and treatment for patients referred with urgent medical problems that are not a threat to their lives. This means that since 2009, there has been one ED (located in UHL) providing emergency care in the Mid West. This change happened even though the extra support UHL received between 2008 and 2009 was limited. A new ED in UHL was opened in 2017.
- *Capacity (how the health system is able to care for people, when they need it)*
  This included ULHG highlighting that between 2014 and 2018 they did not have the resources (like facilities and staff) to meet the needs of patients. There are projects planned or already happening in the Mid West to help increase capacity. These projects include adding new hospital beds, creating a new surgery area, and getting more beds in step-down facilities.
- *Patient flow (how patients move through the health system)*
  This included steps to reduce the need for people to go to the ED in UHL. Reports from 2000 to 2024 noted the creation of minor injury units and medical assessment units, and extending GP opening times outside of regular business hours in the region.
- *Community healthcare (care outside of the hospital setting)*

This included actions to develop acute hospital services, supporting hospitals and communities to work together to provide care. The Enhanced Community Care programme was also developed to help health and social care services manage care closer to the home.

- *Staffing*
  This included recommendations to increase staff numbers, such as consultant and non-consultant hospital doctors to manage demand in the ED. Hiring of health and social care professionals (such as physiotherapists), and staff to manage beds, to support patients after they are admitted, was also recommended. However, a hiring freeze that started in 2009 impacted the hiring of health service staff.

- *Governance (how decisions are made)*
  This included reports from 2022 that found that measures in place in UHL to manage demand and patient flow in the ED and across the hospital were not working well. A 2023 HIQA inspection of the UHL ED found that care is being managed better than before.

- *Funding (money)*
  This included reduced public spending in some of the healthcare budgets between 2007 and 2016. In 2024, ULHG reported that additional funding was helping them to hire more staff, to increase the opening hours in the medical assessment units in the Mid West, to help develop staff, and to get more beds in the community.

Conclusion

A number of changes had a big effect on urgent and emergency healthcare services in the Mid West over the last 24 years. These include:

- the replacement of 24/7 EDs in Ennis, Nenagh and St. John's Hospitals with medical assessment units in 2009
- a hiring freeze that started in 2009
- reduced public spending in some of the healthcare budgets between 2007 and 2016
- the opening of the new ED in UHL in 2017
- extra funding and resources in 2023 and 2024.

Recent increases in funding and resources have led to a number of programmes and projects being put in place to help improve the safety and quality of care in the Mid West. Not all of these have been fully rolled out yet, and the overall impact of these efforts has not been reviewed yet. Key policies, strategies and programmes, like Sláintecare and the National Maternity Strategy, will need to be considered in any future planning for the Mid West.

Key Points

- The term 'Mid West', as used throughout this report, refers specifically to the HSE Mid West health region. Acute hospital care in the Mid West is currently delivered by the University of Limerick Hospitals Group (ULHG) which comprises six hospitals: University Hospital Limerick (UHL), University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St John's Hospital.
- In 2024, the Minister for Health requested that HIQA conduct a review of urgent and emergency care in the Mid West with the primary objective of ensuring safe, quality, acute care in the region.
- This report summarises the key health system and policy recommendations and decisions that have impacted urgent and emergency healthcare services in the Mid West, between 2000 and 2024.
- A grey literature search identified 80 key resources from sources including national public bodies (such as the HSE and HIQA), public body groups and committees (such as the HSE Emergency Department Task Force), regional health bodies (such as ULHG), consulting groups and news sources.
- A descriptive analysis of information and or recommendations was undertaken and summarised with respect to seven key aspects: the health system, capacity, patient flow, community healthcare, staffing, governance, and funding.

The health system

- Since 2000, multiple health service reconfigurations have occurred in the Irish health system. From 2003 to 2009, three reports recommended reconfiguration of urgent and emergency services health services in the Mid West. These recommendations included:
    - closure of emergency departments (EDs) in Ennis, Nenagh and St John's Hospitals
    - designation of the Mid-Western Regional Hospital, Limerick (now known as UHL) as the centre responsible for managing major emergencies in the region
    - that reconfiguration should only occur after UHL had been resourced to facilitate these changes.
- In 2009, the EDs at Ennis, Nenagh and St John's Hospitals were replaced by medical assessment units (MAUs), with patients requiring emergency services

being directed to UHL. This occurred despite limited additional resourcing of UHL between 2008 and 2009.

- In 2010, the National Acute Medicine Programme recommended a new designation system for acute hospitals, with these designated as Models 1-4, based on the services provided. Further clarity regarding the role of, and services provided by Model 2/2S hospitals was provided in the 2013 *Securing the Future of Smaller Hospitals* framework. Acute hospital services in the Mid West were realigned in accordance with this model, with care provided across one Model 4 (UHL) and three Model 2/2S (St John's, Ennis and Nenagh [JEN]) hospitals.
- Multiple reports have recommended integrated care across the health system, with the 2018 Sláintecare Implementation Plan noting the planned development of the Integrated Care Programme for Older People (ICPOP) and the Integrated Care Programme for Chronic Diseases. Since 2020, ICPOP has been operational at ULHG and is reported to be facilitating hospital avoidance and early discharge.

Capacity

- A need for increased bed capacity in both acute and non-acute settings on a national scale was highlighted in reports throughout 2000-2024. Two national reports highlighted that average bed occupancy in Irish hospitals was often between 95% and 100%, exceeding the average upper threshold of 85% for bed occupancy adopted by the OECD.
- Across 2014 to 2018, operational plans from ULHG highlighted that capacity and facilities were inadequate to meet the needs of their patients. A number of projects are underway or planned to increase capacity across ULHG, including the building of new bed blocks, a new surgical hub, and procurement of beds in step-down and rehabilitation facilities.
- An acute medical unit (AMU) opened in UHL in 2013. However, HIQA inspections of the UHL ED in 2023 observed that the practice of accommodating patients awaiting inpatient beds in the AMU was impeding its full functionality. The Geriatric Emergency Medicine Unit (GEMU) opened in UHL ED in 2022, which as of April 2024, was operating seven days a week, with 24-hour operation during weekdays.

Patient flow

- Reports throughout 2000-2024 consistently highlighted the need to expand and maximise use of alternative access routes to urgent care, to reduce ED

presentations. These included the establishment of minor injury units and MAUs, and the extension of GP out-of-hours services.

- The 2024 UHL Support Team reported that referring suitable patients to the MAUs in the Model 2 JEN hospitals was an effective enabler to avoid admissions. However, the team highlighted that better integration of services across the Mid West was required to guide suitable patients to the MAUs in line with available resources.
    - The phased extension of the MAU opening hours to 24/7 across Model 2 JEN hospitals, announced in April 2024, is yet to be achieved (as of January 2025). However, there are concerns around extending MAU hours without appropriate resources.
    - Additionally, St. John's and Nenagh have either limited or a lack of on-site laboratory diagnostics, with samples taken on-site sent to the lab at UHL, as required.
- HIQA's inspection of the UHL ED in November 2023 identified that several programmes or initiatives such as GEMU, ICPOP, community intervention teams and the Pathfinder Programme, were successfully supporting hospital avoidance and discharge. UHL's compliance plan outlined that it would continue to maximise daily transfers to the Model 2 JEN hospitals.

Community healthcare

- The 2018 Sláintecare Implementation Plan included a strategic action to develop and modernise the acute care system to address capacity challenges and increase integration between the hospital sector and community-based care. The 2021 Sláintecare Implementation Strategy & Action Plan included a work stream for an Enhanced Community Care programme. In 2024, ULHG noted that a governance structure had been established to deliver the Enhanced Community Care programme.
- Primary care services in the Mid West include two out-of-hours' GP services, Shannondoc and Limerick Doc. In 2022, Deloitte highlighted continued challenges in accessing primary care in the Mid West.

Staffing

- The 2022 Deloitte Patient Flow Report outlined the need to increase ED and ward staffing at UHL. This included the need to increase availability of consultant and non-consultant hospital doctors to manage pre-admission demand, and the number of health and social care professionals (HSCPs) and bed management resources to manage post-admission demand. Deloitte also

noted a staffing shortage in all HSCP disciplines in UHL, which was exacerbated by historical under-resourcing of these disciplines.

- In 2024, the independent investigation of UHL by former Chief Justice Frank Clarke recommended a review of the role coordination of doctors in the ED, and the application of safer nurse staffing levels across the health service to increase efficiency and transparency in the allocation of staff and resources.

Governance

- Two reports in 2022 (by HIQA and Deloitte) found that effective arrangements were not in place at UHL to manage demand and patient flow in the ED and across the hospital. Following inspection of the UHL ED in November 2023, HIQA outlined that operationally, UHL was functioning better than on previous inspections, and had defined management arrangements in place to oversee the delivery of care in the ED.
- Multiple reports from the early 2000s made recommendations around the governance of AMUs and or MAUs, highlighting the importance of each unit having a designated clinical lead. As of February 2025, it was confirmed that there were dedicated on-site lead consultant physicians at the AMU in UHL and the MAUs in the Model 2 JEN hospitals.

Funding

- The 2021 Sláintecare Implementation Plan, the 2022 Business Case for Implementation of Regional Health Areas, and the 2023 Organisational Reform HSE Health Regions Implementation Plan detailed a move towards a population-based funding model. This model aims to distribute funding based on profiling, segmentation, and needs assessment, which can ultimately be administered by health regions. Accordingly, reconfiguration of the health system into six health regions is underway (with final implementation to take place in 2025). ULHG has highlighted that this reconfiguration, in tandem with the integration of services, will support financial resilience.
- In 2024, UHL reported funding that enabled it to commence recruitment to achieve safer nurse staffing levels in all wards; extend opening hours in the region's MAUs; provide additional step-down and rehabilitation beds; develop GP and ANP roles in the ED; and develop a Social Inclusion Integrated Hospital to Community Team.

Overall

- Key recommendations were identified around the reconfiguration of health services; bed capacity; the optimal use of current capacity; processes to enable

patient flow; integrated healthcare and capacity in the community; and governance.

- Notable actions that have significantly impacted urgent and emergency healthcare services in the Mid West over the last 24 years include: the replacement in 2009 of 24/7 EDs in Ennis, Nenagh and St. John's Hospitals with MAUs; the general moratorium on public service recruitment and promotion implemented in 2009; reductions in some of the healthcare budgets between 2007 and 2016; the opening of the new ED in UHL in 2017; and the provision of increased funding and resourcing across 2023 and 2024.
- Any future planning for the Mid West will need to consider key policies, strategies and programmes, particularly those affecting configuration and design of services, those aimed at centralisation of complex work and those aimed at staffing.
- While increased funding and resourcing in the last number of years has led to a number of initiatives to support the delivery of safe, quality care in the Mid West, not all of these have been fully implemented and systematic evaluation of the individual and collective impact of these initiatives has not yet been undertaken.

List of abbreviations used in this report

A&E	Accident & Emergency
ABF	Activity-Based Funding
ALOS	Average Length of Stay
AMAU	Acute Medical Assessment Unit
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
APP	Alternative Pre-Hospital Pathway
ASAU	Acute Surgical Assessment Unit
CDU	Clinical Decision Unit
CEO	Chief Executive Officer
CHO	Community Healthcare Organisation
CIT	Community Intervention Team
CNU	Community Nursing Unit
CST	Community Specialist Teams
EAG	Expert Advisory Group
ECC	Enhanced Community Care
ED	Emergency Department
EMEWS	Emergency Medicine Early Warning System
GEMU	Geriatric Emergency Medicine Unit

GP	General Practitioner
HALP	Hospital Ambulance Liaison Person
HCA	Healthcare Assistant
HG	Hospital Group
HIQA	Health Information and Quality Authority
HSCP	Health and Social Care Professional
HSE	Health Service Executive
ICPOP	Integrated Care Programme for Older People
ICU	Intensive Care Unit
ISA	Integrated Service Area
JEN	St. John's, Ennis and Nenagh Hospitals
LICC	Local Integrated Care Committee
LIU	Local Injury Unit
LOS	Length of Stay
MAU	Medical Assessment Unit
MDW	Medical Day Ward
MWHB	Mid-Western Health Board
NAMP	National Acute Medicine Programme
NAS	National Ambulance Service
NCHD	Non-Consultant Hospital Doctor

NDTP	National Doctors Training and Planning
OPD	Outpatient Department
POCT	Point-of-Care Testing
RCSI	Royal College of Surgeons Ireland
SDEC	Same Day Emergency Care
UEC	Urgent and Emergency Care
UHG	University Hospital Galway
UHL	University Hospital Limerick
UL	University of Limerick
ULHG	UL Hospitals Group
WTE	Whole Time Equivalent

1 Background

Overcrowding in the emergency department (ED) of a hospital occurs due to deficiencies in hospital and community capacity, capability and control processes resulting in an inability to meet patients' needs in a timely manner.[1-5] Multiple factors can contribute to overcrowding, including challenges with respect to bed capacity; the availability of diagnostics, senior in-house specialty assessment and other ED supports; internal control processes; the level and availability of clinical decision-making; and community and continuing care capacity and processes.[5] ED overcrowding is a significant issue worldwide and can lead to longer waiting times for patients to be assessed and admitted if required. It can also increase the chance of readmission, length of stay (LOS), medication errors, mortality and costs for the hospital.[6]

Within Ireland, hospital overcrowding has been a concern for the last number of decades.[7-13] Recently, this concern has significantly increased, with a bed capacity deficit reported in public acute hospitals.[12] Additionally, it is acknowledged that a growing and ageing population places increased demands on healthcare services in Ireland.[12] ED overcrowding has also been highlighted as a specific area of concern. A HIQA report *(Overview Report: Monitoring programme against the national standards in emergency departments in 2022)* outlined the findings from an initial seven EDs in Ireland that were assessed against four national standards related to governance, leadership and management (National Standard 5.5), workforce (National Standard 6.1), person-centred care (National Standard 1.6) and safe and effective care (National Standard 3.1).[14] This overview outlined that five of the seven EDs assessed were over capacity at the time of inspection,[14] with inspections carried out in the March to September period of 2022.[15-21] It was also outlined that ED overcrowding poses a health and safety risk to patients, and compromises the dignity and respect of patients.[14]

One of the EDs assessed for compliance in 2022 was that of University Hospital Limerick (UHL). Following the March 2022 assessment, HIQA escalated concerns regarding ED capacity to both the University of Limerick Hospitals Group (ULHG) and the Health Service Executive (HSE).[15] This was in line with previous concerns noted by HIQA and ULHG in relation to both overall hospital bed capacity and ED capacity. In 2018, the ULHG Operational Plan outlined that the opening of the new ED in 2017 did not solve already apparent problems in relation to overall hospital bed capacity.[22] HIQA has been in ongoing communication with ULHG regarding ED capacity since 2020.[15]

A number of previous reports and reviews have suggested factors which may have contributed to the challenges experienced at UHL.[15, 23-25] Firstly, since 2009, UHL is the only site in the HSE Mid West health region with 24/7 urgent and emergency

healthcare services for those residing in Clare, Limerick, and North Tipperary (a catchment population of approximately 413,000 people, as of Census 2022).[25, 26] Additionally, a HSE Regional Population Profile published in 2024 outlined that as of 2022, the catchment population in the Mid West health region was older, more deprived and had self-reported lower levels of health when compared to the national comparator.[25] Furthermore, the 2022 Deloitte Patient Flow Report on ULHG outlined that, as of 2021, UHL reported one of the highest ED attendances nationally, compared to other Model 4 hospitals.[23] The Deloitte report also outlined that, as of 2021, the Mid West health region had the lowest private hospital bed capacity in the country, and ULHG reported the lowest absolute number of consultants, non-consultant hospital doctors (NCHDs), nursing and midwifery staff, and health and social care professionals (HSCPs), across all Hospital Groups (HGs) nationally.[23]

In May 2024, the Minister for Health requested that HIQA conduct a review of urgent and emergency care in the HSE Mid West health region with the primary objective of ensuring safe, quality, acute care in the region. In order to conduct this review, an understanding of the key recommendations and decisions related to the provision of urgent and emergency healthcare services in the HSE Mid West health region is required.

For clarity, as outlined within *Protocol for the evidence synthesis to inform the review of urgent and emergency healthcare services in the Health Service Executive Mid West of Ireland*; the term 'Mid West', as used throughout this report, refers specifically to the HSE Mid West health region. The HSE Mid West health region is distinct from the Midwest Region of Ireland, which refers to the geographical area of counties Limerick, Clare and Tipperary.

2 Methods

This report addresses Work Stream 1 of *Protocol for the evidence synthesis to inform the review of urgent and emergency healthcare services in the Health Service Executive Mid West Region of Ireland*.

2.1 Search for and initial review of relevant resources

Similar to the policy assessment conducted within the Health Service Capacity Review 2018,[27] an initial long list of relevant resources was developed. Grey literature providing information relevant to urgent and emergency healthcare services in the Mid West was searched for in the following online repositories and archives:

- Houses of the Oireachtas: Debates[28]
- HSE: Publications and Reports[29]

- Lenus the Irish Health Repository[30]
- Irish Government
    - Publications[31]
    - Policies[32]
- HIQA: Reports and Publications[33]

Each resource identified was included on the long list if it provided information, recommendations and or consideration for any or all of the following aspects (identified during project scoping):

- the health system (including health service reform and delivery, where relevant)
- hospital capacity (including inpatient, surge and ED capacity)
- governance
- community healthcare (including general practices and practitioners and nursing homes)
- staffing (including workforce planning, recruitment and retention)
- funding.

Resource types included, but were not limited to:

- policies, plans and or strategies, such as the *Sláintecare Implementation Strategy*[34] and the *UL Hospitals Group 2023–2027 Strategic Plan*[35]
- reports, such as the *Report of the National Task Force on Medical Staffing (Hanly report)*[36]
- reviews and overviews, such as the *Health Service Capacity Review 2018: Review of health demand and capacity requirements in Ireland to 2031*[27] *and* HIQA's *Overview Report: Monitoring programme against the national standards in emergency departments in 2022*[14]
- government debate transcripts, such as the Joint Committee on Health *debate*[37]
- press releases and blogs which provide supporting information around recommendations, decisions and or actions undertaken (for example, ULHG blogs outlining the implementation of ED initiatives[38] and the extension of MAU operational hours across ULHG hospitals).[39]

To supplement the grey literature identified through online repositories and archives, "snowballing" was undertaken. "Snowballing" is defined as "recursively pursuing relevant references cited in already-retrieved literature and adding them to the search results".[40] Within the current report, reference lists of the grey literature identified were scanned, with forward citation searching conducted via the Google search engine. News reports that provided supporting information around recommendations, decisions and or actions undertaken were also searched for via

the Google search engine. Additionally, resources outlined in Health Service Capacity Review 2018[27] were cross-checked for inclusion.

To note, when developing the initial long list of resources, the following were considered out of scope:

- resources published or focused on the delivery of health services prior to the year 2000
- those focused on specific health conditions, such as the National Dementia Strategy[41]
- resources focused on the delivery of health services in another HSE health region, such *as A review of the governance of maternity services at Cavan/Monaghan hospital* (Flory reports).[42]

2.2 Detailed review and information extraction

Following the initial review, two reviewers then independently reviewed each resource included on the long list for inclusion in the final list of key resources. Any disagreement was resolved through discussion by involving a third reviewer where necessary. Key resources were deemed as such if they provided information, recommendations or consideration for health service delivery that was:

- specific to the Mid West or ULHG, such as the *HSE Mid West Community Healthcare 2016 Limerick, Clare and North Tipperary*[43] and the *UHL Support Team Report 2024*[44] or
- national, but likely to have impacted the Mid West, such as the *Framework for Ambulatory Care On the Acute Floor* [45]and the *Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031.*[46]

Individuals with expertise in the area were then contacted to confirm that all relevant key resources were included, and or to provide additional resources as appropriate.

Data was extracted from each key resource by one reviewer and was crosschecked by another. A data extraction template was used for documents such as plans, policies, strategies, reviews and reports (see Appendix 1 for data extraction template). Documents solely providing evidence of action(s) undertaken, such as press releases, news reports and blogs, were stored in Microsoft Excel.

Data extraction focused on executive summaries and high-level recommendations from key resources aimed at national health service delivery, while more detailed extraction was undertaken for key resources specific to the Mid West or ULHG. Resources on the long list but excluded from the final list of key resources provided context to the overall report. Relevant resources identified prior to 24 December

2024 were included for extraction; resources and or updates identified after this date (up until the end of July 2025) were noted in the results or discussion section, where appropriate.

2.3 Summarise the findings

The information extracted was summarised in accordance with the aspects outlined in section 2.1, along with any further aspects that were regularly identified during data extraction.

3 Findings

The results are presented in three main sections as follows:

- **Section 3.1 Identified information:** presents a descriptive summary of the resources identified.
- **Section 3.2 Timeline of actions and resources:** presents two graphical timelines of notable actions undertaken and resources published; firstly in the 2000 to 2019 period, and then the 2020 to 2024 period.
- **Section 3.3 Resource contents:** presents a summary of information extracted.

3.1 Identified information

A total of 145 resources were included on the initial long list. Following detailed review, 80 resources were included as key resources on the short list (see Table 3.1). Resources excluded, along with the reason for their exclusion, are noted in Appendix 2.

Resources were published from multiple sources. These included:

- national public bodies such as the Government of Ireland,[47-50] the Department of Health,[46, 51-60] the HSE,[43, 44, 49, 52, 53, 61-77] and HIQA[14, 15, 24, 78, 79]
- public body groups and committees, such as the HSE Emergency Department Task Force[5]
- regional health bodies, such as the Mid-Western Health Board (MWHB),[80, 81] HSE West,[82] and ULHG[22, 38, 39, 83-89]
- consulting groups, such as Capita Consulting,[90] the PA Consulting Group,[27, 91] Horwath Consulting Ireland and Teamwork Management,[92] and Deloitte[23]
- news sources, such as The Irish Times,[93, 94] RTE News,[95-97] Limerick Post,[98] Limerick Leader,[99] The Journal,[100] and Clare FM.[101]

The list of key resources included:

- 25 reports (comprising 20 general reports,[5, 23, 36, 43, 44, 47, 53, 60, 76, 90, 102-111], four inspection reports[15, 24, 78, 79] and one technical report[112])
- 18 plans (comprising 13 service plans,[22, 62, 63, 65, 66, 69, 70, 80-85] four general plans,[46, 50, 74, 75] and one strategic plan[88])
- 19 pieces of media communication (comprising 11 news reports,[93-101, 113, 114] five press releases[48, 56, 57, 59, 77] and three blogs[38, 39, 87])
- six frameworks[45, 51, 52, 54, 55, 86]
- six reviews (comprising five reviews[11, 27, 91, 92, 115] and one overview[14])
- three strategies[116-118]
- one piece of guidance[119]
- one circular[61]
- one briefing note.[89]

Table 3.1 List of key resources (in chronological order by publication year)

No.	Author(s) (Year)	Title or Descriptor	Type of resource
1	Mid-Western Health Board (MWHB)[80] (2001)	MWHB Service Plan, 2001	Service Plan
2	Department of Health and Children (DoHC)[116] (2001)	Quality and Fairness - A Health System for You	Strategy
3	DoHC[117] (2001)	Primary Care: A New Direction	Strategy
4	MWHB[81] (2002)	Mid-Western Regional Hospitals Operational Plan 2002	Service Plan
5	Comhairle na nOspidéal[102] (2002)	Report of the Committee on Accident and Emergency Services	Report
6	DoHC[11] (2002)	Acute hospital bed capacity: a national review	Review
7	Watson Wyatt Worldwide, Prospectus Strategy Consultants[104] (2003)	Audit of structures and functions of the health system on behalf of the DoHC (Prospectus Report)	Report
8	Healthcare Consultancy Ltd.[103] (2003)	Report on nurse staffing levels in emergency departments	Report
9	Capita Consulting[90] (2003)	Capita's report to the employers and unions: national review of bed management function: final report	Report
10	Government of Ireland[47] (2003)	Commission on Financial Management and Control Systems in the Health Service (Brennan Report)	Report
11	DoHC[36] (2003)	Report of the National Task Force on Medical Staffing (Hanly Report)	Report
12	Comhairle na nOspidéal[107] (2004)	Acute Medical Units	Report
13	Health Service Executive (HSE) Emergency Department Task Force[5] (2007)	Emergency Department Task Force Report 2007	Report
14	PA Consulting Group, Balance of Care Group[91] (2007)	Acute hospital bed review: a review of acute hospital bed use in hospitals in the Republic of Ireland with an Emergency Department	Review
15	Horwath Consulting Ireland and Teamwork Management[92] (2008)	HSE: Review of Acute Hospital Services in HSE Mid-West An action plan for acute and community health services	Review and Action Plan
16	HSE[61] (2009)	Moratorium on Recruitment and Promotions in the Public Services	Circular providing evidence of action
17	Health Information and Quality Authority (HIQA)[78] (2009)	Report of the investigation into the quality and safety of services and supporting arrangements provided by the HSE at the Mid-Western Regional Hospital Ennis	Inspection report

No.	Author(s) (Year)	Title or Descriptor	Type of resource
18	The Irish Times[93] (2009)	Closure of Ennis, Nenagh and St. John's 24hr A&E services	News report providing evidence of action
19	Comptroller and Auditor General[112] (2009)	HSE emergency departments: Technical Report	Technical Report
20	Royal College of Physicians of Ireland, Irish Association of Directors of Nursing Midwifery, Therapy Professions Committee, Quality and Clinical Care Directorate (HSE)[105] (2010)	Report of the national acute medicine programme	Report
21	HSE[62] (2011)	Regional Service Plan 2011 Area West	Service Plan
22	Government of Ireland[50] (2011)	Government for National Recovery 2011-2016	Plan providing evidence of action
23	HSE West[82] (2012)	HSE West Service Plan 2012	Service Plan
24	Clinical Strategy Programmes Directorate, (HSE) Quality Patient Safety Directorate, Irish Committee for Emergency Medicine, Irish Association for Emergency Medicine, National Board for Ireland, the College of Emergency Medicine, Therapy Professions Committee[118] (2012)	The National Emergency Medicine Programme: A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland	Strategy
25	Department of Health (DoH)[51] (2012)	Future Health A Strategic Framework for Reform of the Health Service 2012 – 2015	Framework
26	HSE[63] (2013)	Mid-Western Regional Hospitals Group Service Plan 2013	Service Plan
27	DoH and the HSE[52] (2013)	Securing the Future of Smaller Hospitals: A Framework for Development	Framework
28	DoH[60] (2013)	The Establishment of Hospital Groups as a transition to Independent Hospital Trusts. A report for the Minister for Health, Dr James Reilly TD	Report providing evidence of action
29	HSE[108] (2014)	Evolution of Recent Structures	Report providing evidence of action
30	UL Hospitals Group (ULHG)[83] (2014)	ULHG Operational Plan 2014	Service Plan
31	HSE[65] (2015)	Acute Hospital Division Operational Plan 2015	Service Plan
32	DoH and HSE[53] (2015)	Emergency Department Task Force Report 2015	Report

No.	Author(s) (Year)	Title or Descriptor	Type of resource
33	HSE[66] (2016)	Acute Hospital Division Operational Plan 2016	Service Plan
34	ULHG[84] (2016)	ULHG Operational Plan 2016	Service Plan
35	HSE[43] (2016)	HSE Mid West Community Healthcare 2016 Limerick, Clare and North Tipperary	Report
36	National Acute Medicine Programme (NAMP) (HSE)[111] (2016)	Report from the site visit by the National Acute Medicine Programme (NAMP) to the University Hospital Limerick on March 1st 2016	Report
37	The Acute Hospitals Division (HSE)[119] (2017)	Developing an Acute Floor Model for Ireland	Guidance
38	HSE[69] (2017)	Acute Services Operational Plan 2017	Service Plan
39	ULHG[85] (2017)	ULHG Operational Plan 2017	Service Plan
40	ULHG[86] (2017)	ULHG submission to the Ireland 2040 National Planning Framework	Framework
41	Limerick Leader[99] (2017)	New emergency department at University Hospital Limerick (UHL) opens to patients	News report providing evidence on action
42	Houses of the Oireachtas[106] (2017)	Committee on the Future of Healthcare Sláintecare Report*	Report
43	NAMP (HSE) and Royal College of Physicians Ireland[45] (2018)	Framework for Ambulatory Care On the Acute Floor	Framework
44	HSE[70] (2018)	Acute Hospital Services Divisional Plan 2018	Service Plan
45	ULHG[22] (2018)	ULHG Operational Plan 2018	Service Plan
46	PA Consulting Group[27] (2018)	Health Service Capacity Review 2018	Review
47	DoH[54] (2018)	Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care settings in Adult Hospitals in Ireland 2018: Final report and recommendations by the Task Force on Staffing and Skill Mix for Nursing	Framework
48	Government of Ireland[48] (2020)	Minister for Health announces plan to expand critical care capacity to 446 beds	Press release providing evidence of action
49	NAMP (HSE)[110] (2022)	Report of the National Acute Medicine Programme site visit to UHL	Report
50	HIQA[15] (2022)	Report of the unannounced inspection of the Emergency Department at UHL against the National Standards for Safer Better Healthcare	Inspection report

No.	Author(s) (Year)	Title or Descriptor	Type of resource
51	DoH[55] (2022)	Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland: Final Report and Recommendations by the Task Force on Staffing and Skill Mix for Nursing	Framework
52	Deloitte[23] (2022)	ULHG Patient Flow Report	Report
53	Limerick Post[98] (2022)	New ambulance service to steer older patients from Limerick emergency department	News report providing evidence on action
54	HIQA[14] (2022)	Overview Report: Monitoring programme against the national standards in emergency departments in 2022	Overview
55	RTE News[95] (2023)	'Major internal incident' declared at UHL	News report providing evidence on action
56	The Journal[100] (2023)	Pilot Project To Ease Overcrowding at Limerick Hospital Underway	News report providing evidence on action
57	HIQA[79] (2023)	Report of an inspection against the National Standards for Safer Better Healthcare (UHL)	Inspection report
58	HSE[115] (2023)	HSE Operations: Integrated Planning Full Report: Review of Medical Assessment Units	Review
59	ULHG[39] (2023)	€5.2m investment to extend all three Midwest MAUs to seven-day service	Blog providing evidence on action
60	ULHG[87] (2023)	New and improved €2m Injury Unit opens at Ennis Hospital today	Blog providing evidence on action
61	HSE[74] (2023)	HSE Urgent and Emergency Care Operational Plan 2023	Plan
62	Irish Times[94] (2023)	HSE boss orders freeze on recruitment of managers and administrators	News report providing evidence of action
63	RTE News[96] (2023)	HSE recruitment freeze extended	News report providing evidence of action
64	ULHG[88] (2023)	ULHG Strategic Plan 2023-2027	Strategic plan
65	ULHG[38] (2023)	UHL Expands Unit Improving Outcomes and Reducing Wait Times for Older Adults Attending Emergency Department	Blog providing evidence on action
66	DoH[56] (2024)	Minister for Health announces progress on development of 'Surgical Hubs'	Press release providing evidence on action

No.	Author(s) (Year)	Title or Descriptor	Type of resource
67	HSE[77] (2024)	HSE CEO appoints new Regional Executive Officers to lead HSE health regions	Press release providing evidence on action
68	Clare FM[101] (2024)	Pilot GP Pathway To Be Rolled Out At Region's Main Hospital	News report providing evidence of action
69	DoH[57] (2024)	Minister Donnelly announces new measures to alleviate overcrowding at UHL	Press release providing evidence on action
70	ULHG[89] (2024)	Briefing note for the DoH - Overview ULHG	Briefing note
71	DoH[59] (2024)	Statement from the Minister for Health and Chief Executive of the HSE	Press release providing evidence on action
72	HIQA[24] (2024)	Report of an inspection against the National Standards for Safer Better Healthcare (UHL, November 2023)	Inspection report
73	DoH[46] (2024)	Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031	Plan
74	HSE[75] (2024)	HSE Urgent and Emergency Care Plan (2024-2026)	Plan
75	RTE News[97] (2024)	HSE recruitment freeze ends	News report providing evidence of action
76	HSE[44] (2024)	UHL Support Team Report 2024	Report
77	HSE[109] (2024)	Independent Investigation University Hospital Limerick (Frank Clarke report) [This report and its recommendations are considered as a part of the Terms of Reference for the overall programme of work. For this report a limited extraction was undertaken focusing on the recommendations of the Frank Clarke report]	Report
78	RTE News[114] (2024)	UHL is 'completely overheated', says HSE chief Gloster [Start of UHL reset]	News report providing evidence of action
79	Limerick Post[113] (2024)	Some appointments and day surgeries to resume at UHL [Resumption of services after reset]	News report providing evidence of action
80	HSE[76] (2024)	HSE NDTP Emergency Medicine Workforce 2024-2038 report	Report

Key: A&E = Accident and Emergency; DoH = Department of Health; DoHC = Department of Health and Children; HIQA = Health Information and Quality Authority; HSE = Health Service Executive; MWHB = Mid-Western Health Board; NAMP = National Acute Medicine Programme; NDTP = National Doctors Training and Planning; RCSI = Royal College of Surgeons Ireland; UHL = University Hospital Limerick; ULHG = University of Limerick Hospitals Group.

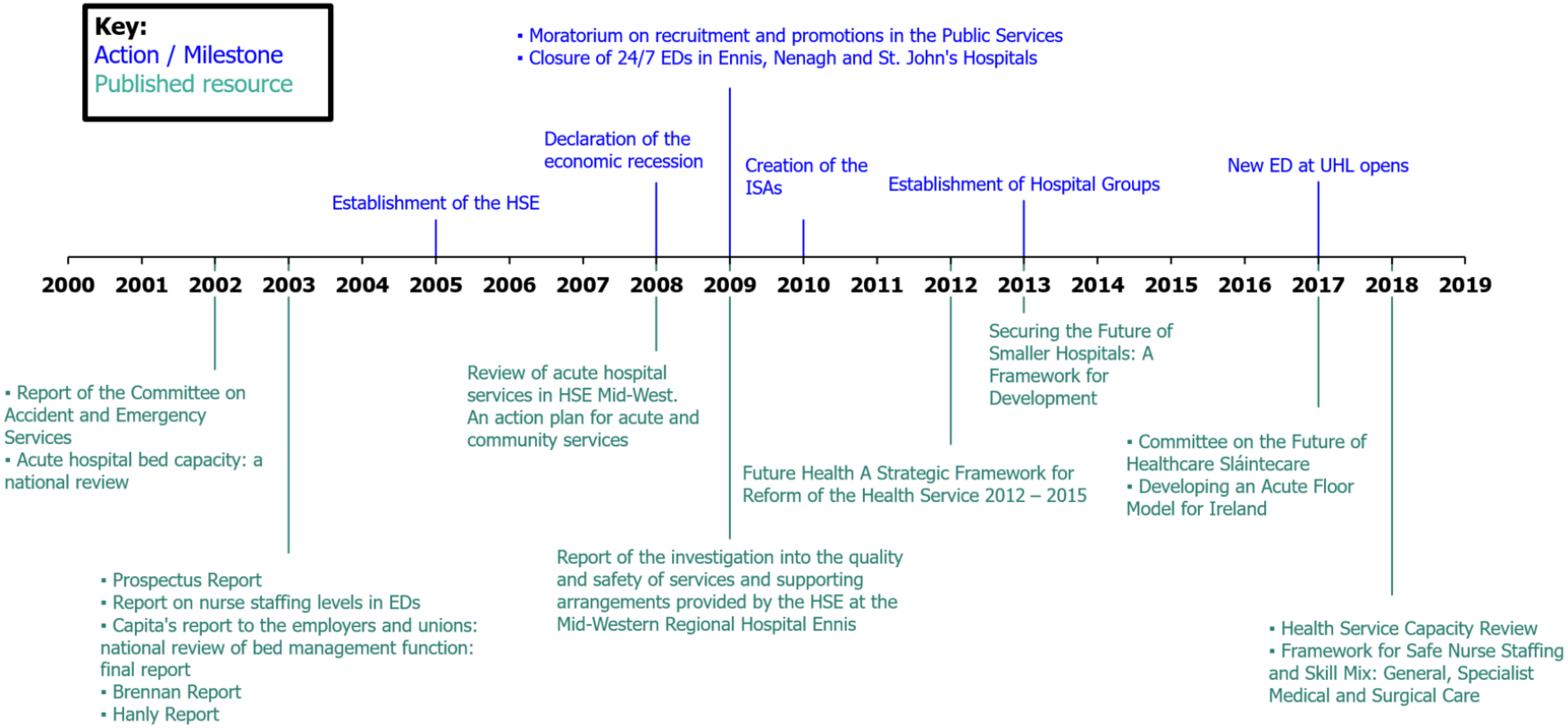
*It is noted that multiple progress reports, action plans, and implementation strategies, related to Sláintecare, have been published following the Houses of the Oireachtas Sláintecare Report. For the current summary, the Houses of the Oireachtas Sláintecare report (2017) was included and extracted as it set out

the foundational vision and strategic plan of Sláintecare. The other Sláintecare reports, plans and strategies were not extracted in full; however they were reviewed as part of the long list (Appendix 2) and are described separately in Appendix 3. Details from progress reports, action plans, and implementation strategies were included throughout the report, where appropriate.

3.2 Timeline of actions and resources

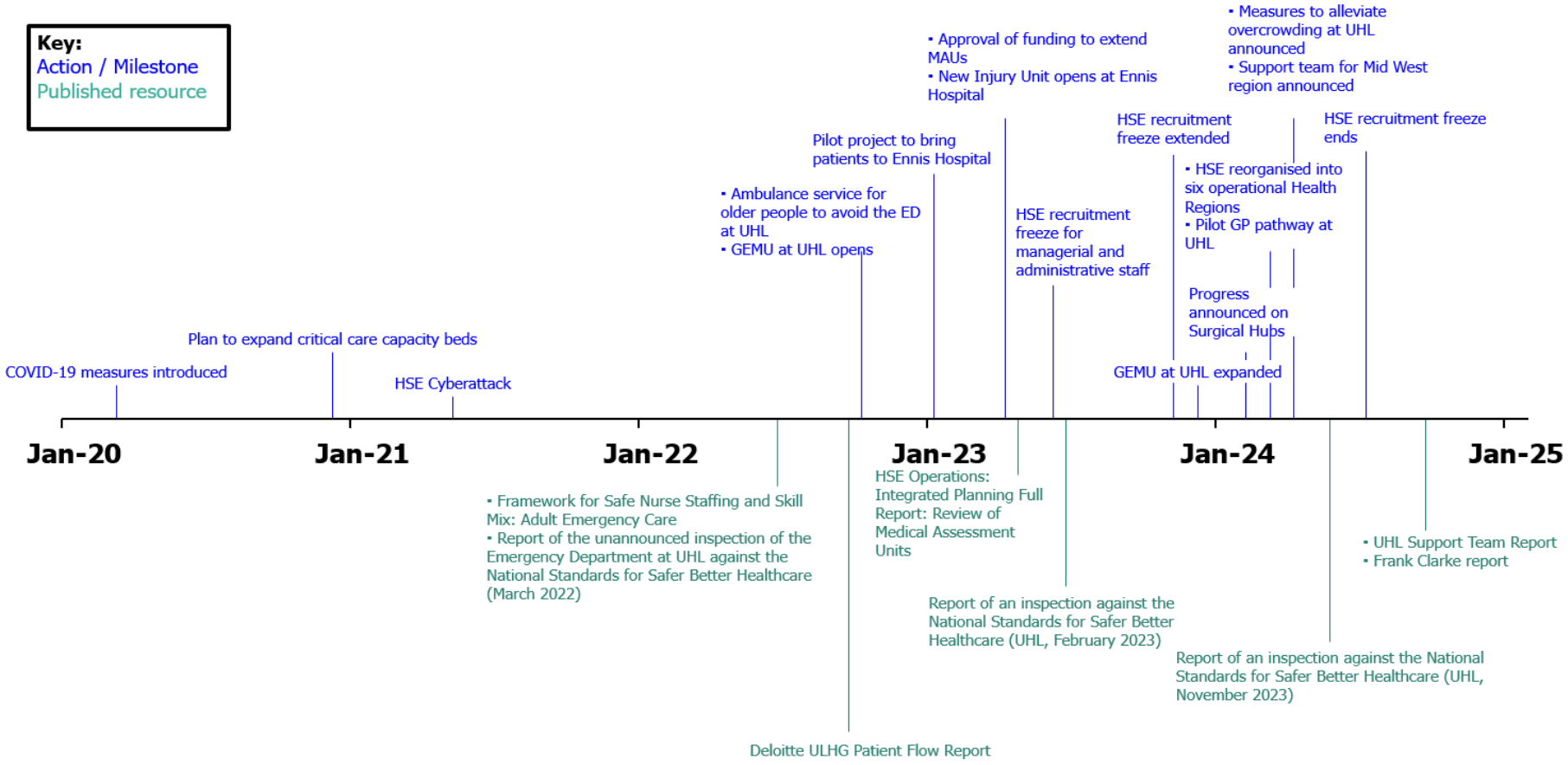
Timelines of notable actions undertaken and resources published in both the 2000 to 2019 period, and the 2020 to 2024 periods were developed (see Figure 3.1 and Figure 3.2).

Figure 3.1. Timeline of notable actions and resources from 2000 to 2019



Key: ED = emergency department; HSE = Health Service Executive; ISA = Integrated Service Area; UHL = University Hospital Limerick.

Figure 3.2. Timeline of notable actions and resources from 2020 to 2024



Key: ED = emergency department; GEMU = Geriatric Emergency Medicine Unit; GP = general practitioner; HSE = Health Service Executive; ISA = Integrated Service Area; MAU = medical assessment unit; UHL = University Hospital Limerick; ULHG = University of Limerick Hospitals Group.

3.3 Resource contents

The data extracted from the key resources is summarised in the following sections:

- the health system
- capacity
- patient flow
- governance
- community healthcare
- staffing
- funding.

While capacity and patient flow were summarised separately, it is acknowledged that these concepts are interrelated. As a result, there is an overlap in the information presented in these sections, which has been limited where possible.

See Appendix 4 for all extracted data. Due to a notable increase in the identification of actions undertaken that were relevant to urgent and emergency care in the Mid West since the year 2020, the summary write-up was structured with an initial focus on the period 2000 to 2019, followed by the period 2020 to 2024. It should be noted that information was not necessarily extracted for each individual year within these periods.

3.3.1 The health system

When summarising extracted information that was relevant to the health system, two specific aspects were identified:

- health services configuration
- integration of health and social care programmes.

Health services configuration

2000 to 2019

Across the 2000 to 2019 period, 11 reports included information about national health service reform[27, 34, 36, 43, 51, 52, 91, 102, 104, 112, 116] and eight included information specific to the Mid West.[22, 36, 62, 63, 78, 82, 83, 92] Between 2001 and 2004, four national reports highlighted the importance of reorganising the Irish health system and standardising care across the country.[36, 102, 104, 116] In 2003, the Hanly report on medical staffing also highlighted that there was a lack of integration of hospital management within regions, and that 'safeguarding' of resources occurred at local level, without consideration for the provision of safe and effective care.[36] The report outlined that while elective care should be provided both in major and local hospitals; an increasing proportion of elective work, primarily in the area of surgical

and medical day procedures, should be carried out in local hospitals. Similarly, outpatient and day care should be delivered locally based on agreed protocols in major and local hospitals. The Hanly report also assessed two pilot regions, of which the Mid-Western Health Board was one, and proposed specific changes to the hospital services in this region.[36] It was recommended that the hospitals in the Mid West should function as a single, integrated network. As such, the Mid-Western Regional Hospital, Limerick (in Dooradoyle) would serve as the major hospital for the region with the Mid-Western Regional Hospital, Ennis (hereafter referred to as Ennis); Mid-Western Regional Hospital, Nenagh (hereafter referred to as Nenagh); and St. John's Hospital (hereafter referred to as St. John's) functioning as local hospitals. Furthermore, it was recommended that a number of specialties that were being provided in the individual hospitals should instead be provided on site in Mid-Western Regional Hospital, Limerick (see section 3.3.5). Following these reports to establish a national health service, the Health Act 2004 was published, leading to the creation of the HSE in 2005.[102, 104, 116]

From 2007 to 2009, at a national level, both the Acute Hospital Bed Review[91] and the HSE EDs technical report[112] highlighted the need for national service reconfiguration and the concentration of emergency services at regional 'centres of excellence'. Specific to the Mid West, in 2008 and 2009, two reports (the Review of Acute Hospital Services[92] and the HIQA inspection into the quality and safety of services at the Mid-Western Regional Hospital, Ennis[78]) provided recommendations and or information in line with the Hanly report. The 2008 review of acute hospital services in the HSE Mid West stated that based on its findings, full and effective pre-hospital services needed to be established down to local level in the Mid West in order to achieve the implementation of national standards of acute care.[92] The report highlighted that at that time, there were four individual A&E units in the Mid West with only three A&E consultants staffing the units, providing only 99 contracted hours of work per week (see section 3.3.5). Furthermore, it was noted that the populations serviced by Nenagh, Ennis and St. John's did not generate enough workload to be viable, stand-alone, A&E services. The report concluded that one regional hospital, the Mid-Western Regional Hospital, Limerick, should be in charge of managing major emergencies. It was also specifically highlighted that acute services should continue to be provided at Ennis, Nenagh and St. John's, until Dooradoyle was sufficiently resourced to become a regional 'centre of excellence', in line with international quality standards.

In 2008, HIQA also conducted an inspection into the quality and safety of services and supporting arrangements provided by the HSE at the Mid-Western Regional Hospital, Ennis.[78] The investigation occurred following concerns raised about the treatment received by numerous patients at the hospital, across a variety of services. HIQA reported that the service configuration in place in Ennis at that time

was not safe to continue, as the volume of patients attending the ED was not high enough to ensure healthcare professionals maintained safe standards of clinical skill and expertise.[78] This was similar to what was noted in the 2008 review of acute hospital services in the HSE Mid West.[92] HIQA reported that patients with major or complex emergency conditions should not be treated at the ED in Ennis, and that 24-hour emergency care at the hospital was not sustainable.[78] As a result, the report found that this service should not continue. Additional findings included that there should be no acute or elective inpatient surgical services provided at Ennis, and that all acute and major surgery should be transferred to the Mid-Western Regional Hospital, Limerick. As outlined in the 2008 review of acute hospital services in the HSE Mid-West,[92] HIQA also concluded that prior to the movement of services to Dooradoyle, reassignment of resources and changes to infrastructure would need to occur.[78]

In April 2009, the EDs at Ennis, Nenagh and St. John's hospitals were replaced with medical assessment units (MAUs).[93, 112] This resulted in the three hospitals no longer providing 24-hour emergency services. In 2009, these MAUs provided a 12-hour service (five to seven days a week depending on location), with patients referred to the MAU by their GP. Patients requiring emergency services, or MAU services outside of these hours, were directed to the Mid-Western Regional Hospital, Limerick.[93, 112]

Also in 2009, the HSE established four regions, including HSE West (which included both the West and Mid West), as preliminary steps towards an integrated organisation of acute hospitals and community services.[62] The following year, 17 integrated service areas (ISAs) were established based on catchment areas within the HSE regions. The aim of the ISAs was to create a governance structure between acute hospitals and community services.[108] Service plans for HSE West in both 2011 and 2012 outlined planned reconfiguration and restructuring of clinical services (for example, centralisation of acute cardiology services at Dooradoyle) for integrated care across the regions[62] and the development of hospital networks with new governance structures.[82]

In 2012, the Department of Health published a strategic framework for reform of the health service.[51] One specific action was to develop hospital groups, with the Mid-Western Regional Hospital Group established on 9 January 2012.[63] The following year, in 2013, the HSE and Department of Health jointly published a framework for the future of smaller hospitals.[52] This framework described the planned role and services within Model 2 hospitals, which were to be part of a network, with links to Model 3 or 4 hospitals, operating under a single governance structure. The Model 1-4 hospital designations had previously been recommended by the National Acute Medicine Programme (NAMP) report in 2010.[105] The smaller hospitals framework outlined that Model 2 hospitals were to provide inpatient and outpatient care for

low-risk differentiated medical patients who were not likely to require resuscitation; with a focus on ambulatory care, diagnostics and rehabilitation.[52] Within the smaller hospitals framework, Ennis and Nenagh Hospitals were designated Model 2 hospitals. St. John's Hospital was designated a Model 2S, that is, a Model 2 hospital geographically close to and administratively part of a group or network with Model 3 or 4 hospitals, which could provide less than a five-day stay surgery. These three hospitals are hereafter collectively known as the Model 2 JEN (St. John's, Ennis and Nenagh) hospitals. In line with the future of smaller hospitals framework, in 2013 the Model 2 JEN hospitals opened local injury units (LIUs), alongside the MAUs which had been in place since 2009.[87, 120]

The Mid-Western Regional Hospitals Group was renamed as UL Hospitals Group (ULHG) in 2014.[83] The 2014 ULHG Operational Plan highlighted the work towards implementation of the small hospitals framework, with development of acute medical assessment units (AMAUs) and MAUs in the Model 2 JEN hospitals. In 2015, the 17 ISAs were replaced by nine Community Health Organisations (CHOs).[43] The CHOs enable and support integrated care within community healthcare services; between the community and acute hospital services; and with wider public service organisations (such as local authorities, child and family agencies, and education and local voluntary organisations).[121]

The 2018 Sláintecare implementation plan noted a strategic action of developing regional governances and structures.[34] Sub-actions included 1) finalising decisions and geographic alignment of HGs and CHOs (following public consultation), and 2) introducing modifications to HGs and CHOs to ensure geographic alignment.

Key priorities identified in the 2018 ULHG operational plan included realignment of services and increases in ambulatory care and day surgery capacity in Model 2 hospitals.[22] ULHG representatives confirmed that continuous review occurs in the Model 2 JEN hospitals, to ensure ambulatory care and day surgeries are maximised. In 2018, the Health Service Capacity Review concluded that the national health system, at the time of review, was operating at or beyond capacity in most aspects.[27] The review outlined that there was a need for a much more integrated approach to the future delivery of healthcare across acute and primary care settings and services for older persons. However, it noted that the wider implications of changes, such as the reconfiguration of hospitals and public access to safe and high quality services, must be considered within any healthcare reform.[27]

2020 to 2024

Six reports included information about national health service reform across the 2020 to 2024 period.[77, 122-124] The Sláintecare Implementation and Action Plans all included actions for reorganising service delivery into health regions.[122-124] In line with implementing Sláintecare, the HSE is reorganising service delivery into

Integrated Healthcare Areas, which are substructures within the six HSE health regions.[49, 77, 125] These health regions will be responsible for both hospital and community care, with the intention of better integration of these services. The HSE Mid West Region overlaps fully with the previous region boundaries in this area.

Integrated care

Integrated care aims to join up health and social care services, to deliver safe, timely, and efficient care at the lowest complexity level, as close to home for the patient as possible.[126] Of note, the following section will focus on a high-level summary of the development of integrated care programmes and pathways in the Irish health system. For a focused understanding of integrated care within the context of primary care, ambulance and paramedic, and step-down care facility services, see section 3.3.4.

2000 to 2019

Eleven national reports[5, 34, 51, 65, 66, 69, 70, 104, 106, 117, 127] and five reports specific to the Mid West[22, 43, 62, 82, 84] included information and or made recommendations for integrated care across the health system. From 2001 to 2013, four national reports highlighted the need for integrated care pathways across the Irish healthcare system for various health conditions.[5, 51, 104, 117] In line with this, the 2008 HSE review of acute hospital series in the Mid West noted that integrated care pathways need to be standardised to improve efficiency, and to avoid some hospital admissions, in the Mid West.[92] HSE West service plans for both 2011 and 2012 also included the implementation of national clinical programmes as a major initiative to move towards a more integrated model of healthcare.[62, 82]

Operational plans for the HSE Acute Hospital Division and ULHG, published across the 2015 to 2018 period outlined the development and implementation of clinically led, multidisciplinary, service-user centred integrated models of care programmes as a priority.[22, 65, 66, 69, 70, 84] The 2017 Sláintecare Report outlined the planned development of five integrated care programmes (in older people, chronic diseases, children, maternity, and patient flow).[106] Two of the integrated care programmes (chronic diseases and older people) were subsequently identified for accelerated implementation in the 2018 Sláintecare Implementation Plan and the 2019 Sláintecare action plan.[34, 127] Early results from developed programmes, such as the Integrated Care Programme for Older People (ICPOP), showed positive outcomes for patients and the health system.[106] The ICPOP provides support and services to older people who have complex needs and need specialist, multidisciplinary intervention to help maintain their independence and live well at home.[128] EAG representatives have confirmed that at the time of writing a number of these programmes have not yet been implemented.

2020 to 2024

More recently, one national report[115] and two reports specific to the Mid West Region[15, 24] included information related to integrated care programmes. Following the inspection of the UHL ED in March 2022, HIQA reported that UHL had introduced the ICPOP in 2020 (see 3.3.4).[15] An ICPOP hub was operating in UHL, Ennis and Nenagh Hospitals to directly stream patients aged 75 and over attending the ED, to appropriate areas in the hospital. Following an inspection of the UHL ED in November 2023, HIQA also highlighted that programmes such as ICPOP were facilitating hospital avoidance and early discharge.[24] Furthermore, to support a move toward integrated care, the report from the March 2022 HIQA inspection noted that the Model 2 JEN hospitals and UHL were each resourced to appoint at least one consultant for integrated care.[15] ULHG representatives confirmed that, as of January 2025, all positions were advertised, with a number already filled.

3.3.2 Capacity

Healthcare capacity is the ability of a system to deliver healthcare effectively to those who need it, when they need it.[129] This requires having the appropriate resources working efficiently in the correct infrastructure to deliver successful care. These resources may include facilities (such as theatres and wards), equipment (such as hospital beds), and staffing or workforce. Detailed information regarding staffing and or workforce capacity is summarised in section 3.3.5, Staffing. Additionally, any information in relation to post-acute hospital capacity was summarised in section 3.3.4, Community healthcare.

Therefore, when summarising information extracted relevant to capacity, three specific aspects were identified:

- Model 4 capacity
- acute floor capacity
- Model 2 hospital capacity.

Model 4 capacity

2000 to 2019

Six national[5, 11, 27, 53, 112, 116] and seven reports specific to the Mid West[22, 81, 83-85, 92] provided information and or recommendations related to Model 4 capacity. Nationally, across the 2001 to 2019 period, it was widely acknowledged that increased acute hospital bed capacity was required across the Irish health system to meet demand.[5, 11, 27, 116] The 2001 Department of Health Quality and Fairness strategy outlined that over the ten-year period from 2001 to 2011, a total of 3,000 additional acute beds was required for the system.[116] The strategy outlined that the government had committed to providing 3,000 beds by 2011, taking account of

investment in non-acute facilities and community support services, increased use of day beds and a number of other factors.[116] It also outlined that the government was committed to fully exploring the scope for the private sector to provide additional capacity.[116] Accordingly, the extra beds in the period to 2011 were to be provided by a combination of public and private providers, through a strategic partnership.[116]

The need for increased bed capacity was also supported nationally by the 2002 Acute Hospital Bed Capacity Review.[11] This review outlined that in 2002, the number of acute hospital beds per capita in Ireland was one of the lowest among European Union and Organisation for Economic Cooperation and Development countries at 3.1 beds per 1,000 population; compared with 5.1 per 1,000 population in 1980.[11] This review estimated that at that time, approximately 883 beds were required to adjust for the high average bed occupancy levels being experienced in the major hospitals and intensive care units (ICU) nationwide.[11] Between 2,840 beds (net) and 4,335 beds (gross) were estimated to be required over the period to 2011. However, it was stated that investment in day facilities and a substantial shift of elective inpatient surgery to day-case surgery could reduce the need for additional beds by 11%.

In the period 2007 to 2018, two national reports outlined that Irish hospitals were working over capacity, with a greater than 85% average occupancy rate.[5, 27] In 2007 the ED Task Force report outlined that a number of the hospitals examined by the Task Force were operating at close to 100% capacity, with the majority operating at 95% capacity.[5] It was noted that this was resulting in sub-optimal management of elective and emergency workloads.[5] In 2018, the Health Service Capacity Review outlined average bed occupancy was running at around 95% across the hospital system and in a number of cases, individual hospitals were running at close to 100% occupancy. The review outlined that to reach international standards of bed occupancy (85% average occupancy as the upper average threshold by the OECD), the Irish healthcare system would need an immediate injection of the equivalent of an additional 1,260 beds.[27] It was outlined that in practice, an increase in capacity would likely be achieved with a mix of hospital beds, residential care, homecare packages and enhanced primary care services, as well as management measures to improve patient flow and open currently closed beds.[27] This was supported in a number of national reports which noted that hospitals should also aim to improve existing inpatient bed capacity usage,[5] particularly in relation to delayed discharges.[53] Suggested ways of optimising existing hospital capacity included daily reviews undertaken by senior decision-makers; examining the LOS variance for core patient groups at consultant level (by clinical directors and hospital management supported by appropriate data); and extending the use of outreach services to reduce inpatient stay.[53] The 2002 Acute Hospital Bed Capacity

Review also outlined that to reduce the need for additional beds, investment in measures to reduce delayed discharge from acute hospitals would have the greatest impact.[11] It was suggested that this alone could 'provide' 16% of the capacity required at that time.[11]

More specifically, when focusing on the Mid West in the 2000 to 2019 period, it was repeatedly noted that an increase in capacity, and or specifically inpatient bed capacity, was required. The 2002 Mid-Western Regional Hospitals Operational Plan stated that inadequate inpatient bed capacity was leading to occupancy levels continuously above 85%, which in turn was leading to bed shortages on an ongoing basis.[81] In 2008, the review of the acute hospital services in the Mid West outlined that the Mid-Western Regional Hospital, Limerick, as of 2005, had 375 inpatient beds.[92] It noted that reconfiguration of the Dooradoyle site was required prior to it being designated as the regional 'centre of excellence' (see section 3.3.1) and based on modelling at that time, the Dooradoyle site would need to have the capacity to accommodate 642 inpatient beds (an increase of 267 inpatient beds).[92] To increase overall capacity, the site also required a new obstetrics, midwifery and neonatal unit; a new elective orthopaedics unit; and a new or refurbished ED. The review also advised against the withdrawal of acute services from the smaller regional hospitals until the regional 'centre of excellence' was resourced and ready to deliver that service, with reference to international quality standards. It was estimated that, excluding new builds, the programme should be delivered within 3-4 years. The following year in 2009, the 24/7 EDs in the Model 2 JEN Hospitals were closed, with a centralisation of urgent and emergency services to Dooradoyle.

A number of ULHG operational plans across the 2014 to 2018 period outlined that ULHG continued to struggle with inadequate capacity and facilities to meet all the needs of its patients.[22, 83-85] Strategies to optimise existing capacity and or movement towards increases in inpatient and outpatient capacity were outlined in four operational plans.[22, 83-85] These included reducing LOS and shifting care to appropriate settings including primary care,[84] reconfiguration of the outpatient department (OPD),[85] and improving access to diagnostics.[22] Actions to increase capacity included the opening of additional beds at UHL and the commissioning of new theatres at Nenagh Hospital,[83] capital planning for a 96-bed block in UHL,[85] and the reconfiguration of the 2017 vacated ED, to create a medical short stay unit.[22] In January 2025, ULHG representatives confirmed that there was no medical short stay unit in UHL.

2020 to 2024

More recently, two national[46, 130] reports and five reports specific to the Mid West[23, 24, 89, 110, 131] outlined information, and or recommendations, related to Model 4 capacity. In 2022, ULHG outlined that they had added 98 inpatient beds, and 10

critical care beds during 2020/2021, in response to the COVID-19 pandemic.[131] This brought the inpatient bed complement at that time to 530 beds. The extra capacity supported safe management of vulnerable patients, including haematology, oncology and renal patients; to provide a safe pathway for people attending UHL for surgery; and to isolate COVID-19 positive patients.[131] However, the 2022 Deloitte ULHG Patient Flow Report outlined that an additional 302 inpatient beds and 63 day beds were required to address the demand placed upon UHL by 2036.[23] It was suggested that this could be delivered through a number of means, including additional bed capacity on the UHL site, a stand-alone Model 3 hospital, an elective-only facility, or a combination of the above.[23]

In December 2022, the Government approved the next stage of the Enhanced Provision of the Elective Care Programme to include the development of new elective hospitals at proposed sites in Cork and Galway.[132] These elective hospitals allow for the separation of elective and non-elective care, with the aim of releasing capacity in existing healthcare facilities to better address unscheduled care needs.[132] In 2024, additional preferred sites in Dublin were identified for two further elective hospitals. It was noted in the Elective Hospital Programme Overview that the locations of Cork, Galway and Dublin were chosen in order to 'enable the provision of a national service while maximising the coverage of the elective hospitals as far as is reasonably possible.'[133] While Limerick was not selected as a site for an elective hospital it was noted that more than 80% of the population of Ireland will be within 90 km (120km journey distance) of the new elective hospitals.[133]

In April 2024, a ULHG briefing note to the Department of Health outlined that there were 535 beds available at UHL (of which 51 were paediatric beds), with 872 inpatient beds in total across ULHG.[89] The briefing note also outlined a number of projects that were underway and or planned to help address capacity shortages in UHL in the coming years.[89] These included a 96-bed block on which work commenced in September 2022; a second 96-bed block that is envisaged to be delivered and operational in 2029; a 16-bed rapid build ward which was to be available by winter 2025; and a surgical hub containing two new operating theatres and two procedure rooms at the old Scoil Carmel site.[89] The HIQA report following the November 2023 inspection of the UHL ED outlined that 44 of the beds within the first 96-bed block would be replacement beds (and therefore would not add to the bed stock of the hospital).[24] However, following review by ULHG, all of the first 96-bed block were recategorised as new beds. Of note, the 2024 independent investigation of UHL by former Chief Justice Frank Clarke indicated that the UHL hospital site in Dooradoyle may be approaching capacity in terms of built infrastructure.[109] As of July 2025, ULHG representatives confirmed the first 96-bed block is due to open in September 2025.[134] The second 96-bed block, and a 66-bed unit are still in the initiation stage, with plans to deliver both blocks within the next

four years.[135] Additionally, one 16-bed rapid build ward opened in December 2024 and the second 16-bed ward is due to open in Winter 2025. As of July 2025, ULHG representatives confirmed that proposals from a capacity study of the UHL campus for the expansion of the site over the next 20+ years are still under consideration.[135]

Nationally, an increase in inpatient capacity was also required, with the 2024 Department of Health Acute Hospital Inpatient Capacity Expansion Plan outlining that from 2020 to March 2024, an additional 1,218 new acute inpatient beds were opened.[46] Additionally, while already committed to a further 441 new and 574 replacement acute inpatient beds (that were in various stages of development in 2024), the Capacity Expansion Plan set out a further 2,997 new and 355 replacement acute inpatient beds to be added across the hospital network for Ireland over the period 2024–2031.[46] It was also noted in the Capacity Expansion Plan that 118 inpatient beds had been delivered in UHL across the 2021 to 2024 period.[46] More recently, the 2025 Draft Programme for Government also stated that the Government was committed to increasing inpatient hospital bed capacity nationally, by between 4,000 and 4,500 new and refurbished beds.[130] A commitment to increased capacity specifically in UHL and the Mid West was also outlined, along with the establishment of the aforementioned surgical hub in Limerick.[130] The HSE 2025 Capital Plan outlined that the surgical hub will include two operating theatres and two minor procedure rooms including a recovery unit and associated support services and staff facilities,[136] with construction on the hub having commenced in April 2025.[137] It is noted that the surgical hub will operate as a satellite of UHL, with key staff moving between sites. It will also allow for greater separation of scheduled and unscheduled care, creating elective capacity to support the achievement of Sláintecare access targets.[137] Once fully operational the surgical hub will be able to deliver over 25,000 day cases, minor operations and outpatient consultations annually.[132] The HSE 2025 Capital Plan also outlined that expansion of an existing single story ward block in UHL was in the appraisal phase.[136]

Acute floor capacity

The acute floor concept was developed for the efficient streaming and management at the front door of acute hospitals. Acute floors can incorporate a number of areas or units including the ED, acute medical unit (AMU) and acute surgical assessment unit (ASAU), resuscitation unit, frailty teams and other services working in tandem with immediate streaming and access to relevant senior decision-makers at the earliest opportunity.[138] While the acute floor concept was first proposed in the 2010 *Report of the National Acute Medicine Programme*, and guidance on establishing these was provided in the 2017 *Acute Floor Model for Ireland*,[119] many of the elements contained within the acute floor had been in place prior to this. This section will therefore discuss these elements with regards to capacity and service

provision. The acute floor is discussed further in relation to patient flow in section 3.3.3.

2000 to 2019

Nine national[5, 102, 107, 116, 118] and six reports specific to the Mid West[80, 92] provided information on, and or recommendations in relation to, acute floor capacity. Nationally, in the early 2000s, a number of reports outlined that improvements in the delivery of emergency services were required.[5, 102, 116] In 2001, the Department of Health Quality and Fairness Strategy outlined a substantial programme of improvements for EDs nationally.[116] This included increased capacity in terms of ED staffing, with the addition of ED consultants to organise and run ED departments and the appointment of advanced nurse practitioners (ANPs) specialising in emergency medicine to acute hospitals.[116] The 2002 Comhairle na nOspidéal Accident and Emergency Services Report also noted that significant improvements in emergency services were required, but this would not occur without changes in the organisation of emergency care; better use of care pathways; increased and more timely access to diagnostics; and better access to and management of inpatient beds.[102]

In 2007, the ED Task Force visited 18 EDs nationally, including the ED in the Mid-Western Regional Hospital, Limerick, and outlined that at least seven of the EDs visited were unfit for purpose, while a number of the remaining hospitals were less than optimal in terms of space and overall design (which did not enable effective streaming of patient cohorts).[5] A number of national recommendations were made by the Task Force in terms of ED capacity, including ensuring access to existing capacity using targeted initiatives relating to issues such as diagnostics and long-term care; and managing capacity according to prioritised need (ensuring freed capacity is appropriately balanced between emergency and elective admissions).[5] Extended-hours access to diagnostics and assessment was also recommended to avoid admission to the acute hospital setting by the 2007 Acute Hospital Bed Review.[91] Full implementation of the 8-8 working day (in line with the national protocol in all sites for diagnostic services) to increase access to diagnostics and optimise access for emergency services was also outlined by the 2015 ED Task Force Report.[53]

As outlined in section 3.3.1, in 2008 the review of acute hospital services in the Mid West highlighted that, across the Mid West, there were three A&E consultants, and four stand-alone A&E services that were mostly delivered without any consultant supervision.[92] The review outlined that the three services at the Model 2 JEN hospitals (as they are now known) were deemed not viable, could not be considered as true A&E services and lacked the critical mass criteria to become sustainable A&E services in the future.[92] The 2008 review therefore recommended that 24/7 ED

services were consolidated to the Mid-Western Regional Hospital, Limerick to become a regional 'centre of excellence'. This consolidation occurred in 2009 as a part of the reorganisation of acute hospital services in the Mid West (as outlined in section 3.3.1).[92] The 2008 review also outlined a number of actions to ensure the safe delivery of services in the Mid-Western Regional Hospital, Limerick. Among these, it was recommended that a new or refurbished ED was delivered.[92] The new ED subsequently opened in UHL in 2017.[99, 139]

Across the period of 2009 to 2017, service and operational plans for the Acute Hospital Division, HSE Area West, the Mid-Western Regional HG, and ULHG all outlined key priorities of improving access to services by reducing waiting times for emergency or unscheduled care.[63, 66, 82, 83] From 2013, NAMP was also implemented in ULHG, with the 2013 Mid-Western Regional Hospitals Group Service Plan outlining actions to appoint acute physicians, have an AMU functioning 24/7 and to open a short stay unit in the Mid-Western Regional Hospital, Limerick.[63] While not a short stay unit, in 2013, an AMU was opened in UHL.[110] Support for the use of AMUs, co-located with EDs, had been longstanding, with Comhairle na nOspidéal suggesting the use of AMUs to manage acutely ill medical patients in 2004.[107] An AMU is a rapid assessment facility for some medical patients who are acutely unwell, and are referred from GPs, the ED, and or the hospital's outpatient department (OPD).[110] Comhairle na nOspidéal outlined that AMUs should have priority access to acute investigative facilities and inpatient beds within the hospital. While bed capacity requirements were not outlined by Comhairle na nOspidéal, it was outlined that if an AMU was providing both assessment and admission, the unit should be open 24/7.[107] The ULHG Operational Plan in 2014 indicated that the AMU in UHL was not operating seven days a week at this time, and also that the short stay unit had not been established.[83]

A number of short and long-term actions were outlined in the 2015 ED Task Force report in relation to AMUs and the ED.[53] These included that ED triage should seek to divert all clinically appropriate medical patients to AMUs; that the ANP model of care for low-acuity chronic illness be developed in the ED and AMU to allow assessment, treatment and discharge of low-acuity chronic illness; and that there should be targeted use of fast-track units such as clinical decision units (CDUs) and rapid access units, to reduce volumes and wait times in EDs.[53] The ULHG Operational Plan in 2016 outlined that improving performance in relation to unscheduled care by continuing to implement the 2015 ED Task Force Report was a priority.[84] Despite this, the 2016 NAMP visit to UHL outlined that while nursing staff worked well across the ED and AMU to identify appropriate patients, and consult services and rapid access OPD slots facilitated early discharge, the NAMP was not implemented to its full potential, and functioning was constrained by the location and size of the AMU.[111] The AMU at that time comprised 12 assessment beds open

for new assessments from 8am to 5.30pm every day, and was located within the OPD. It was noted by NAMP in 2016 that ongoing capacity pressures were leading to the use of AMU for boarders. There was no short stay ward under the governance of the AMU physicians and at that time, it was estimated that 10% to 20% of acute medicine went through this pathway (which was below the goal of 40%).[111] Following this, the 2017 Acute Floor Model for Ireland outlined a number of considerations for the acute floor. These included the use of the National Early Warning System for early recognition, escalation and response to the deteriorating patient; a single point of contact to access mental health services; multi-disciplinary morning huddles and discharge planning to be commenced within assessment, where appropriate.[119] It should be noted that the Emergency Medicine Early Warning System (EMEWS) was later introduced in January 2024, and was noted by the UHL Support Team to have had a positive impact on patient safety concerns in the ED.[44]

2020 to 2024

More recently, one national report[14] and five reports specific to the Mid West[15, 24, 44, 79, 89] outlined information, and or recommendations in relation to, acute floor capacity. In 2022, the HIQA Overview Report on EDs outlined that there was a need to assess capacity requirements on a regional basis (as was previously recommended in the 2018 Health Service Capacity Review[27]) and that the prioritisation of investment should be informed by the outputs from such an assessment.[14] During a HIQA inspection of the UHL ED in March 2022,[15] it was outlined that at that time, the ED in UHL comprised of four triage rooms (three for adults and one for paediatrics) and 49 single-treatment cubicles set out in four zones. The ED also had a CDU with 12 cubicles. This is a designated area where patients are monitored and treated for a period of time (usually between six and 24 hours), according to disease-specific protocols under the care of a consultant physician specialised in emergency medicine.

On the day of inspection (March 2022), HIQA noted that the ED was grossly overcrowded; UHL had enacted its escalation plan; and chronic overcrowding related to the ED was the only open high-rated risk recorded on the hospital's corporate risk register.[15] HIQA also reported that on the day of inspection, the number of patients in the resuscitation area was double its intended capacity. Patients were boarding in the resuscitation area while awaiting an inpatient bed, which had the potential to impact on the ED's capacity and ability to deal with acutely ill patients and or major trauma and emergencies.[15] Furthermore, HIQA reported that the AMU was acting — like many other areas of the hospital — as an overflow ward for non COVID-19 patients from the ED, and therefore was not functioning as designed.[15]

The findings of the 2022 HIQA report were supported by the 2022 visit of NAMP to UHL, where it was noted that 100% of AMU assessment capacity was occupied by boarders.[110] It was therefore recommended that a zero-tolerance approach to boarding in the AMU be adopted and that AMU assessment spaces be protected to enable the timely assessment of acutely ill medical patients in a safe and dignified manner. A number of other recommendations regarding the AMU were outlined. These included the provision of access to isolation facilities for AMU patients; the securing of a location for medical short stay patients with a LOS of up to 72 hours (as previously outlined in the 2018 ULHG operational plan[22]); and the strengthening of both GP communication and the AMU referral process to help align demand with the services and capacity available.[110] It was noted that since NAMP's visit to UHL in 2016,[111] the AMU had moved to an area adjacent to the ED with 13 assessment beds, six trolleys, one work-up space and six chairs, and that there had been a sustained increase in admissions to the AMU.[110] Following an inspection of UHL by HIQA in November 2023,[24] HIQA reported that the hospital's 25-bedded AMU provided a 24/7 rapid assessment service for some medical patients who presented to UHL and were acutely unwell. The unit accepted referrals from the ED and directly from primary care. The referrals were coordinated by the bed bureau service in UHL. Over 50% of the 14 admitted patients in the AMU during the November 2023 inspection, were there longer than 48 hours. Patient flow through the AMU was therefore affected and this in turn impeded the way the unit functioned, with respect to how it was designed to work. The pathways for the AMU were under review at the time of that inspection.

Further initiatives to increase acute floor capacity have also been implemented in recent years. In October 2022, the Geriatric Emergency Medicine Unit (GEMU) became operational on the acute floor in UHL.[24] This unit had a defined eligibility criteria and a dedicated team of HSCPs and NCHDs who assessed and treated people aged 75 years and over who presented to the UHL ED. The initiative aimed to avoid hospital admission for this cohort of patients in an ED setting that was more appropriate to their specific needs, with appropriate referral to and delivery of care by community services such as the ICPOP and OPTIMEND (a dedicated team of HSCPs in the hospital's ED focused on ensuring the timely assessment and intervention of people aged 65 years).[24] The ULHG briefing note to the Department of Health in April 2024 outlined that GEMU had been expanded to nine treatment bays, seven days a week, with 24-hour operations during weekdays.[89]

Across 2023 and 2024, both HIQA and the UHL Support Team reported functional limitations across the acute floor due to apparent overcrowding. For example, following an inspection of UHL ED in November 2023,[24] HIQA reported that the ASAU was operating 24/7 at the time of visit, with a planned capacity of 24. However, as with the two previous HIQA inspections (March 2022[15] and February

2023[79]), the operational function of the ASAU was limited due to inpatients being accommodated in the ASAU. This was supported by the 2024 UHL Support Team Report, which outlined that while a number of potential streaming options were co-located with the ED in UHL (such as the AMU, ASAU and GEMU), these were over capacity (due to overcrowding) and therefore the opportunity for these units to function was non-existent.[44] The Support Team noted the presence of effective hospital admission avoidance pathways in UHL's CDU, but noted with concern that this unit was typically used to accommodate admitted patients including oncology, terminally ill patients, and those requiring isolation. There was much evidence to support the view that 'decision to admit' was largely made by specialty NCHDs and, that subsequently, overcrowding and a 'nervousness' among the NCHD group resulted in a higher admission rate.[44] The HSE 2025 Capital Plan outlined that the fit-out of the basement area on the acute medical floor in UHL (which includes AMAU, GEMU and CDU relocation), was at the appraisal phase.[136]

Model 2 hospital capacity

2000 to 2019

Four national reports[5, 52, 53, 91] and two reports specific to the Mid West[83, 84] provided information and or recommendations related to Model 2 hospital capacity. Nationally in 2007, the ED Task Force report outlined that there was a need to create additional and alternative access routes to urgent care, thereby obviating the need for ED attendance.[5] This was supported by the 2007 Acute Hospital Bed Review which outlined that the roll-out of MAUs was essential to facilitate assessment without admission.[91] While MAUs were established in the St. John's, Ennis and Nenagh hospitals in 2009 (following the reconfiguration of services in 2009), as outlined previously (see section 3.3.1), these hospitals were designated Model 2 (or Model 2S) hospitals in the Future of Smaller Hospitals Framework in 2013.[52] This framework outlined an overview of services in Model 2 hospitals, including a daytime Urgent Care Centre comprising a MAU and LIU; the capacity to provide day surgery and admit some patients overnight on a pre-agreed criteria; and the ability to provide the vast majority of outpatient services.[52]

In the 2014 ULHG Operational Plan, it was outlined that ULHG planned to ensure maximum usage of the Model 2 JEN hospital beds to assist with delays in the UHL ED.[83] UHL's ability to direct patients to Model 2 hospitals at the time, was commended by the ED Task Force report in 2015, which outlined that this should be replicated nationally (acknowledging the fact that there is variation in the capacity and capability of small hospitals in different HGs).[53] Following this, across the 2016 to 2019 period, optimisation and use of the Model 2 JEN hospitals' capacity was outlined within a number of ULHG operational and service plans.[84, 85] In 2016, the ULHG Operation Plan outlined that there would be a reorganisation of HG services

with an increased focus on small hospitals managing routine, urgent or planned care locally.[84] It also specifically outlined that a plan would be agreed to optimise the use of CT in both Ennis and Nenagh, and that the number of elective admissions could be maintained in 2016 (compared to 2015) partly though the reduction of medical LOS in the Model 2 JEN hospitals.[84] Furthermore, a number of priority areas to increase capacity in Model 2 hospitals were outlined for 2016 and 2017, including a ward block extension and refurbishment programme at Nenagh Hospital and more generally, to develop and expand the MAUs at JEN Hospitals.[84, 85]

2020 to 2024

In recent years, one national report[115] and three reports specific to the Mid West[24, 79, 89] provided information and or recommendations related to Model 2 hospital capacity. As previously noted, following HIQA's inspection of the ED in UHL in February 2023, HIQA reported that the AMU and ASAU were not functioning to effectively take pressure off the ED.[79] Following this, UHL outlined within its compliance plan that it aimed to increase MAU capacity in the Model 2 hospitals during weekends; that there was ongoing promotion of attending the MAU in Model 2 sites; and that it was expanding its patient flow teams to ensure timely discharges and transfers to the Model 2 JEN hospitals. Subsequently, HIQA inspectors reported following the November 2023 visit to the UHL ED that evidence of improvements in operational efficiencies was provided, such as increases in Model 2 MAU services.[24] Additionally, it was noted that patients waiting in the UHL ED were being signposted to the services and waiting times within the MAUs in the Model 2 JEN hospitals. Patients in the ED were also transferred to these hospitals when appropriate. Since the February 2023 inspection, the weekend capacity of these MAUs had also been increased from 32 to 38 slots overall and the Patient Flow Team had been expanded to support the maximum transfer of suitable patients to these Model 2 hospitals.[24]

Nationally, the 2023 Review of MAUs outlined that at the time of review, there were over 27,000 admissions to MAUs annually. It was noted that there was potential to increase this by approximately 34,000 additional admissions if all sites captured the same proportion of their catchment population as the busiest unit (the MAU in Ennis).[115] It was outlined that on average, 7,600 patients per year who would have otherwise attended an ED, attended the MAU in Ennis. This was estimated to equate to almost 20 more patients per day through an ED, and even with a 1 day ALOS, this would result in almost 20 additional inpatient beds required in a Model 3 or 4 hospital.[115] The review also noted that demand for MAUs was driven through GPs and available MAU slots, differentiating them in demand terms from injury units (IUs), where patients can walk in without a referral.[115] This means that activity in the MAUs is not necessarily a reflection of demand, but of capacity within the services and within primary care. The review also noted that there may be an opportunity to use point-of-care testing (POCT) where MAUs have limited access to

laboratory diagnostics. As of January 2025, St. John's and Nenagh reported limited or no access on site to laboratory diagnostics, with samples taken on site sent to the lab at UHL where required. It was outlined that the use of POCT in Model 2 hospitals may improve turn-around times (and therefore ALOS for patients), and may also support the ability to increase activity within the units, and free up capacity in lab diagnostics.[115] In 2023, it was reported that the MAUs (as a whole) in the Model 2 JEN hospitals benefited from an investment of €5.2 million to secure current services and provide staffing for extended operational hours. A new €2 million IU also opened in Ennis Hospital in 2023. It was noted that over 11,000 patients attended the IU in 2022.[87]

Support for increased capacity within the MAUs was also highlighted in the April 2024 ULHG briefing note to the Department of Health, where it was noted that the opening hours of the MAUs in the Model 2 hospitals were being extended to 24/7 on a phased basis (at the time, they were operating from 8am to 8 pm daily).[89] As of February 2025, EAG representatives confirmed that the MAUs in Ennis and Nenagh hospitals were open from 8am until midnight, seven days a week. While the 2024 ULHG briefing note highlighted that expanded access to the MAUs was having a positive impact on the delivery of care to patients, EAG representatives noted a poor uptake of these extended opening hours by GPs, potentially because GP out-of-hours services cannot refer patients for diagnostics. Current demand for rehabilitation services was also noted to have remained low. EAG representatives also noted that the extension of MAU hours to 24/7 is not recommended in the HSE Model of Care for Acute Medicine (the 2010 NAMP report), with concerns raised around the extension of MAU hours without sufficient resources, suggesting that six consultants would be required to staff an MAU operating 24/7.

It was also noted that, as of April 2024, the LIUs in the Model 2 JEN hospitals were open every day for injuries in adults and children aged five and upwards.[89] As previously noted, in the 2025 Draft Programme for Government, it was outlined that the Government intended to standardise the opening hours of IUs to ensure a consistent 7-day service from 8am to 8pm, and to open at least an additional 12 IUs nationally.[130]

3.3.3 Patient flow

When summarising information extracted relevant to patient flow, three specific aspects were identified:

- alternatives to ED presentation
- patient flow on the acute floor
- patient flow out of the hospital.

Alternatives to ED presentation

2000 to 2019

Four national reports[52, 53, 90, 91, 116] and one report specific to the Mid West[63, 83] provided information on, and or recommendations related to, alternatives to ED presentation. In 2001, the Department of Health Quality and Fairness strategy outlined a substantial programme of improvements for EDs nationally, a number of which were aligned with directing patients to the most appropriate form of care, potentially avoiding the ED.[116] These recommendations included the establishment of minor injury units for the appropriate treatment and management of non-urgent cases; strengthening diagnostic facilities available to GPs; and development of admission protocols that ensured emergency patients would be the only group of patients admitted to hospital through the ED. In 2003, the Capita Consulting review of bed management function outlined that MAUs, rapid access alternatives to the ED (located primarily in Model 2 hospitals since 2013), were only in situ in eight hospitals visited within the review, while six others had included them in plans for 2003.[90]

As previously noted in section 3.3.2, the 2007 Acute Hospital Bed Review highlighted the importance of increasing access to diagnostics and assessment without admission, and recommended the roll out of MAUs to facilitate assessment without admission where appropriate.[91] Following the publication of the 2010 NAMP report,[105] and the 2013 publication of the HSE Smaller Hospitals Framework (which outlined the services that should be available at each model of hospital),[52] the 2013 Mid-Western Regional Hospitals Group Service Plan and the 2014 ULHG Operational Plan noted planned priorities for services outside of the ED.[63, 83] These included GP and ED rapid referral access clinics, the development of LIUs at St. John's and Ennis,[63] and the development and extension of the MAUs in the Model 2 JEN hospitals.[83] Furthermore, in 2015, the ED Task Force Report highlighted as an objective the need to develop and extend alternative access routes to urgent care to minimise the need for ED attendance.[53] Actions included extending the use of CITs and establishing a national campaign to promote LIUs, rapid access units, and GP out-of-hours services.

2020 to 2024

More recently, three national reports[75, 115, 130] and two reports specific to the Mid West[44, 110] outlined information on, and or recommendations related to, alternatives to ED presentation. Following NAMPs visit to UHL ED in 2022, it was recommended that UHL should maximise the effectiveness of systems such as the Navigational Hub, bed bureau and Healthlink by using them to signpost patients to the most appropriate care pathway in advance of presenting to the hospital.[110] Nationally, the 2023 HSE review of MAUs recommended that referral pathways to these MAUs should be standardised with the local integrated care committees (LICC).[115]

Additionally, the 2024 HSE Urgent and Emergency Care Plan outlined a number of hospital avoidance actions which should be undertaken.[75] These included standardising the opening hours of all acute hospital LIUs to provide a 7-day service from 8am to 8pm including Bank Holidays; the opening of additional injury units; and optimising the usage of paediatric rapid access clinics. This is in line with the 2025 Draft Programme for Government which, as previously noted, outlined intentions to standardise the opening hours of IUs (to provide a 7-day service from 8am to 8pm) and to open at least an additional 12 IUs.[130]

Further hospital avoidance actions outlined in the 2024 HSE Urgent and Emergency Care Plan included working with GP out-of-hours-services to maintain and or increase GP out-of-hours contact and reduce the level of GP out-of-hours referrals to EDs, and put plans in place to expand the use of video-enabled care for select services.[75] Specific to UHL, it was outlined that an ED in the home (EDITH) frailty response service should be operationalised. Similar to the Pathfinder Programme, EDITH aims to deliver healthcare services to adults aged 65 years and older in their home.[140] However, EDITH is targeted at emergency medical care, and includes a full medical and targeted functional assessment by a senior decision-maker (doctor and or ANP) and occupational therapist, including mobile echocardiograms and bloods. EDITH accepts referrals from local GPs and other community-based HCPs, nursing homes, the National Ambulance Service (NAS), and from the hospital's ED team.[140] The initiative was operationalised in UHL in January 2025.

The 2024 UHL Support Team report outlined that senior clinical staff in the ED positively noted their ability to refer suitable patients to the MAUs in the Model 2 JEN hospitals, and reported it as an effective enabler to admission avoidance.[44] However, the Support Team report outlined that all services across the Mid West needed to be better integrated to ensure appropriate prioritisation of patients in line with available resources. The report outlined that each 'speciality' should be reviewed by the respective Clinical Director and Directorate Nurse Manager to identify issues of concern that impact on the specialty's ability to proactively see and treat patients and positively impact on patient flow across the Mid West. It was noted that directorates must work collaboratively to address identified concerns and ensure optimisation of resources and equity of access.[44]

Patient flow on the acute floor

2000 to 2019

Six national reports[5, 45, 105, 107, 112, 118] and three reports specific to the Mid West[62, 63, 83] outlined information on, and or recommendations related to, patient flow on the acute floor. In 2004, the Comhairle na nOspidéal report on AMUs highlighted that all hospitals receiving acutely ill patients should have an AMU to combine the functions of medical assessment and medical admission.[107] The report

recommended using these units for two categories of patients: those who are acutely ill and need immediate care, and those with clinical uncertainty who may require further assessment and treatment. It was proposed that some patients with an anticipated short LOS should remain in the AMU, while those requiring specialised care or with an anticipated long LOS should be admitted to the appropriate ward via the AMU. The recommended maximum LOS in the AMU was three to five days.[107] The report also outlined a number of limitations to the patient pathway following presentation at an ED. These limitations included a shortage of acute medical inpatient beds; repeat inappropriate re-assessment by ED staff of acutely-ill patients already referred by GPs for admission; the majority of ED care being delivered by junior doctors (many of whom may have been relatively inexperienced); and the admission of patients to any bed that was unoccupied in the wider hospital. The report also included factors important to ensure appropriate admissions, including extended access to rapid assessment clinics and outpatient services; rapid assessment and access to diagnostics; early availability of senior medical decision-makers at admission; streamlining patients into categories; and rapid access to facilities such as AMUs. Specific to the Mid West Region, the 2004 Comhairle na nOspidéal report highlighted that a Medical Day Ward (MDW) initiative had been introduced in Limerick. This ward aimed to bridge outpatient clinics with the ED, providing an alternative assessment pathway for some specific diagnoses, such as deep vein thrombosis, falls and shortness of breath. At the time, it was found that the introduction of the MDW had led to a reduction in average LOS for patients over 75 years by 1.2 days.

The need for AMUs to facilitate patient flow in the hospital was also highlighted in the 2007 ED Task Force Report.[5] This report also identified a number of other initiatives to improve patient processing and management including establishing CDUs for some patients to be seen and treated rapidly, and fast tracking of specialist consultant clinics. However, as previously stated, the ED Task Force Report noted that in a number of hospitals visited by the Task Force in 2007, the existing space and design would not allow for efficient implementation of these initiatives.[5]

Nationally, in 2009, the HSE technical report of EDs outlined that a number of hospitals had begun to implement initiatives to improve patient flow and establish patient pathways through the hospital.[112] However, at that time there was no systematic mechanism to share good practice initiatives to facilitate replication on a wider basis.[112] The 2010 NAMP report outlined the concept of the acute floor to enhance patient flow and enable a standardised approach to service provision,[105] with the Acute Floor Model subsequently proposed by NAMP in 2017.[119] The 2011 HSE Regional Service Plan Area West outlined a continued focus on the development and use of AMUs and ASAUs for emergency admissions.[62] Related actions outlined for 2011 included the appointment of three ambulatory care physicians to the region

for the NAMP in the Mid West Regional Hospital, Limerick, and the implementation of the NAMP in St. John's.[62]

In 2012, the National Emergency Medicine Programme outlined a number of recommendations related to patient flow in the ED.[118] These included that CDUs should be developed in all 24/7 EDs; patients requiring ICU admission should be admitted to an ICU bed within six hours of ED arrival; emergency diagnostics should be routinely available from 8am to 8pm, seven days a week; and emergency on-call services should reflect service need.[118] This report also recommended the development of a new paradigm of care for older patients within emergency care networks.[118] This included closer collaboration with the Primary Care, Medicine for the Elderly, and Acute Medicine programmes in providing education and training in core geriatric competencies and recognition of atypical presentations within EDs, and improving the integration of geriatric care.[118] This was supported in the 2018 Framework for Ambulatory Care, which reported that that frail, older patients should be prioritised for ambulatory care, and recommended a list of clinical conditions seen in those over 75 years that would constitute relevant ambulatory-sensitive conditions. Initiatives for this age group, such as 'Frailty at the Front Door', was recommended as part of the Geriatric Emergency Medicine Service (GEMS).[45] 'Frailty at the Front Door' commenced in the ED in UHL in November 2021, as a part of ICPOP.[141]

2020 to 2024

More recently, one national report[75] and three reports specific to the Mid West[23, 24, 44, 110] provided information and or recommendations related to patient flow on the acute floor. Following the 2022 visit of NAMP to UHL, it was noted that the pathway for accepting GP referrals through the UHL bed bureau to the AMU had resumed following its curtailment during the COVID-19 pandemic.[110] NAMP also made a number of recommendations in relation to patient flow on the acute floor, including to strengthen engagement with GPs and or primary care (possibly facilitated by LICCs) and to co-design and agree an operational policy with acute floor stakeholders on the streaming of patients to AMU.

The 2022 Deloitte Patient Flow Report also outlined that a review of the AMU pathways should be undertaken, as there was an opportunity to reduce emergency admissions by 10% (2,625 bed days) over a year, equating to a potential bed saving of eight inpatient beds, given an ALOS of one day with these admissions.[23] Deloitte advised this could be achieved if admission to the AMUs was limited to patients who had been referred by a GP (and provided with an AMU slot via the bed bureau) or who had been referred following assessment by an ED doctor. The UHL compliance plan provided to HIQA following its November 2023 inspection noted that the AMU referral criteria was under review to improve patient selection and comply with a

maximum LOS in the AMU of 48 hours.[24] The review was due for completion in Q2 2024.

The UHL compliance plan subsequent to the November HIQA 2023 inspection also outlined ongoing daily review of patients in the ED with diagnostic requirements through Red2Green, with early communication to pathology, radiology and cardiology to ensure prioritisation.[24] Red2Green is an electronic patient flow system to assist in managing patient flow, predicting date of discharge or transfer of patients.[142] Access to ED diagnostic imaging was later confirmed as an enabler to patient flow in the 2024 UHL Support Team report, with UHL staff advising the Support Team that this represented significant improvement on recent years.[44]

The 2024 HSE Urgent and Emergency Care Plan outlined that there should be high levels of streaming (to units such as the AMU and GEMU) following presentation to the ED.[75] However, as outlined previously in section 3.3.2, HIQA's inspection of the UHL ED in November 2023 found that although the AMU and ASAU were providing a pathway to patients from the ED and those with GP referral, their full functionality was impeded due to a practice of accommodating patients awaiting inpatient beds in the units.[24] Consequently, these units were noted to be less effective at promoting patient flow than intended.[24]

The 2024 UHL Support Team report also outlined that UHL's 'Urgent and Emergency Care Escalation Plan' required revision to ensure that the sequenced actions identified effectively supported patient flow.[44] For example, it was outlined that there was a need for assessment units to be able to function, scheduled care to continue, use of private capacity to be incorporated, and staffing resources to focus on patient flow.[44] Additionally, the UHL Support Team suggested a 'reset' in 2024 to address the historical backlog of inpatients, restore balance and enable daily active management of flow (scheduled care, unscheduled care and cancer services).[44] This 'reset' aimed to relieve the pressure on front-line staff, and create capacity for them to focus on improved patient flow processes together with the overall patient experience. The 'reset' took place on 8 August 2024, where a number of inpatient, outpatient and day cases across ULHG were deferred to a later date and the service focussed instead on unscheduled care.[114] Following this reset, normal services began to resume after 19 August 2024.[113]

Patient flow out of the hospital

2000 to 2019

Five national reports[53, 91, 112, 118, 119] and three reports specific to the Mid West[22, 80, 119] provided information on, and or recommendations relevant to, patient flow out of the hospital. The 2001 Mid-Western Health Board Service Plan outlined that a proper transport system for inter-hospital patient transfers had been set up to

facilitate the movement of patients across acute settings.[80] The 2007 Acute Bed Review, while making recommendations around increases in capacity (see section 3.3.2), also outlined that there was a significant opportunity to use the current complement of acute beds more efficiently through changes in hospital practice.[91] This could be facilitated through implementing protocol-based discharge planning, use of estimated discharge dates and reviewing internal hospital processes to reduce patient delay.[91] Similarly, the 2009 HSE technical report on EDs found a need to improve discharge planning. The report recommended wider use of early discharge planning based on standard targets for each condition, distributing discharges more evenly across the week and discharging of patients earlier in the day.[112] This report also noted that a dedicated bed management function could facilitate coordination of discharges. This was further reflected in the 2015 ED Task Force Report which noted requirements to develop sustainable solutions to the issues of delayed discharges to optimise existing hospital capacity.[53] Recommendations included application of predicted date of discharge for patients, that the first discharge from each ward occurred no later than 9.30am, and that discharges occurred seven days a week.[53]

In 2016, UHL and University Hospital Galway (UHG) took part in the National Patient Flow Improvement Programme.[119] The programme was aimed at testing the 'scientific management' of patient flow. Multiple issues were identified regarding operational flow management in the hospitals. These included multiple overlapping communications and a reactive culture of bed placement rather than a proactive culture of operational capacity planning. However, while taking part in the programme, UHL and UHG were able to demonstrate improvements by focusing on some key areas; such as reframing the bed management meetings around capacity management, improving the flow of information to inform bed management, and targeting early-morning discharges. As a result, pre-noon discharges increased by 200-300%, thereby creating inpatient capacity earlier in the day and reducing pressure on the ED. Following this, in 2018, the ULHG Operational Plan included goals of improving internal efficiencies and more appropriate bed usage by reducing LOS and facilitating early discharges.[22]

2020 to 2024

More recently, two reports specific to the Mid West[15, 24] outlined information, and or recommendations relevant to, patient flow out of the hospital. Following the March 2022 visit by HIQA to UHL, UHL outlined its compliance plan that it would ensure the Model 2 JEN hospitals took a minimum of five patients per day (including weekends) and that Croom Orthopaedic took two patients per day.[15] During the HIQA inspection of UHL ED in November 2023, HIQA noted that UHL was performing relatively well in relation to patients' ALOS and delayed transfer of care in comparison to many other Model 4 hospitals, which demonstrated good patient flow processes through the hospital and on to the community.[24] HIQA noted that UHL

had undertaken significant work both internally and with colleagues in the community setting to establish measures to improve patient flow and provide alternate pathways for patients. It was outlined that UHL's use of GEMU, OPTIMEND, ICPOP, the Pathfinder Programme, Model 2 JEN hospitals, community links (such as CIT and the Alternative Pre-Hospital Pathway (APP) Car (see section 3.3.4)) was supporting hospital avoidance and discharge.[24] UHL then further outlined within its compliance plan following the November 2023 HIQA inspection that it would continue to maximise the transfer of patients to the Model 2 JEN hospitals, with daily performance reviews.[24] The creation of a virtual ward in UHL in 2024 now also supports patients with specific cardiovascular or respiratory conditions in receiving care, monitoring and treatment in their own home.[143] In a virtual ward, a patient remains under the care of the hospital team, but is managed at home with the help of remote monitoring (via a provided phone or tablet).[143] As of February 2025, EAG representatives confirmed that there is also a Community Discharge Team with 'in-reach' function to UHL (composed of two nurses and two occupational therapists), and a liaison post with the CIT which supports patient discharge to the home.[144]

3.3.4 Community healthcare

When summarising information extracted relevant to community healthcare, three specific aspects were identified:

- integration of primary care services
- ambulance and paramedic services
- step-down care facilities in the community.

Integration of primary care services

2000 to 2019

Twenty national reports[5, 27, 34, 36, 45, 51-53, 65, 66, 90, 91, 104, 105, 112, 116-119, 127] and eight reports specific to the Mid West Region[22, 43, 62, 63, 80, 82, 86, 92] noted the importance of, or included recommendations related to the integration of community and hospital care. Several of these reports stated that the integration of services needed to be facilitated, without outlining specific actions to do so.

More specifically, in 2001, the Mid-Western Health Board (MWHB) highlighted the intended appointment of a Director of Primary Health Care Services and a review of the Primary Care Unit.[80] This was prior to two publications from the Department of Health and Children in 2002 which included actions to facilitate the integration of primary and secondary care nationally.[116, 117] These included the development of a new primary care model and the establishment of a National Primary Care Task Force; investment in the extension of GP co-operatives; the establishment of

national out-of-hours GP services; an increase in primary care teams and primary care networks; and the piloting of community-based diagnostic centres. This was supported by two further national reports in 2003 which highlighted a lack of access to community care services outside of standard business hours[90] and recommended that regional management structures should be put in place to support integration between health services at the local level.[104]

In 2006, in an effort to develop integrated care pathways across the acute hospitals and community care, community intervention teams (CITs) were established; with two teams operating in Dublin, and one each in Cork and Limerick.[112] The aim of these teams was to provide a rapid response to patients who were medically suitable for treatment in the home. Despite the implementation of this initiative, a 2007 HSE review of acute hospital services in the Mid West found that a range of primary and community services were still needed to support care in acute hospital settings.[92] It was recommended that these services include out-of-hours services, community chronic disease management programmes, and community facilities to enhance diagnostics.[92] This was also supported at a national level with the 2007 HSE Emergency ED Task Force outlining that there were no formal structures to provide ongoing links between primary care, community care and hospitals, and that out-of-hours community services were variable.[5] The report highlighted that CITs may enable the formal links, however at the time of the ED Task Force report, there were few CITs operational nationally.

Across the years 2007 to 2010, a number of national reports highlighted that hospital and primary care services needed to be further integrated, extended and or reviewed.[90, 91, 112] Specifically, the 2007 review of acute hospital bed use in hospitals in Ireland recommended the re-orientation of services to ensure more appropriate placement of patients,[91] with the 2009 Capita Consulting review of bed management noting that community care services were not generally available outside of standard business hours.[90] Additionally, a 2010 national review of GP out-of-hours' services identified that while Shannondoc provided a 24-hour service to Clare, North Tipperary and Limerick County since 2002, it did not service Limerick City.[145] In September 2011, Shannondoc out-of-hours GP service was extended to Limerick City.[146]

In the Mid West, service plans for 2011 and 2012 (which included both the West and Mid West of Ireland area), and 2013 (which was specific to the Mid West) all outlined priorities related to the integration of community and hospital services.[62, 63, 82] Priorities included increasing the number of primary care teams[62, 63, 82] and improving disease management in both primary and ambulatory care services.[62, 82] As of February 2025, an EAG representative confirmed that there were 39 primary care teams across the Mid West, all of which were operational.[144] The 2012 plan

also noted that GP out-of-hours contracts were to be provided, however it was acknowledged that this would be at reduced funding levels from 2011.[82]

As previously mentioned, in 2013, with the establishment of HGs, the HSE and Department of Health jointly published a framework aimed at reorganising and supporting the future of smaller hospitals.[52] This framework emphasised the importance of the integration of GP and community services with smaller hospitals, with an aim of providing 90% of health and social care in local communities. This integration of care services across community and hospital sectors was further supported (with regards to all acute hospitals) in a number of national reports[34, 53] and reports specific to the Mid West Region[22, 43, 63, 86] across the 2015 to 2018 period.

The 2018 Sláintecare Implementation plan included a goal of providing high quality, accessible and safe care that meets the need of the population.[34] This included strategic actions for 1) improving population health-based planning and developing new models of care to deliver more effective and integrated care; 2) expanding community-based care to bring care closer to home; developing and modernising the acute care system to address current capacity challenges and increasing integration between the hospital sector and community-based care; and 4) expanding eligibility on a phased basis to move towards universal healthcare and supporting a shift to community-based care. Additionally, the plan noted as part of the three-year actions, the priority for investment in community interventions teams, community diagnostics, and community nursing services. These actions were set out in order to expand the range of services in the community to ensure appropriate provision of, and access to, services in the community. The 2019 Sláintecare Action Plan included an action to scope community-based diagnostics.[127]

2020 to 2024

More recently, ten national reports[14, 74, 75, 147-149] and eight reports specific to the Mid West Region[15, 23, 24, 44, 79, 88, 89, 110] included information on integrating community and primary care services with acute services. The 2021 Sláintecare Implementation Strategy & Action Plan included a workstream for the Enhanced Community Care (ECC) programme.[122] The ECC aims to increase community healthcare services and reduce the pressure on hospital services. This is delivered through community specialist teams predominantly aimed at older people (through ICPOP), and people with chronic disease.[89] The implementation strategy outlined actions over the following three years which included: establishing 96 Community Healthcare Networks which would provide foundation and organisational structures that would enable integrated care with primary and acute care partners, scaling of CITs, implementing Community Specialist Hubs (including ICPOP), and enabling direct GP access to community radiology. Additionally, the 2022 and Sláintecare

Action Plan included deliverables for establishing 30 community specialist teams (CSTs) for ICPOP and 30 CSTs for chronic disease, established for the management of chronic disease and older people with complex needs.[123, 124] The 2021-2023 Sláintecare Progress report noted that 24 of the planned 30 CSTs for both ICPOP and chronic disease, were operational.[150] The 2025 Sláintecare and Programme for Government 2025+ report noted that the full implementation of the remaining CSTs will be dependent on both funding allocation in Budget 2026/27 and the availability of suitably qualified staff for recruitment to the programme.[149] Additionally, the report highlighted a plan that the ECC programme will have a full cohort of operational teams by 2027 to enhance delivery of end-to-end care and allow for the optimisation of virtual care in the community.[149]

The 2022 Deloitte Patient Flow Report highlighted challenges for accessing primary care in the Mid West.[23] This report recommended that national-level strategies were needed to address the challenges; that increasing the use of existing funded community services would be beneficial; and that it was important to evaluate the impact of increased community services on demand for acute services. This was supported by the 2022 HIQA Overview Report of EDs, which highlighted that progression of Sláintecare implementation would facilitate moving services away from hospitals, and that a greater investment was needed for access to primary care services and diagnostic services.[14] At this time (2022), in the Mid West, it was noted that a number of community services were in place including the ICPOP and the Community Diagnostics Programme.[151] From January to September 2022, the ICPOP received 600 referrals (with no waiting list apparent), and the Community Diagnostics Programme was supporting an average 760 people a month.[151] As of February 2025, an EAG representative confirmed that all GPs in the Mid West have a referral access pathway to community diagnostics under the private provider model, supporting hospital avoidance.[144]

Furthermore, following a HIQA inspection of the UHL ED in March 2022,[15] a number of actions related to primary care and community integration were included within the UHL compliance plan. These included progressing initiatives between ULHG and the community services to improve patient flow (once approved and funding secured); developing closer working relationships with community services through the Unscheduled Care Committee; and addressing the reduction in GP referrals, and increase in self-presentation, to UHL ED. It was noted within the HIQA inspection reports from visits conducted in February[79] and November of 2023,[24] that hospital management at UHL had received "substantial external supports and resources" to strengthen integration with community healthcare. Notable impacts as a result included the use of community links (such as CITs) which supported hospital avoidance and discharge, and the establishment of an Unscheduled Care Committee in 2022.[24] This committee includes the ULHG and the Mid West CHO and is

responsible for preparing and implementing an integrated response for patients accessing unscheduled care in hospitals.

The 2024 ULHG briefing note to the Department of Health also provided an update on the ECC programme.[89] It was noted that ULHG and HSE Mid West Community Healthcare had formalised a governance structure and formed a number of sub-committees to deliver the ECC programme. As of February 2025, an EAG representative confirmed there are three chronic disease hubs based in Ennis, Limerick City and Nenagh, and that expansion of the CSTs for chronic disease programme is on a phased basis, subject to staff recruitment.[144] A January 2025 report from the Chronic Disease Management Programme noted that GP uptake of the programme was high, and a reduction in health service usage for the cohort included in the programme, however it highlighted the need for increased access to diagnostic technologies (such as echocardiogram and spirometry) in the hubs.[147] In 2025, a report from the ESRI on national capacity projections for general practice (both GPs and general practice nurses), highlighted that there would be increasing demand on GP practice as eligibility and participation in the treatment arm of the Chronic Disease Management Programme expands over the coming years.[148]

Additionally, the 2024 ULHG briefing note to the Department of Health highlighted that a strategy of making GPs and ANPs available within the EDs (termed GP at the door strategy) had commenced in April 2024.[89] This initiative was operating every day from 12pm to 10pm to enable non-urgent patients without a referral to be seen by a GP.[101] The 2024 HSE UHL Support Team report noted that this service supported hospital avoidance.[44] The 2024 HSE UHL Support Team report also highlighted the importance of maximising numbers of daily discharges to community units and maximising the use of CITs.[44] As of February 2025, an EAG representative confirmed that multidisciplinary CITs were based in Ennis, Nenagh and Limerick, and playing a role in supporting hospital avoidance and or hospital discharge. CITs provide support through disciplines including nursing, HCA, physiotherapy and occupational therapy, supporting discharges from the Acute Hospital Group by providing intensive therapy at home for a two-week period. The CITs aim for a response time of 48 hours following acute hospital discharge.[144] Furthermore, the HSE 2025 Capital Plan outlines the equipping of dedicated areas in Nenagh and Ennis primary care centres, to accommodate ECC hubs.[136]

Further primary care services being used in the Mid West include two out-of-hours GP services; Shannondoc and Limerick Doc. Shannondoc provides out-of-hours medical care seven days a week, with Limerick Doc providing out-of-hours medical care on Saturdays, Sundays and Bank Holidays. In 2023, it was reported that Shannondoc rostered more doctors than previous years, with a 30% increase in medical manpower on duty.[152] In the same year, Shannondoc was also provided

with an extra €193,000 to roster additional doctors and nurses to deal with the increased patient volumes, prior to the Christmas surge.[152]

Ambulance and paramedic services

2000 to 2019

One national report[116] and three reports specific to the Mid West noted a need to improve ambulance services.[78, 80, 92] In 2001, a report by the Department of Health and Children noted that measures to provide the highest standard of pre-hospital emergency care and or ambulance services would be advanced.[116] These measures included upgrading the ambulance fleet, 24-hour staffing of all ambulance stations, and crewing of all ambulances with emergency medical technicians. At this time in the Mid West (2001), it was noted in the MWHB Service Plan that two-person ambulance crews were only operating in Limerick City and Ennis (at night), but this would need to be established region-wide for an effective service.[80] The 2008 HSE Mid West review of acute hospital services recommended the development of an advanced paramedic service. In this service, paramedics would be specifically trained to carry out urgent clinical assessment and start emergency resuscitation in the patient's home, working as the front-line for local emergency response.[92] This was supported within the 2009 HIQA review of services at the Mid-Western Regional Hospital, Ennis, which noted that there was no differentiation in ambulance crews for providing pre-hospital emergency care and patient transport services.[78] A number of further recommendations were outlined within this HIQA report, including that the HSE needed to ensure there was a suitable number of qualified ambulance staff locally (without a reliance on the on-call rota), and that ambulance crews provided transport only to patients who required emergency care. This required the establishment of appropriate resources to provide non-emergency transport of patients.

2020 to 2024

More recently, one national report[74] and three reports specific to the Mid West[15, 24, 79] included recommendations for ambulance services. In 2023, the HSE Urgent and Emergency Care Operational Plan recommended the establishment of a Hospital Ambulance Liaison Person (HALP) in all Model 3 and 4 hospitals.[74] As of February 2025, an EAG representative confirmed that the NAS had a HALP deployed in UHL.[153] This is an unfunded role filled by front-line staff on alternative duties, on rehabilitation from illness and or injury and so on. It was noted that while NAS HSE Mid West has endeavoured to fill this role on an ongoing basis, it is not possible seven days a week. The grade for a Hospital Ambulance Liaison Supervisor has also been approved, but as of February 2025, these positions remain unfunded. NAS would require both WTE ceiling adjustment and recurrent funding in order to progress these positions.

UHL compliance plans, following HIQA inspections in 2022 and 2023, included actions for the implementation of the Pathfinder Programme.[15, 24, 79] This programme aims to deliver an alternative to the ED for patients over 65 years. The service provides an ambulance team that includes an advanced paramedic, clinical specialist in occupational health, or physiotherapist to treat low-acuity older patients at the scene rather than bringing them to the ED. The programme was implemented in the region in October 2022, and as of 2023, was operating Monday to Friday from 8am to 8pm in the Limerick region.[79, 98] Following a HIQA inspection of UHL ED in February 2023, UHL outlined actions within their compliance plan to reduce the age limit for the Pathfinder Programme from 65 years to 60 years and older, and to accept calls from the Clare region.[79] In October 2023 the programme was extended to County Clare and North Tipperary,[154] although the age criteria has remained at 65 years and older. In addition, an APP programme, in collaboration between ULHG and NAS, commenced in September 2023.[155] As of January 2025, this was operating from 10am to 6pm, Monday to Friday, for calls within a 45-minute radius of the ambulance centre in Limerick City. It comprises of an emergency medicine specialist or registrar, and an emergency medical technician or paramedic, responding in an ambulance car (APP Car) and aims to provide care in the community for low-acuity emergency calls.[155] The 2024 HIQA report (following the November 2023 inspection) outlined that the Pathfinder and APP programmes, along with several other initiatives implemented across 2023 to 2024 (such as Hear and Treat and community paramedics) were supporting hospital avoidance and discharge.[24] It was also recommended in the 2024 HSE Urgent and Emergency Care Plan that the use of NAS alternative care pathways, including the Pathfinder Programme, and the use of community paramedics, be further maximised nationally.[75]

Step-down care facilities in the community

2000 to 2019

From 2002 to 2018, seven national reports[5, 11, 27, 53, 65, 90, 102] and three reports specific to the Mid West[80-82] included information about step-down care facilities in the community. The 2002 Report of the Committee on Accident and Emergency Services reported that access to inpatient beds in general hospitals was influenced by the lack of alternative facilities for the elderly and facilities for young, chronically-sick patients.[102] The 2002 Department of Health and Children review of hospital bed capacity and the 2003 Capita Consulting report of bed management function outlined that a lack of capacity for post-acute care in appropriate facilities (rehabilitation, step-down, intermediate care and nursing home and or long-term care facilities) contributed to either bed days lost in hospital,[11] and or high levels of delayed discharges in the major tertiary hospitals.[90] The 2002 Acute Hospital Bed Capacity Review outlined that, at that time in one major acute hospital (unnamed),

19,323 bed days were lost due to delayed discharge, and this represented approximately 12% of bed days used in that hospital that year. Additionally, 85% of bed days lost were due to a lack of appropriate placement facilities (long-term care, rehabilitation, hospice care, convalescence, etc.) and 15% of bed days lost were due to inadequate social and or community support services to enable a return to home.[11]

This was also evident in both the 2001 and 2002 MWHB operational and service plans which highlighted that an initial 35 additional beds, subsequently increased to 70 additional beds, needed to be contracted in the nursing home sector as part of a winter initiative to facilitate discharge from beds in the acute setting.[80, 81] In 2002, additional funding was available to provide a range of supports including medical aids and appliances to facilitate the discharge of older people from acute hospitals and reduce the level of hospital re-admissions.[81] In 2007, the Emergency Task Force Report recommended that (specific to the Mid-Western Regional Hospital, Limerick) access to St. Camillus' long-stay facilities needed to be urgently reviewed to ensure patient flow was optimised and delayed discharges contained, and an urgent review of local arrangements for nursing home funding and long term care be conducted to ensure that options in other areas were optimised.[5]

The 2012 HSE West Service Plan noted a priority to administer the Nursing Homes Support Scheme.[82] This plan noted a commitment to allocate funding to increase intermediate care capacity (that is, step-up and or step-down beds), and to provide additional community services such as home care packages. The plan also highlighted a commitment to keeping public long-term care beds open as long as was practical, however this was noted to be at risk, given financial challenges at that time. The decision-making process for long-term residential care placements would also need to be enhanced to ensure all support options were explored prior to placement in a long-term care facility. A need to support step-down facilities in the community in order to reduce the number of delayed discharges from hospitals was again noted nationally across the 2015 to 2018 period. The 2015 HSE Acute Hospitals Division Operational Plan recommended a programme for the development of a discharge pathway for patients who require access to long-term care,[65] while the 2018 Health Service Capacity Review found that capacity overall in the health system needed to be increased, with this increase likely to include residential beds.[27]

2020 to 2024

More recently, two national reports[74, 75] and three reports specific to the Mid West[15, 24, 89] included information on care outside of acute settings. Following HIQA inspections of the UHL ED in March 2022 and November 2023, UHL compliance plans included actions related to community care homes.[15, 24] These actions

included the delivery of mobile diagnostics in private nursing homes (as a hospital avoidance measure),[15] and enhanced collaboration with community services to maximise capacity in rehabilitation, long-term care, and home care services.[24] As of January 2025, ULHG representatives confirmed that mobile diagnostics were taking place in nursing homes, patients' homes and in the primary care centre in Ennis. The ULHG briefing note to the Department of Health in April 2024 outlined that procurement was underway for a temporary operation of 50 beds in the Community Nursing Unit (CNU) in Nenagh.[89] The intention was for these beds to be used as a step-down and rehabilitation facility for elderly people in North Tipperary for one year, until the first 96-bed block at UHL had been opened. This briefing note specified that the unit would open 12 to 18 months after the contract commenced with the successful private provider, and that it would require an additional 65 whole time equivalents (WTEs) to facilitate the opening of this facility as a CNU. It was also outlined in the ULHG briefing note to the Department of Health in April 2024 that a further 20 permanent step-down transition and rehabilitation beds were to be procured in Clare.[89] As of February 2025, an EAG representative confirmed that 50 beds had been procured in the CNU in Nenagh, and that this was open and operational. It was also confirmed that 25 rehabilitation beds had been procured in Cahercalla Community Hospital, Co. Clare. The HSE 2025 Capital Plan also outlined that the phased replacement and refurbishment of the CNU at St. Camillus's Hospital Limerick, and the refurbishment and extension of the CNU in St. Ita's Newcastle West, were currently in the construction phase.[136] It also outlined the replacement of the CNU in St. Josephs, Ennis, which would include long and short stay beds, was at the detailed design phase.

Two further HSE Urgent and Emergency Care reports across 2023 and 2024 made recommendations for care outside of acute settings; however, the impact of these recommendations in the Mid West is unknown.[74, 75] For hospital avoidance, both plans recommended a Nursing Home Conveyances Flex ECC model to provide an interface for public and private nursing homes.[74, 75] The 2024 plan also recommended that this model could include a community specialist team for inpatient geriatric assessment to support admission to nursing homes.[75] In terms of supports for discharge operations, both plans recommended the introduction of transitional care funding (TCF) as a surge measure, so that all patients awaiting Nursing Home Support Scheme funding could be transferred to private residential care facilities.[74, 75] As of February 2025, EAG representatives confirmed that community specialist teams are well-established in the Mid West, and that TCF is an important surge measure used to manage the flow. However, it was noted by EAG representatives that there was a need to decrease the dependency on TCF, and that there can be a delay with its deployment.

3.3.5 Staffing

When summarising information extracted relevant to staffing, three specific aspects were identified:

- overall staffing in acute hospitals
- staffing in the ED
- staffing in primary care and or the community.

Overall staffing in acute hospitals

2000 to 2019

In total, eight national reports[34, 36, 54, 61, 65, 66, 70, 92] and ten reports specific to the Mid West[22, 62, 63, 78, 80-85] provided information on and or recommendations relevant, to staffing in acute hospitals. During 2001 and 2002, the Mid-Western Health Board operational and service plans noted staff deficits across Ennis, Nenagh and the Mid-Western Regional Hospital Limerick, which were being addressed as funding allowed.[80, 81] In 2001, 16 additional posts were appointed to Ennis to address core service deficits in medical, surgical, paramedical services and clerical support.[80] In 2002, two consultant anaesthetists were appointed to the hospitals in Nenagh and Ennis, one temporary ED consultant was appointed at the Mid-Western Regional Hospital, Limerick, and an additional 13 staff were appointed to the new observation unit that had opened in August 2001.[81] However, as previously outlined in section 3.3.1, the 2003 Hanly report on medical staffing made recommendations on health systems reform piloting in two areas, of which the Mid-Western Health Board was one.[36] The report noted that on the 1 January 2003, there were 109 consultants employed by the Mid-Western Health Board, of whom one specialised in emergency medicine. The Hanly report proposed the appointment of an additional 195 consultants in the Mid West over ten years, (2003 to 2013) of which eight appointments were proposed for emergency medicine. This increase was with a view to providing 24/7 availability of senior clinical decision-makers, and a move to team-based, consultant-provided services.[36]

This was supported in 2008 by the review of acute hospital services in the Mid West which identified key gaps in consultant staffing.[92] As also noted in section 3.3.1, fragmentation of the services in general medicine, emergency surgery and ED in the Mid West meant that the Model 2 JEN hospitals (as they are now known) did not have enough consultants to maintain a safe service, yet did not have the workload to justify additional consultants. This resulted in the services not meeting the international quality standard which would require at least eight consultants within core medical and surgical services.[92] In general medicine and emergency medicine, any of the Model 2 JEN hospitals individually did not have either a catchment population large enough to qualify as an acute regional centre, and or were not suitable to act as an acute regional centre due to their low consultant staffing and

volume of workload.[92] However the report highlighted that the services could meet international standards if limited to one acute regional general medicine service across the Mid West. Specifically, considering a population of 360,000, across the services there were enough general medicine consultants (10 full-time and 8.2 part-time consultants in total) and enough surgeons and anaesthetists (11.9 surgeons and 21.4 anaesthetists) to manage a daily average of 39 medical admissions and 14.8 emergency surgical admissions, respectively.[92]

Specific to the ED, the 2008 review identified serious gaps in consultant staffing with only three WTE consultants across the four A&E services, with over 100,000 annual attendances.[92] At the time, the Mid-Western Regional Hospital, Limerick employed 2.63 WTE consultants for over 50,000 annual attendances. While this was deemed a clinically viable service, it was less than the British Association of Emergency Medicine recommended level of one consultant per 12,000 attendances to provide 24/7 cover. The review proposed that, due to the workloads and unsatisfactory consultant staffing arrangements, the Model 2 JEN hospitals should be developed as nurse-led Urgent Care Centres (containing a MAU and LIU).[92] This was supported by a 2009 HIQA report that following an investigation into the quality and safety of services in the Mid-Western Regional Hospital, Ennis.[78] HIQA reported that there were insufficient numbers of consultant staff in surgery, anaesthetics and emergency medicine to provide a sustainable, safe, 24-hour service for surgical patients attending the hospital.

Following the 2009 reconfiguration of services in the Mid West, across the 2011 to 2018 period, three acute hospitals division operational plans[65, 66, 70] and seven service plans specific to the Mid West[22, 62, 63, 82-85] highlighted the changes in staffing required at a local and national level to deal with challenges faced by the health system. The 2011 HSE West Service Plan outlined a number of strategies employed to operate within the WTE ceiling set by the HSE Employment Control Framework during the general moratorium on recruitment and promotion (in place since 2009[61]).[62] These included reconfiguration and integration of services, reorganisation of existing work, and redeployment of current staff (which would be necessary to maintain volume, quality and safety of services).[62] This strategy remained a priority between 2011 and 2014 within the Mid West.[62, 63, 82, 83]

The 2012 HSE West service plan[82] noted that there had been an increase of 34 medical consultants since 2009, with further increases expected with the approval of consultant posts under the National Clinical Programmes. However, in the context of austerity and an employment control framework, this growth was to be offset by the rebalancing of NCHD numbers and through a 50% target reduction on medical overtime and agency and or locum expenditure.[82] Overall, the 2012 plan provided for an overall staffing reduction of 784 WTEs (3% of the HSE West workforce), 615 WTEs of which would result from retirements. HSE West noted that this reduction, in

combination with reduced agency staff numbers, would require staff prioritisation to minimise the impact on front-line services.[82] Focus on meeting the EU Working Time Directive and reducing reliance on agency staff, overtime and reducing absenteeism within the workforce, continued through subsequent years. This was at a time when there was an ongoing reduction in HSE WTE staffing (with a 4% reduction required by the HSE Employment Control Framework in 2013), combined with accelerated retirements. It was anticipated that further efficiencies in staffing would occur because of voluntary redundancies offered through the Haddington Road Agreement.[36, 63, 70, 83, 84]

In 2016, Acute Hospital Division and ULHG operational plans noted that by October 2015, the total WTE number nationally, and more specifically employed by ULHG, had returned to pre government-moratorium levels (with a total of 3,369 WTE employed in ULHG in October 2015, compared to 3,109 in December 2014).[66, 84] However, it was noted that employment and recruitment policies had impacted the skills mix, with an increase in medical staffing and a reduced level of nursing and support service staff.[66, 84] It was also noted that hospitals nationally, and more specifically ULHG, would need to reduce total staff numbers in 2016 to achieve the financial targets contained within the Acute Hospital Division Operational Plan.[84] The workforce at ULHG continued to grow to 3,596 WTE in December 2016 and 3,974 in December 2017.[22, 85]

In 2018, the Department of Health Framework for Safe Nurse Staffing (general, specialist medical, and surgical care) made national recommendations on staffing and the Sláintecare Implementation Plan.[34, 54] The framework advocated for detailed analysis of bed occupancy and bed utilisation rates at ward, hospital and HG level to identify patterns of predictable demand and to allocate nurse staffing resources according to these patterns.[54] The 2018 Sláintecare Implementation Plan included priorities to develop and expand existing workforce strategies, including fully implementing Phase 1 and Phase 2 of the work on the Taskforce on Safe Nurse Staffing and Skill Mix.[34] This was supported by the 2018 Acute Hospital Services Divisional Plan, which recommended national roll out of Phase 1 of the framework, and implementation of a pilot for Phase 2 of the framework in emergency care settings.[70] EAG representatives noted in February 2025 that Phase 1 and Phase 2 of the Framework for Safe Nurse Staffing were implemented in UHL and the Model 2 JEN hospitals, with 21 additional nurses allocated to UHL following the reassessment. However, it was noted that there was no new funding to continue implementation of the framework. It was also noted that the Pay and Numbers strategy was likely to impact the number of posts filled within the framework.

2020 to 2024

More recently, five national reports[46, 122, 149, 150, 156] and seven reports specific to the Mid West[23, 24, 44, 79, 88, 89, 109] provided information on and or recommendations related to, overall staffing in acute hospitals. The 2021 Sláintecare Implementation Plan outlined the development of the Sláintecare Consultant Contract. This contract permits consultants to only carry out public care in public hospitals, to ensure that the public hospitals are used only for public patients, to ensure they can be accessed based on clinical need.[122] It was expected that this would ensure more consultant senior decision-makers would be available out of hours and at the weekend. The 2021-2023 Sláintecare Progress Report noted that the contract (now called the Public Only Consultant Contract) was implemented in March 2023.[150] The 2024 Sláintecare Progress Report noted that the HSE had set up a steering committee to monitor and measure the impact of the contract, with the first meeting occurring in September 2024.[156] As of February 2025, it was reported that 62% of consultants working in the public health service had signed the Public Only Consultant Contract.[157] However, it was also reported that despite the Public Only Consultant Contract providing for rostered work from 8am-10pm Monday to Friday, and 8am-6pm on Saturdays, the majority of consultants were still only working during the day Monday-Friday.[157] The Sláintecare and Programme for Government 2025+ report highlighted that the contract continued to be rolled out and that monitoring of its impact is ongoing.[149]

The 2022 Deloitte Patient Flow Report highlighted that when comparing HGs in Ireland, ULHG had the absolute lowest number of WTE staff across all categories. Considering specifically HSCP disciplines, staffing deficits were considered largely a result of a historical low level of funding for these posts, rather than a recruitment issue. The 2022 Deloitte Patient Flow Report also noted that in UHL at that time, numerous wards had no funded occupational therapists or medical social work staff.[23]

As of December 2024, ULHG had 565 WTE HSCPs, representing an approximately 20% increase relative to December 2022 (471 WTEs). While this was the highest relative increase observed across the HGs; as of December 2024, ULHG still had the lowest absolute number of WTE HSCPs.[158] Differences were also noted when considering management and administrative staffing for acute adult care services, with ULHG noted to have a substantially lower number of WTE compared with all other HGs.[158] When limited to Model 4 hospitals, HSE workforce data from December 2019 and January 2025 also suggest that UHL has one of the lowest absolute number of WTE HSCPs, with this difference persisting despite increases in staff numbers over this time period.[159] However, it should be noted that absolute figures do not take into account the population size of the health region which that HG, or hospital, serves.

Following its February 2023 inspection of the UHL ED, HIQA noted that a Head of Operations had been appointed by UHL to enhance and increase operational effectiveness and efficiencies in the unscheduled care pathway.[79] HIQA also reported that there were ongoing efforts to recruit staff, with two additional WTE consultants in emergency medicine and 20 WTE NCHDs at registrar and senior house officer grades in post since its March 2022 inspection. This had resulted in increased on-site presence of consultants for senior clinical decision-making and triage during the week (8am to 8pm) and at weekends (8am and 1pm). At the time of inspection, there were also increased numbers of NCHDs available for overnight cover in the ED and to cover the GEMU during the day. This brought ED medical staffing to 11 consultants and 46 WTE NCHDs, with recruitment for an additional 21 NCHDs expected in the ED by August 2023.

The HIQA February 2023 inspection report also identified other progress since previous investigations relating to staffing in UHL, including that ULHG had recruited an additional 50 staff to resource AMUs across the Model 2 JEN hospitals. National and international recruitment for nursing staff was completed resulting in additional nursing capacity to enable implementation of safe nurse staffing levels, and clinical skill training on EMEWS as part of the safe nurse staffing initiative was implemented with expected completion by the end of August 2023.[79] ULHG had also established patient flow co-ordinators across the site to identify and resolve blockages to discharges, with HIQA noting that considerable work was underway to fill vacant HSCP posts and recruit HCAs. Following its November 2023 inspection of UHL ED, HIQA reported that safe nurse staffing levels had been implemented, with recruitment also of 22.38 WTE HCAs to support nursing staff.[24] The report noted that while increased nurse staffing levels in the ED had resulted in issues with skill mix, clinical facilitators were involved in upskilling new nursing staff.[24]

In 2024, the UHL Support Team report recognised the significant uplift in medical staffing numbers in the ED since 2023 and the positive impact it had on ED operations.[44] The report also highlighted that recruitment restrictions at the time were impacting upon the front-line, such as nurses, HSCP and clerical staff, and that specific to the nursing workforce; consideration should be given to a temporary pause in the filling of promotional posts to prevent further removal of staff nurse and Clinical Nurse Manager roles. This was supported by the ULHG Strategic Plan 2023-2027, which outlined priorities to support staff retention. These included the development of an education and training model to create a reputation of excellence and enable staff to succeed in their careers, along with driving a high-performance culture that prioritised continuous improvement.[88] A plan to facilitate staff retention that included the development of quality improvement plans based on analysis of staff exit interviews was also proposed.

Former Chief Justice Frank Clarke's independent investigation of UHL in 2024 also provided some key recommendations regarding staffing within UHL.[109] These included a review of the coordination of roles of doctors in the ED, including when it was appropriate for a senior clinician present to oversee overall coordination of the service during busy periods. The report also recommended the application of objective measures (such as the Framework for Safe Nurse Staffing) to determine the allocation of staff and resources across the health service, in order to increase efficiency and transparency. It was highlighted that approval for staff numbers should occur at the same time as approval for capital expenditure, to ensure sufficient time to access additional capacity.[109]

Staffing in the ED

2000 to 2019

In total, seven national reports[5, 53, 90, 102, 103, 112, 118] provided recommendations on staffing in the ED. The 2002 Comhairle na nOspidéal report on A&E services recommended a skill mix for staffing of hospital emergency services.[102] It proposed that each regional ED should be staffed by a number of consultants in emergency medicine (one with a special interest in paediatric emergency medicine if the ED accepted children) and a multi-professional team including consultants in medicine, surgery and paediatrics; NCHDs in a range of specialties; and nursing staff (including ANPs).[102] One of the consultants in emergency medicine should act as director of the regional ED and as the regional co-ordinator of emergency services with responsibility for advising the Health Board on emergency services, and developing and implementing protocols in emergency services across the Health Board area.[102] Specific to the Mid West, it was recommended that a regional emergency service be established with the regional co-ordinator post based at the Mid-Western Regional Hospital, Limerick. Two further consultants in emergency medicine were also recommended to be based at the Mid-Western Regional Hospital, Limerick to give a total of three posts with sessional commitments to the Model 2 JEN hospitals.[102]

Two national reports in 2003 made recommendations regarding specific staffing positions in the ED.[90, 103] The report on nurse staffing levels in EDs recommended that all EDs should urgently introduce a non-qualified grade of staff to undertake non-clinical work previously managed by nursing staff.[103] The Capita report on bed management suggested that hospitals should also have dedicated senior posts for bed managers leading a team of people involved in all aspects of admission, transfer and discharge of patients.[90]

Across the 2007 to 2015 period, four national reports recommended increasing ED consultant workforce levels.[5, 53, 112, 118] In 2007, the ED Task Force Report recommended increasing the consultant workforce levels in admitting specialties and in EDs, to support early access to senior clinical decision-making.[5] This would

facilitate EDs to achieve the 2007 target of ED registration to disposition within six hours.[5] However, the HSE technical report of EDs in 2009,[112] highlighted that 23 of 33 EDs in Ireland had delays in accessing senior decision-makers at that time. It was noted that incoming changes to medical consultant contracts should allow for increased working hours and extend the time that decision-makers were available.[112] The National Emergency Medicine Programme in 2012 and the ED Task Force Report in 2015 then further recommended increases in ED consultant numbers.[53, 118] Improved access to senior clinical decision-makers who are critical in addressing admission and discharge issues was suggested.

2020 to 2024

More recently, five national reports[14, 55, 74-76] and two reports specific to the Mid West[15, 23] provided information on, and or recommendations related to, staffing in the ED. In 2022, HIQA's Overview Report of EDs outlined that a mismatch of demand and capacity, alongside insufficient staffing levels, were major contributing factors across five EDs that would continue to pose a risk to patient safety unless adequately addressed.[14] To address this, a number of recommendations were made nationally across the 2022 to 2024 period. The 2022 Department of Health Framework for Safe Nurse Staffing (in adult emergency care) recommended that a systematic, triangulated evidence-based approach to determine safe nurse staffing and skill mix based on patient demand (supported by ED data) be implemented nationally in emergency care settings.[55] Both the 2023 and 2024 HSE Urgent and Emergency Care operational plans recommended that (in parallel to the proposed seven day programme of care), surge measures for additional and extended hours for senior decision-makers and staff integral to patient flow should be optimised.[74, 75]

The HSE National Doctors Training and Planning Emergency Medicine Workforce 2024-2038 report also highlighted a rapid expansion in the number of non-training scheme doctors to meet immediate demand and service gaps in individual hospitals.[76] However, it noted that, in keeping with HSE policy and a move towards a consultant-delivered health system, there needed to be an immediate restructuring at a national and regional level to address staffing shortfalls and reduce the reliance on non-training scheme posts.[76] The report outlined that conversion of non-training to training schemes, and expansion of all levels of the programme was imperative to ensure the training pipeline for the consultant workforce in EDs, for which the estimated demand was to reach 338 WTEs by 2038. In the Mid West, this equated to a recommended increase in the ED consultant workforce of 11 WTEs between 2024 and 2038. However, it did caveat that even with increased training output, it would be necessary to hire consultants from outside of the domestic training programmes to meet immediate unmet demand and service expansion targets while the training programme expands in capacity.

In the Mid West, the 2022 Deloitte Patient Flow Report outlined that ED staffing needed to be increased at UHL.[23] In particular, it was outlined that an increase in consultants and NCHDs was required to manage increased demand at pre-admission. The report also recommended additional staffing (such as HSCP staff and bed management resources) for post-admission across the hospital, to facilitate patient flow.[23] However, following the HIQA inspection of UHL ED in March 2022, it was reported that ULHG planned to increase the NCHD workforce by 96 additional posts to assist senior decision-makers, and support increased work demands.[15] Additionally, the Senior Nursing Management Team had redeployed nursing staff with experience to the ED, and ULHG had been successful in recruiting approximately 286 WTE nurses to UHL in 2021.

Staffing in primary care and or the community

2000 to 2019

Two national reports detailed staffing in primary care.[27, 117] In 2001, the Department of Health Primary Care Strategy planned a phased introduction of primary care teams with the aim of 20-30 teams being in place by the end of 2003, 40-60 by the end of 2005 and 400-600 by the end of 2011.[117] In 2018, the Health Service Capacity Review highlighted that without reform, a 37% increase in primary care workforce would be required by 2031.[27] With reform and greater investment in primary and community-based care, a 48% increase in primary care workforce would be required with a greater increase in non-medical roles.[27]

2020 to 2024

One report specific to the Mid West provided information on staffing in the wider community.[89] A briefing note from ULHG to the Department of Health in April 2024 reported that recruitment was planned for a Social Inclusion Integrated Hospital to Community Team, a Child and Adolescent Mental Health Services Paediatric Liaison Team and an additional 31 WTEs for chronic disease management and ICPOP teams.[89] As of January 2025, there was a Social Inclusion Integrated Hospital to Community Team in place in UHL resourced by a part-time consultant post and one nursing post.

3.3.6 Governance

When summarising information extracted relevant to governance, two specific aspects were identified:

- overall governance of the delivery of urgent and emergency services
- governance of AMUs and MAUs.

Overall governance of the delivery of urgent and emergency services

2000 to 2019

Twelve national reports[5, 36, 52-54, 66, 69, 90, 102, 105, 119] and nine reports specific to the Mid West[22, 43, 63, 78, 82-85, 92] outlined information on, and or recommendations in relation to, overall governance of the delivery of urgent and emergency services. In 2003, the Hanly Report on medical staffing recommended that nationally, the management structure of acute hospitals should be strengthened to establish clear lines of accountability and ensure appropriate availability in the context of a 24-hour service.[36] In the pilot regions assessed within the report, of which the Mid-Western Health Board was one, it was recommended that an integrated network of hospitals be managed by a Chief Executive Officer (CEO).[36] There was no immediate action taken in relation to this recommendation, and in 2008, HIQA conducted a review of services in the Mid-Western Regional Hospital, Ennis. This included HIQA inspectors conducting a site visit to Ennis. Inspectors reported that, on the day of inspection, there was a lack of clarity around local accountability and the authority to make decisions.[78] Additionally, it was noted that there were limited systems in place for effective clinical governance in order to provide the necessary assurance to patients.[78] HIQA surmised at that time there was no single person at hospital level who was fully accountable for the quality and safety of services.[78] Following this, it was recommended that all acute hospitals contributing to the Mid West Region acute care system should form a HG. This HG would be under an integrated operational governance and management structure, based at the Mid-Western Regional Hospital, Limerick.[78]

The closure of 24/7 EDs in the Mid-Western Regional Hospital, Ennis, Nenagh and St. John's hospitals occurred in 2009 (see section 3.3.1). In 2010, HIQA began extensive engagement with the Mid-Western Regional Hospital, Limerick.[160] While this was initially regarding delayed access to emergency surgery and the management of mechanically ventilated patients in the ED, in 2012 HIQA also expressed concerns about the absence of interim formal clinical governance structures across the newly-formed Mid-Western Regional HG. The establishment of the HG in 2012 had brought a new governance structure in which the CEO of the HG now had legal authority to manage the group, delegated to them under the Health Act 2004.[66] It was outlined that the CEO now reported to the National Director for Acute Services, and was accountable for their planning and performance under the Accountability Framework of the HSE.[66]

In 2012 HIQA wrote to the HSE advising that the level and speed of progress that had been made to mitigate persistent and serious risks regarding leadership, governance and management, effective care and use of resources was slow and unsatisfactory.[160] The letter stated that there were insufficient assurances to demonstrate that persistent shortcomings in the way that the HG was leading, governing and managing its services, were being resolved.[160] In 2013, HIQA

undertook a further review of governance in the HG and acknowledged that substantial governance and operational changes had been undertaken at UHL since the CEO was appointed (January 2012). These included the subsequent appointment of the Chairman of the Board and the formation of a clinical directorate structure.[160] It was also noted in the Mid-Western Regional Hospitals Group service plan in 2013 that a new model of corporate and clinical governance had been developed.[63]

Across the 2014 to 2018 period, ULHG[22, 83-85] and HSE Acute Hospital Division operational plans[22, 65, 66, 69, 70, 85] all outlined embedding robust governance structures as a key priority. This was supported nationally, with the 2015 ED Task Force Report outlining a number of actions for HG CEOs and individual hospitals to undertake to ensure effective leadership and oversight in hospitals.[53] These included establishing clear lines of accountability within the hospital for the management of patient flow; establishing leads for scheduled and unscheduled care in all HGs with clear reporting lines to chief operating officers for each group; and developing and maintaining centralised bed management to ensure consistent oversight of scheduled and unscheduled workloads.[53] It was also noted in 2016 that the nine CHOs were in the process of being further developed under the leadership of the nine chief officers, and therefore reorganisation of management and governance structures reporting to the chief officers was to occur.[43]

2020 to 2024

More recently, from 2020 to 2024, two national reports[55, 75] and seven reports specific to the Mid West[14, 15, 23, 24, 44, 79, 88] provided information on, and or made recommendations in relation to, overall governance. During a HIQA inspection of the UHL ED in March 2022, inspectors outlined that they were not assured that the management arrangements in place supported and promoted the delivery of a high-quality, safe and reliable service, or were effective in managing the demand, overcrowding and patient flow in the hospital's ED. This was broadly echoed in 2022 by the Deloitte ULHG Patient Flow Report which outlined that clarity on governance was required over the patient flow continuum,[23] and by the HIQA Overview Report on EDs in 2022 which outlined that more responsive leadership, governance and management was needed at local, regional and national level.[14] HIQA also noted that some hospitals cope better than others with the demands placed upon them, and that this was often driven by better local operational management.[14] While UHL hospital management had developed a plan comprising short, medium and long-term measures to address the ED overcrowding, the HIQA inspection in March 2022 reported that the short-term measures enacted by management had limited impact on the day-to-day workings of the ED.[15] UHL provided a compliance plan that outlined a number of actions, including to review the current UHL site management arrangements; to review current escalation plans and specifically to review the internal escalation processes within the ED.[15] In 2022, UHL was

provided with a HSE Support Team, on site at UHL for a four-week period between May and June to support hospital management and clinical staff to improve operational and clinical efficiencies across the hospital.[79] This, combined with financial resourcing for ULHG (approximately €6m per year which included funding for a Head of Operations post in UHL), aimed to improve operational and clinical effectiveness and efficiencies at UHL and ULHG, and to further strengthen and enhance integration with the Mid West CHO.[79] As of January 2025, ULHG representatives confirmed that this position was filled.

In October 2022, the ULHG and Mid West CHO Integrated Unscheduled Care Committee was established. This committee had responsibility to prepare and implement an integrated response to ensure that patients could appropriately access unscheduled care at the hospital.[24] This included ensuring timely access to care in the most appropriate setting, while also optimising patient flow through acute and community services; improving compliance with national key performance indicators. This was followed in June 2023 by the establishment of the Urgent and Emergency Care (UEC) Directorate.[24] The UEC Directorate is responsible for the operational and strategic governance of the ED and AMU in UHL, and the LIUs and MAUs in St John's, Nenagh and Ennis. It is led by a Clinical Director, Director of Nursing, and General Manager. A subsequent HIQA inspection of the UHL ED in November 2023 outlined that UHL had defined management arrangements in place to manage and oversee the delivery of care in the ED, and operationally, was functioning better than on previous inspections.[24] This was in part due to the UEC Directorate, with HIQA reporting that on the day of inspection in November 2023, there was evidence of strong executive, clinical and nursing leadership in the ED. Despite this, as of November 2023, HIQA reported that UHL ED still had a way to go to match the best-performing EDs which they inspect.[24] Furthermore, the 2024 UHL Support Team report noted that at the time of visiting UHL in April 2024, while a member of management was on leave, it was unclear from an organisational perspective who was in charge on site.[44] It was noted in the ULHG Strategic Plan 2023-2027 that a review of organisational structures and governance arrangements would be undertaken to develop a blueprint of the future operating model for the organisation as it transitions to HSE Mid West.[35]

Governance of AMUs and MAUs

2000 to 2019

Three national reports[105, 107, 119] and one report specific to the Mid West[111] also made recommendations specifically regarding the governance of AMUs and or MAUs. In 2004, a Comhairle na nOspidéal AMU report recommended that, nationally, in each individual AMU, one consultant general physician should be clearly identified as having a lead role in the management, running, auditing and development of that

AMU.[107] It was outlined that the success or failure of AMUs was the presence or absence of a designated consultant physician leader for the unit, and the management skills of this consultant physician. It was also noted that this role could be a renewable appointment with the additional option of a rotation among interested consultant physicians involved in the unit. This was further supported in the 2010 report of the National Acute Medicine Programme (NAMP)[105] and in the 2017 Acute Floor Model of Care.[119] The 2010 NAMP Report outlined that this role included accountability for clinical governance, risk management, strategic development of the unit and supporting education and training in acute medicine.[105] The AMU lead should also liaise closely with further professions with responsibility for the governance of the AMU including the Director of Nursing and Acute Medicine Therapy Lead and maintain close links with primary care and hospital specialities which interface with acute medicine.[105] In March of 2016, representatives from the NAMP visited the ED in UHL and reported that the NAMP had been adopted over the previous three years, and that one of the four permanent acute physicians working in the AMU was allocated a lead role, on a two-year rotating basis.[111]

The establishment of an acute medicine governance group was also recommended in the 2010 NAMP Report and was deemed a key requirement for clinical governance.[105] Responsibilities of this group included ensuring all staff were clear on their role and the role of colleagues, all relevant staff were aware of GP access protocols, and a formal liaison group with GPs was established. There was no evidence identified that an AMU governance group was established in 2010. The 2016 NAMP Report outlined that one of the acute physicians sat on the Medical Directorate.[111]

2020 to 2024

More recently, one national report[115] and three reports specific to the Mid West[24, 79, 110] made recommendations regarding the governance of AMUs and or MAUs. Following the 2016 NAMP visit to UHL,[111] a further visit was conducted by representatives in 2022.[110] The NAMP again recommended the establishment of an AMU Governance Group (having previously recommended this in 2010[105]) and recommended the development of an AMU operational plan to ensure that there was no ambiguity as to who was responsible for patient care.[110] The NAMP also noted that there was still no designated Clinical Lead for the AMU, and this position was therefore recommended again.[110] EAG representatives confirmed in February 2025 that a designated Clinical Lead for the AMU was in place, with this position rotating every two to three years. The HIQA inspection of the UHL ED in February 2023 also observed that, at the time of inspection, the AMU was not functioning as intended. In response to the inspection report, UHL noted in its compliance plan that a review of AMU governance and the existing pathways would be undertaken.[79] As outlined

previously, the UEC Directorate (established in June 2023), has taken responsibility for both operational and strategic governance of the AMU.[24]

The establishment of the UEC Directorate in UHL was also in line with recommendations outlined in the 2023 HSE review of Model 2 hospital MAUs. Specifically, the review recommended enhanced integration of MAUs into overall HG governance structures,[115] to include a dedicated point of contact in the HG, with responsibility for ensuring that MAUs were developed and their use maximised. EAG representatives confirmed in February 2025 that development of the MAUs was under the remit of the UEC Directorate in UHL. The 2023 HSE MAU review[115] also recommended that all MAUs should have a designated lead consultant physician with a dedicated on-site presence (previously also recommended in the NAMP report 2010[105]), and noted at the time of review that both hospitals in Ennis and Nenagh had this position in place.[115] The review noted that activity in the MAU in Nenagh had increased following the appointment of this position in 2023.[115] EAG representatives confirmed in February 2025 that a lead consultant physician with dedicated on-site presence was in post in St. John's.

3.3.7 Funding

When summarising information extracted relevant to funding, three specific aspects were identified:

- annual budgetary allocations
- funding recommendations for specified purposes
- financial management and control systems.

Annual budgetary allocations

2000 to 2019

Limited information was identified in relation to budgetary allocations relevant to the Mid West across the period 2000 to 2010. Information was identified from a number of annual reports at national, regional and HG level between 2011 and 2018.[22, 62, 63, 65, 66, 69, 70, 82-85] Reports highlight that in the early 2000's, despite increasing budgetary allocations to the Mid-Western Health Board and Mid-Western Regional Hospitals, additional funding was required in order to meet funding pressures in core services.[80, 81] From 2010 to 2012, budgetary allocations to the acute hospitals division and the primary, community and continuing care divisions in the Mid West reduced year-on-year by up to 5.2%.[62, 63, 82] Nationally, following the 2008 financial crisis, the HSE budget was reduced, with a 22% decrease in budget observed between 2008 and 2013.[161] Total public expenditure on health was also reduced at this time, with a 4.7% decrease in expenditure in 2010 (compared to 2009) and a 4.6% decrease in expenditure in 2011 (compared to 2010).[162] From 2013, although

budgetary allocations began to increase marginally, they were consistently below previous annual and current year projected cost out-turns for the Mid-Western Regional HG.[63, 83, 84] Mid-Western Regional HG and ULHG service plans across 2013 and 2014 outlined that the magnitude of the financial challenge to be overcome came to approximately 9% of the allocated budget in 2013, and 12% in 2014.[63, 83] Overall, it was also noted that annual capital public health expenditure for the Acute Hospitals Programme budgets fell 24% from 2007 to 2016.[162]

A variety of national and regional cost-containment measures, income targets and service restructuring programmes were critical to bridge the funding shortfall, clear deficits carried forward from previous years, and maintain services during this time.[62, 63, 82, 83] Cost-containment measures (outlined in HSE West service plans for 2011, 2012 and 2013, and the 2014 ULHG operational plan) included staff restructuring measures (pay savings as a result of decreased WTEs and Haddington Road agreements, as discussed in section 3.3.5), and non-pay savings (such as reduced discretionary spending, reduced drug costs, procurement and contracts management, and controlled activity levels).[62, 63, 82, 83] HSE West service plans in 2011 and 2012 reported savings related to the staff moratorium of €19.2m and €34.7m respectively.[62, 82] The ULHG Operational Plan in 2014 reported specific staff budgetary savings in UL hospitals of €8.2m, arising from the Haddington Road Agreement.[83] Additional payroll savings of approximately €1m in respect of employment control frameworks and incentivised career breaks were also noted.[83] Further cost containments at ULHG in 2014 included a €3m saving on further expansions to critical care that were commissioned in 2013, and €0.5m on bed capacity over the full year.[83]

Targets were adjusted for income generation by increasing charges for private and semi-private accommodation within public hospitals, and changes to the way private beds in public hospitals were designated, in 2013. [22, 62, 82-84] By 2016, the financial challenge to ULHG budgets had improved to a 3% shortfall between proposed funding and out-turns.[84] However, further financial challenges were faced in 2016 with the move to activity-based funding (ABF).[84] Under the ABF model, funding was allocated on a case basis, compared to hospital funding under the previous block-billing model.[84] This required hospitals in the Mid West to control activity volumes to ABF target levels in the face of demographic-driven demand for services.[84] In 2018, the budgetary allocation for ULHG exceeded the previous year's final allocation, and was supplemented by income generation of over €70m.[22]

2020 to 2024

The HSE UEC Operational Plan in 2024 included information about annual budgetary allocations.[75] It outlined that the National Service Plan for 2024 allocated a total budget of €23.8m, and funding for 2,951 additional enduring WTEs and 359

additional beds, across services. Additionally, funding of €13.26m for surge measures in urgent and emergency care was provided in the 2024 health budget. These surge measures included extended GP hours, additional NAS private capacity, extended hours for diagnostics, and overtime hours for patient flow (hospital avoidance and in hospital operations) and discharge operations.[75] As of December 2024, the HSE had increased staff numbers nationally by 2,283 WTE (1.6%), when compared to December 2023.[158]

In the Mid West, the ULHG briefing note to the Department of Health in April 2024 highlighted an additional €160m in capital funding and €79m in recurring revenue funding for ULHG.[89] This funding allowed for the extension of safer staffing for nurses across UHL, with immediate sanctions to commence recruitment; extended opening hours in the region's MAUs; additional step-down and rehabilitation beds in the region; the development of GP and ANP roles in the ED; and the development of a Social Inclusion Integrated Hospital to Community Team.[89] As a result, the GP at the door initiative commenced in April 2024,[163] and the CNU in Nenagh was developed and accepting patient transfers (see section 3.3.4).[164] Additionally, MAU opening hours in Ennis, Nenagh and St. John's were all extended over the 2023 to 2024 period.[37, 165] As previously noted, as of January 2025 there is a Social Inclusion Integrated Hospital to Community Team in place in UHL, and the team is resourced by a part-time consultant post and one nursing post.

It should be noted that the 2024 independent investigation of UHL by former Chief Justice Frank Clarke recommended that when approving capital expenditure to provide extra capacity within the health service, consideration should be given to the long-term expenditure commitment arising from additional staff to allow the extra capacity to be used in a timely fashion.[109]

Funding recommendations for specified purposes

2000 to 2019

Three national reports[69, 116, 117] and five reports specific to the Mid West[22, 81, 82, 84, 92] included funding recommendations for specific causes. The 2001 Department of Health and Children Quality and Fairness Strategy recommended that additional investments in the health system nationally would continue for specified purposes.[116] On foot of this report, an additional €530,000 was provided to the Mid-Western Regional Hospitals for consultant appointments in ED and anaesthetics.[81]A second report by the Department of Health and Children in 2001 highlighted that implementation of the new model of primary care would require a sustained programme of investment in staffing, buildings and equipment over ten years.[117] Specifically, this investment would require a capital outlay of approximately €127m for primary care teams during the initial five-year implementation phase, and the

infrastructure required for development of co-operative groups for out-of-hours health coverage would cost approximately €32m.[117] Projects to implement primary care in each of the ten Health Boards were approved in October 2002, with revenue funding of €4.5m, funding of €3m to support IT and capital works, and an additional recurring €990,000 provided to the Health Boards to meet additional costs.[166] A primary care team was active in West Limerick from 2003.[167]

In 2008, the HSE's review of acute hospital services in the Mid West advised that capital investment was required for the additional build and redevelopment of the Mid-Western Regional Hospital in Dooradoyle to support its role as the regional 'centre of excellence'.[92] The report highlighted likely revenue costs from the recruitment of additional medical staff to reduce clinical risk and improve patient safety in the short term, with some costs offset by staff redeployment within the Mid West.

Despite overall budget reductions, HSE West improved services during 2012 with the opening of a new critical care facility in the Mid-Western Regional Hospital, Limerick, with an estimated overall capital investment cost of €35m.[82, 168] Other capital projects completed in the Mid West during the 2015 to 2018 period included the opening of the Leben building in UHL in 2015 at a cost of €16.5m;[84, 169] the redevelopment of Ennis General Hospital in 2016 at a cost of €1.19m;[84] and the opening of the new ED in UHL in 2017, at a cost of €24m.[22, 84, 99, 139] Specific to UHL, this has resulted in increased capacity in a number of areas including the provision of a 24-bed neurology and or stroke unit, a nine-bed cystic fibrosis adult inpatient unit, an outpatient unit for cystic fibrosis, and a new renal dialysis unit.[22, 84, 169]

A greater focus on income generation within Irish hospitals was evident nationally after the economic crash in 2008. ULHG had a budget target set for income generation of €61.7m with an additional increase of €4.9m set for revenue from private patients in public hospitals in 2014.[83] An additional income generation target of €8.5m was also set in 2016,[84] along with an expected growth of over 4.5% in the private patient market, with the overall income target reaching €78m in 2017.[69]

2020 to 2024

More recently, two national reports,[46, 54] and three reports specific to Mid West[15, 24, 79] outlined funding recommendations for specific causes. The Department of Health 2018 Framework for Safe Nurse Staffing (general and specialist medical and surgical) proposed that with initial seed investment to fund implementation of the framework, additional staff costs would be eventually offset by savings in agency costs, and additional efficiencies would be realised, for example, through better patient outcomes.[54] Since 2020, over €31.2m has been invested in the framework

including €25m for 470 additional WTE registered nurses and HCAs across Model 4 hospitals, and €6.2m for 101 additional WTE registered nurses in EDs.[170] Arising from this initiative, UHL received funding for and recruited 21.5 WTE nursing positions in the ED, in 2022.[79]

Following the HIQA inspection of UHL ED in March 2022, the UHL compliance plan outlined it would explore the funding of staff for the provision of an assessment area in the ED for older people (as a hospital avoidance measure), and the funding of additional consultants and NCHD resources to support the delivery of a high-quality and reliable service.[15] A HIQA report confirmed that by February 2023, consultant and NCHD staffing in the ED had been increased by two WTEs, and 20 WTEs respectively, and a dedicated GEMU had been established.[79] Furthermore, as outlined in section 3.3.6, HIQA reported that support and financial resourcing of approximately €6m per year was provided to improve operational and clinical effectiveness and efficiencies at UHL and across ULHG, and to enhance integration with the Mid West CHO. UHL also outlined in its compliance plan, following the February 2023 HIQA inspection, that it would aim to secure approval for additional core nursing and HCA staff in the ED to support patient admission, and to procure additional equipment to support ongoing care needs of patients in the ED.[79] Recruitment for consultant and clinical nurse specialist posts in UHL commenced in 2024.[171, 172] Furthermore, as of January 2025, ULHG representatives confirmed increases in core nursing and HCA numbers, with increases also particularly noted in relation to HSCP staffing. Additionally, there was evidence that initiatives arising from the increased support and resourcing of UHL were in the process of being implemented at subsequent inspections.[24]

The Department of Health's *Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-31* noted that since 2020, Irish hospitals have received an unprecedented uplift in funding and workforce, as well as an increase in bed capacity.[46] It also highlighted that the realisation of current expansion plans, estimated to cost between €0.75m and €1.1m, was dependent on the provision of funding as allocated through the National Development Plan, and Government support for pay and non-pay costs.[46]

Financial governance

2000 to 2024

Eleven national reports[27, 34, 45, 47, 51, 65, 106, 116, 118] and two reports specific to the Mid West[35, 84] outlined information on, and or recommendations around, financial governance. Only one report was identified over the 2020 to 2024 period (the ULHG Strategic Plan for 2023 to 2027[35]) and therefore the information was summarised over the 2000 to 2024 period. In 1993, casemix financing was initially introduced in Irish hospitals, with an aim to strengthen incentives for greater efficiency by allowing

comparison based on diagnoses between Irish acute hospitals.[173] By 2001, it was being used in 32 hospitals and the Department of Health recommended further expansion in its use, along with the use of multi-annual budgets.[116] This was supported in 2003 by the government-commissioned report on financial management and control systems in the health service, which also recommended that service plans were framed on a multi-annual basis.[47]

Two national documents in 2012 highlighted the challenges faced by the health service.[51, 118] The National Emergency Medicine Programme strategy in 2012 recommended that ED-based initiatives be cost-neutral and deliverable through the reorganisation of existing work practices.[118] The Department of Health's 2012 Future of Health Strategic Framework emphasised that despite growing demand for services, the funding available was decreasing and financial reforms were necessary to ensure that the financing system was based on incentives that were aligned to fairness and efficiency while reducing costs, improving control and also improving quality.[51] As such, the "Money Follows the Patient" funding model was introduced to create incentives that encouraged treatment at the lowest level of complexity that was safe, timely, efficient and delivered as close to the home as possible; while supporting integration between primary, community and hospital care.[51] This was rolled out as the ABF model in 2015, which set greater responsibility to manage expenditure within the confines of an existing level of service.[65] By 2016, ABF was impacting upon the funding allocated to ULHG, with prices offered to the hospitals already discounted by 2%, requiring savings to be made on procurement.[84]

Further, a goal in the 2018 Sláintecare Implementation Plan included ensuring the health service is financially sustainable, and highlighted that additional funding and capacity must be invested strategically and must support the overall vision for reform, with a consistent focus on productivity and achieving value for money.[34] As part of its objectives, the 2018 Sláintecare Implementation Plan included actions for developing new funding allocation models and developing multi-annual budgeting. Multi-annual budgeting was also recommended by the Health Service Capacity Review in 2018.[27] The 2021 Sláintecare Implementation Strategy, the 2022 Business Case for Implementation of Regional Health Areas, and the 2023 Organisational Reform HSE Health Regions Implementation Plan also called for a move towards a population-based funding model, which aims to distribute funding based on profiling, segmentation, and needs assessment, that can ultimately be administered by health regions.[49, 122, 125] This population-based resource allocation model will apply when the HSE structure transitions fully to health regions from 2025.[174] As set out in the 2024 HSE Pay and Numbers strategy, each HSE health region will be provided with a specified number of WTEs and within that approved number they can replace, recruit and prioritise.[175] The Pay and Numbers strategy was agreed as part of the overall funding arrangement for the HSE for 2024.[176]

Separately, in 2018 NAMP estimated that 12.7% of income for acute hospitals was derived from private health insurance and, as such, the move to eliminate private services in public hospitals (as outlined by Sláintecare) would require phased replacement from public funds.[45] The ULHG Strategic Plan for 2023 to 2027 highlights that financial resilience will be enabled by the integration of services across the system with the move to health regions, with an expectation that it would increase cost avoidance and improve budget management.[35]

4 Discussion

In May 2024, the Minister for Health requested that HIQA conduct a review of urgent and emergency care in the HSE Mid West health region with the primary objective of ensuring safe quality acute care in the region. In order to conduct this review, an understanding of the key recommendations and decisions related to the provision of urgent and emergency healthcare services in the HSE Mid West health region was required. A detailed review of 80 key resources (including policies, strategies, reports and reviews), published across the 2000 to 2024 period was undertaken. The analysis focused on identifying information, recommendations or considerations for health-service delivery that were either specific to the Mid West or ULHG, or if at a national level, were likely to have impacted the Mid West.

A number of health system reconfigurations have occurred in Ireland, both at national and regional level, across the 2000 to 2024 period. Nationally, since the HSE was established in 2005, this has included the creation of Integrated Service Areas in 2010,[108] the establishment of Community Healthcare Organisations in 2015,[121] and most recently, the planned reconfiguration of the health service into an Integrated Healthcare Area structure comprising six HSE health regions, including HSE Mid West. Under the latter reconfiguration, as of March 2025, five of the six health regions are in the implementation phase, with completion due by October 2025. Implementation in HSE Mid West is due to begin at a later date.[177] The health regions are intended to facilitate the integration of hospital and community care services under one governance, in line with Sláintecare.[77] Specific to the Mid West, the most notable reconfiguration of health services occurred in April 2009, when 24/7 emergency services in Ennis, Nenagh and St. John's hospitals were closed, and replaced with MAUs. The closure of these EDs occurred following the publication of three reports; the Hanly report on medical staffing;[36] the review of acute hospital services in HSE Mid West;[92] and the HIQA investigation into the quality and safety of services in the Mid-Western Regional Hospital, Ennis;[78] all of which recommended the establishment of one regional 'centre of excellence' in UHL, providing all specialist acute care. This reconfiguration of services was recommended due to safety concerns over the volume of activity in Ennis, Nenagh and St. John's hospitals at that time.[36, 78, 92]

This practice of ED closures and concentration of ED services in a smaller number of hospitals has also been observed internationally, in an effort by countries to improve efficiency and quality of care, limit costs and resolve staffing issues.[178] Similar reconfiguration has been noted in England and Denmark, with the Netherlands beginning discussions around ED reconfiguration in 2020.[178] In Denmark, a before-and-after study investigating the impact of emergency healthcare system reconfiguration reported no change on in-hospital mortality, and a slight increase in 30-day mortality.[179] However, it was noted that emergency care reconfiguration is complex, and factors such as reconfiguration implementation and the geographical location of hospitals may affect the impact of reconfiguration.[179] Further alternative models of emergency healthcare delivery include where specialist emergency care is provided in a purpose-designed, emergency care only hospital. An example of this is the UK's Northumbria Specialist Emergency Care Hospital, which was developed in 2015 following the centralisation of three distinct general hospital EDs to a high-volume emergency care hospital with earlier specialist contact.[180] An analysis of adult index admissions, pre and post-centralisation (at one and two years post-centralisation) outlined that the centralised site was associated with a reduced probability of 60-day mortality, with older patients having the highest probability of a better outcome.[180]

The importance of integrated care across the Irish health system was evident in the included resources. Integrated care aims to deliver care at the lowest-acuity setting, thereby potentially reducing the need for ED attendance. Specific strategies and or programmes identified both nationally and specifically in the Mid West included Enhanced Community Care; Hear and Treat; virtual wards to support care monitoring and treatment in the patient's own home; the Integrated Care Programme for Older People; the introduction of Community Intervention Teams; the extension of GP out-of-hours services; and the introduction of alternative ambulance services (such as the Pathfinder Programme and the Alternative Pre-Hospital Pathway car).[24, 44] In the Mid West, it was noted that these initiatives are facilitating hospital avoidance and promoting early discharge.[24, 44] Nationally, in 2023 it was noted that 91% of patients with chronic disease were now routinely fully managed close to home.[181] EAG representatives also noted increases in the annual number of home support hours, with 23.8 million home support hours delivered nationally in 2024 to over 58,000 individuals. This represents a 7.4% increase in the number of hours delivered compared with 2023. However, EAG representatives also highlighted the potential for financial and legal complexities to arise when transitioning older people from acute care back to the community or their homes, particularly if their care requirements have increased.

A 2021 analysis of the impact of two national health and social care integration programmes on emergency hospital admissions in England outlined that these

programmes can mitigate, but not prevent rises in emergency admissions over the longer term.[182] However, the analysis recommended that system-level integration initiatives need to be sustained over time to have any chance of changing use of hospital care.[182] In Ireland, implementation of integrated care programmes is in line with the Houses of the Oireachtas Sláintecare vision plan, with five integrated care programmes either developed (the Integrated Care Programme for Older People and the Integrated Care Programme for the Prevention and Management of Chronic Disease) or being developed (children, maternity and patient flow).[34, 106, 122] Additionally, building capacity outside of the Model 4 hospitals, particularly in urgent care centres, medical assessment units and or local injury units was highlighted as a priority in recent years both nationally and in the Mid West, with increased operational hours occurring as of 2024.[44, 75, 130]

With regard to bed capacity, reports over the 24-year period highlighted that an increase in acute hospital bed capacity was required to meet demand in the Irish health system.[5, 11, 27, 116] From the early 2000s, commitments were made, both nationally and regionally, to increase bed numbers in acute and non-acute settings, in both public and private facilities.[116] However, reports from 2007 to 2018 indicated that hospitals were working close to, or at, full capacity, suggesting any increase in bed capacity made was insufficient to meet demand. Inpatient boarding in the EDs has been identified as a significant issue, with international literature suggesting that that this occurs due to inadequate capacity in inpatient wards.[183] From 2020 to 2024, the Department of Health reported an increase in acute inpatient beds nationally,[46] with a further increase committed to in coming years; both nationally and in the Mid West.[130]

Multiple reports highlighted that limited access to diagnostics in the community contributed to increased ED presentation, with delayed access to diagnostics within the ED also contributing to ED overcrowding.[14, 92, 116, 117] This is supported within the international literature.[183-186] Service and operation plans both nationally and specific to the Mid West included strategies to improve access to diagnostics.[15, 22, 24, 106] In the Mid West, the 2022 HSE Joint Committee on Health statement noted that the Community Diagnostics Programme was in place,[151] with ULHG representatives confirming in January 2025 that mobile diagnostic services were being used to support access to diagnostics in community nursing homes. While initiatives to improve community diagnostics may have been implemented as of January 2025; ongoing limited access to, or a lack of, on-site laboratory diagnostics in St. John's Hospital and Nenagh Hospital were identified as potential causes of slower diagnostic turn-around times and increased average length of stay in these hospitals.[115] Additionally, the 2023 National Review Cardiac Services noted that ULHG and South/Southwest HG are the only HGs that do not have direct GP access to ambulatory cardiology diagnostics.[187] These HGs do have direct GP access to

electrocardiogram. The HSE Outline Strategic Plan for Laboratory Services (2026 – 2035) highlighted that the relationship between clinical laboratory services and the community services they support, particularly GPs, are poorly defined.[188] The report further noted a need to redesign service orientation around the move to greater care in the community. Furthermore, opportunities were noted that may arise with the implementation of the HSE Health Regions. This included the potential to develop networked laboratory services where they do not currently exist, to meet the needs of the population and help deliver integrated community and hospital-based care.

Point-of-care testing (POCT) has been suggested as an alternative to on-site laboratory diagnostics; however, the impact of POCT is mixed within the literature. A 2020 cluster-randomised controlled study of 23,231 patients attending the ED in one hospital outlined that while the implementation of an extended panel of POCT solutions reduced the time to a result in the ED, compared with processing of diagnostics in the central laboratory, it did not significantly reduce the length of stay.[189] While patients and ED staff reported higher satisfaction levels with POCT, it was suggested that additional local steps may be required to get laboratory test results as close as possible to the decision-making process for POCT, to result in reduced ED length of stay and improve crowding targets.[189]

Models, pathways and strategies have been developed to improve system efficiency and optimise the care and flow of patients who present to the ED, with an aim of avoiding inpatient admittance, or minimising average length of stay where admittance is required. One such strategy is the development of AMUs for rapid assessment of acutely ill patients.[190] International literature suggests that for these acute units to function efficiently, they should be co-located with the ED and follow standardised protocols, which include not acting as an overflow area for patients, and having zero tolerance for boarding.[105, 107, 191-193] While the AMU in UHL is co-located with the ED, HIQA inspection reports across 2022 and 2023 reported that the AMU was not operating as designed, with capacity mostly occupied by boarders.[15, 79, 110] Internationally, the use of AMUs is supported, with the National Institute for Health and Care Excellence (NICE) outlining a recommendation to 'assess and treat people who are admitted with undifferentiated medical emergencies in an acute medical unit',[194] as a way of managing hospital admissions. Of note, the evidence review undertaken by NICE to assess whether admission or assessment through an AMU increases hospital discharges, improves patient outcomes or hospital resource usage, only identified low-quality evidence to support the role of AMUs, with the included evidence limited to three observational studies of low quality.[195] However, a strong consensus recommendation in favour of retaining AMUs was provided by the evaluation committee, based on the evidence provided, along with their experience of AMUs in practice.[195]

The SAMEDAY strategy was also published by the NHS in 2024, and aims to support the delivery of same day emergency care (SDEC) across England in a standardised and consistent way.[196] SDEC allows specialists, where appropriate, to assess, diagnose and treat patients on the same day of arrival who would otherwise have been admitted to hospital.[196] It is recommended that it is located close to an AMU or ASAU to allow for quick transfer of patients, but that it should also have its own external entrance for direct access. SDEC requires access to diagnostics services (including point-of-care tests), and clear processes from referral to arrival to support early decision-making, thereby maximising the opportunity to complete patient care within the same day.[196] SDEC is part of the 2023 NHS *Delivery plan for recovering urgent and emergency care services,*[197] which also outlines actions to increase capacity, grow the workforce, speed up discharge, expand new services in the community, and help people access the right care first time.[197]

Reports across the years highlighted deficient staffing levels both nationally and in the Mid West. The staffing deficit was reported in hospitals (notably across consultants and nursing staff) and in the community (notably across paramedical and clerical staff).[80, 81] Initiatives to address the staff deficit, (while complying with the HSE Employment Control Framework and or any recruitment embargos) included reconfiguring and redeploying existing services, staff, and work.[62, 63, 82, 83] Literature has suggested that staff specifically dedicated to addressing patient flow management can be beneficial in addressing overcrowding.[4] More recently, a number of positions have been filled to support hospital operations (such as the Head of Operations post), in the Mid West.[79] Additionally, the Mid West has seen increased staffing levels, specifically for the on-site presence of consultants, potentially leading to a reduction in delays for clinical decision-making.[44, 79] Despite these staffing increases, there continues to be calls for increased staffing levels,[88, 109] particularly for nursing staff in line with the Framework for Safe Nurse Staffing levels in emergency care.[55] The OPTIMISE Interim Report Review of Internal Medicine Training in 2023 also outlined the importance of the preservation of general medical skills to maintain standards of care in Ireland.[198] OPTIMISE outlined that internal medicine accounted for approximately two-thirds of hospital bed days and included recommendations to ensure the internal medicine training programme is fit-for-purpose and ensures graduates are provided with the skills and expertise required to meet the needs of patients and society into the future.[198]

Governance, founded on the *Principles of Good Governance*,[199] including responsiveness, competence and capacity, transparency and accountability, is vital for the delivery of high-quality health services. The governance of a health system can shape its ability to respond to various issues.[200] This is supported by the HIQA *National Standards for Safer Better Healthcare* which outlines that a well-governed health service is clear about what it does, how it does it, and is accountable to its

stakeholders.[201] Good governance arrangements acknowledge the inter-dependencies between organisational arrangements and clinical practice, and integrates these to deliver high-quality, safe and reliable care and support.[201] Notable developments in governance in the Mid West have been reported in the last number of years, including the establishment of the ULHG and Mid-West Community Healthcare Organisation Integrated Unscheduled Care Committee in 2022; the establishment of the Urgent and Emergency Care Directorate in 2023 and the appointment of a Head of Operations at UHL. Additionally, the most recent HIQA report following an inspection of the UHL ED in 2023[24] indicated that there were improvements in defined management arrangements in recent years. With the implementation of the HSE health regions due by March 2025, the ULHG Strategic Plan 2023-2027[88] has outlined that a review of organisational structures and governance arrangements in the HSE Mid West will be conducted. The review should consider how governance arrangements have changed with the implementation of the health regions. It should also consider how measurement and reporting of these arrangements should occur; to determine any impact on health service delivery and for clarity on the influence of governance arrangements. Additionally, measurement and comparison of governance arrangements are an important undertaking to determine the nature and quality of governance.[200]

While patient safety was not explicitly summarised within the findings, it is acknowledged that this is an underpinning factor when considering any decisions or recommendations made in relation to capacity, patient flow, community healthcare and so on. Decisions with regard to the reconfiguration of healthcare services in the Mid West in 2008; the implementation of strategies and initiatives (such as the Pathfinder Programme and Geriatric Emergency Medicine Unit); and the provision of additional funding and resources were all made with the primary objective of improving patient safety through the delivery of safe, quality healthcare.

Overall, it was clear given the volume of key resources included, that a considerable number of reviews and reports have been undertaken over the last 24 years related to urgent and emergency services in the Mid West. However, whether these reviews and reports resulted in policy change and or the implementation of recommendations, varies considerably.[202] Within the literature five key dimensions are outlined when translating evidence to policy. These are (i) the substantive nature of *the policy problem*, (ii) *'agenda setting'* (where evidence is sought and used), (iii) the *filtration process* (which shapes and moulds how evidence is used), (iv) the *policy apparatus* for policy design and implementation (including legislation) and (v) the critical role of *evidence translators* at every stage of the process.[202] These dimensions should be considered prior to undertaking further reviews of the Irish health system, to ensure impactful change can be made.

Where impact has been noted, a number of reports have led to the development and implementation of numerous strategies and initiatives, both nationally and locally in the Mid West, with continued development occurring to date. While some of the initiatives have been outlined to be beneficial in avoiding ED attendance and improving discharges (such as the Pathfinder Programme), there is a general lack of short and long-term monitoring and evaluation data in relation to these initiatives. No specific evaluation frameworks were cited in the included resources; therefore the ability to systematically evaluate whether the initiatives are leading to a decrease in overcrowding in the ED, is limited. This is in line with literature that has suggested a requirement to systematically assess the impact of strategies to reduced ED overcrowding.[203-205]

Lastly, this report focused on policy recommendations and decisions that impacted urgent and emergency healthcare services in the Mid West health between 2000 and 2024. However, a number of key policies, strategies and programmes will also need to be considered in any future planning for the Mid West. These include policies:

- affecting configuration and design of services, such as:
    - the National Trauma Strategy for Ireland[206]
    - Securing the Future of Smaller Hospitals: A Framework for Development[52]
    - the Strategic Plan for Critical Care, which is aligned with the National Critical Care Clinical Programme[207]
    - Sláintecare, and the development of elective and primary care capacity[106]
    - Project Ireland 2040: National Planning Framework[208]
    - Framework for Ambulatory Care on the Acute Floor[45]
    - the National Clinical Programmes[209]
    - the National Virtual Ward Programme[143]
- aimed at centralisation of complex work, such as the:
    - the National Maternity Strategy: Creating a Better Future Together 2016-2026[210]
    - the National Cancer Strategy 2017-2026[211]
    - the National Review of Adult Specialist Cardiac Services in Ireland[187]
- aimed at staffing, such as the:
    - Public Only Consultant Contract 2023[212]

- Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland 2018[54]
- Health and Social Care Professions (HSCP) Advanced Practice Framework[213]

Recommendations and or actions, arising from these policies, strategies and programmes may impact the configuration and or delivery of urgent and emergency healthcare services in the Mid West. Examples of actions include, the:

- relocation of maternity services currently provided at the University Maternity Hospital Limerick, Ennis Road, to UHL, Dooradoyle.[208]
- designation of UHL as a cancer centre.[211]
- establishment of a national Trauma System comprising two regional Trauma Networks (Central and South) each of which has a Major Trauma Centre (in the Mater Misericordiae University Hospital, Dublin and Cork University Hospital, respectively) and a number of Trauma Units.[206] As part of this planned consolidation of trauma services, UHL has been identified as a potential Trauma Unit (in the South Trauma Network) on the basis that it meets the minimum criteria of having a 24/7 Emergency Department with Trauma & Orthopaedic Surgery and General Surgery available on-call.[206]
- continued designation of UHL as a primary percutaneous coronary intervention (PCI) centre, with the provision of PCI for acute heart attacks 24/7.[187]
- the impact of the public only consultant contract on the distribution of patients across public and private hospitals. The need for a future impact assessment of the new private hospital
- the phased elimination of private care from public acute hospitals[212]
- the new undergraduate medical programme in University of Limerick, with the first programme due to begin in September 2026.

4.1 Limitations

While this summary presents a comprehensive analysis of the key recommendations and decisions that have impacted urgent and emergency healthcare services in the Mid West (2000 to 2024), there are notable limitations. Firstly, when reviewing resources that provided information on national health service delivery, this summary focused solely on those deemed likely to have impacted the Mid West. A review was not conducted on how other health regions may have been impacted by key recommendations and decisions, and therefore comparison between health regions was not possible. Additionally, while efforts were made to identify if recommendations were implemented (and, where relevant, their impact) this was particularly difficult for the 2000 to 2019 period. Engagement with representatives

from ULHG was therefore undertaken to provide insight and or clarity into the information outlined.

Furthermore, the landscape of urgent and emergency healthcare services is complex; spanning multiple clinical specialities, impacting many patient sub-groups and encompassing acute and primary healthcare services. While an inclusive search of grey literature was conducted and efforts were made to include all relevant information, it is acknowledged that resources deemed in scope by others may have been excluded and or some information may have been missed. To overcome this, individuals with expertise in the area were contacted to confirm and or provide additional key resources. This report also primarily focused on qualitative data, with no attempt to use traditional health service datasets in Ireland (such as the Hospital In-Patient Enquiry (HIPE) and Patient Experience Time (PET) datasets) to assess the impact of recommendations and or decisions. These data are further explored within the *Evidence synthesis to inform the review of urgent and emergency healthcare services in the Health Service Executive Mid West Region of Ireland*.

5 Conclusion

This summary outlines the key recommendations and decisions that have impacted urgent and emergency healthcare services in the HSE Mid West health region, over the 2000 to 2024 period. This includes key recommendations around the reconfiguration of health services; bed capacity; the optimal use of current capacity; processes to enable patient flow; integrated healthcare and capacity in the community; and governance. Notable actions that have had a significant impact on urgent and emergency healthcare services in the Mid West over the last 24 years include: the replacement in 2009 of 24/7 EDs in Ennis, Nenagh and St. John's hospitals with MAUs; the general moratorium on recruitment and promotion implemented in 2009; reductions in some of the healthcare budgets between 2007 and 2016; the opening of the new ED in UHL in 2017; and the provision of increased funding and resourcing across 2023 and 2024.

While increased funding and resourcing in the last number of years has led to a number of initiatives to support the delivery of safe, quality care in the Mid West (including increased bed capacity, implementation of the Pathfinder Programme, and extended opening hours for medical assessment units, local injury units, and the Geriatric Emergency Medicine Unit); not all of these have been fully implemented, and systematic evaluation of the individual and collective impact of these initiatives has not yet been undertaken.

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Appendix 1: Data extraction template

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	
The health service system (including health service reform)	**Recommendation/considerations:** **For information:**
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** **For information:**
Governance	**Recommendation/considerations:** **For information:**
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** **For information:**
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** **For information:**

Funding	**Recommendation/considerations:** **For information:**
Other	**Recommendation/considerations:** **For information:**

Appendix 2: Additional resources not included in list of key resources (in chronological order by publication year)

No.	Author(s) [Reference] Year	Title or Descriptor	Type of resource	Reason for exclusion from list of key resources
1	Houses of the Oireachtas[214] 2000	Dáil Debate providing information about the Winter Initiative Package	Dáil Debate	Countrywide initiative with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
2	Health Boards Executive[215] 2003	Admissions and discharge guidelines: health strategy implementation project 2003	Guidelines	Implementation strategy with guidelines, with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
3	Health Service Executive (HSE)[216] 2006	HSE Annual Report 2005	Report	Countrywide annual report with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
4	HSE 2006	HSE Accident and Emergency (A&E) Framework	Framework	Unable to access.
5	HSE[217] 2006	A&E departments: background briefing	Report	Briefing note with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region
6	HSE, West Mott MacDonald Ireland Limited[218] 2010	Review of operational controls and an assessment of cost-containment measures for HSE West	Review	Review of costs for all HSE West with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
7	National Treatment Purchase Fund[219] 2013	Special delivery unit technical guidance introducing demand and capacity planning	Strategy	Guidance document with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
8	Department of Health (DoH)[220] 2013	The path to universal healthcare: preliminary paper on universal health insurance	Report	Framework for health insurance with no measurable impact specific to the urgent

				and emergency healthcare services in the Mid West Region.
9	HSE[64] 2014	Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group	Review	National level and covered within actions and a number of included reports around reform.
10	DoH[221-228] 2014	Strategic review of medical training and career structure report on medical career structures and pathways following completion of specialist training (and 4th to 10th progress reports (first three unavailable)) (MacCraith report)	Report	Review of medical career training with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
11	Health Information and Quality Authority (HIQA)[229] 2014	Review of pre-hospital emergency care services to ensure high quality in the assessment, diagnosis, clinical management and transporting of acutely ill patients to appropriate healthcare facilities	Review	Review of ambulance services across Ireland with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
12	National Clinical Programme for Surgery (NCPS) (HSE)[230] 2015	Sporadic outsourcing of healthcare activity from the public to the private sector – a surgical perspective	Review	Focused on quantitative data and relative information covered elsewhere.
13	HSE[231] 2016	Strategy for the Design of Integrated Outpatient Services 2016-2020	Strategy	Strategy for outpatient services across Ireland with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
14	HSE[67] 2016	National Adult Critical Care Capacity and Activity Census 2016	Report	Focused on quantitative data and not heavily linked to policy.
15	UL Hospitals Group (ULHG)[232] 2016	ULHG: Healthy Ireland Implementation Plan 2016-2019	Implementation Plan	Plan for public health initiative (Healthy Ireland) with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.

16	Frank Keane (for the HSE)[233] 2016	Towards Successful Consultant Recruitment, Appointment and Retention: Recommendations of a Committee appointed by the HSE regarding reform of the processes for creation, approval recruitment and appointment to Consultant posts (Frank Keane report)	Report	Report on consultant recruitment and retention in Ireland with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
17	DoH[210] 2016	National Maternity Strategy – Creating a Better Future Together 2016-2026	Strategy	Report on the maternity strategy across Ireland with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
18	DoH[211] 2017	National Cancer Strategy 2017 - 2026	Strategy	Report on the cancer strategy across Ireland with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
19	DoH[234] 2017	Acute Hospital Expenditure Review	Review	Report on expenditure with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
20	HSE[68] 2017	National adult critical care capacity and activity census 2017	Report	Focused on quantitative data and not linked to policy.
21	HSE[235] 2017	Review of the Emergency Medicine Medical Workforce in Ireland	Review	Review of emergency medicine medical workforce in Ireland with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
22	HSE[236] 2017	A Health and Wellbeing Strategic Plan for HSE Mid West Community Healthcare	Plan	Plan for public health initiative with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
23	DoH[206] 2018	A Trauma System for Ireland: Report of the Trauma Steering Group	Report	Focuses specifically on Trauma, as a section of acute care.

24	Government of Ireland[34] 2018	Sláintecare Implementation Strategy	Implementation strategy and action plan	Considered with other Sláintecare reports as a body.
25	DoH[127] 2018	Sláintecare Action Plan 2019	Action plan	Considered with other Sláintecare reports as a body.
26	DoH[237] 2019	Sláintecare Action Plan 2019 Mid-Year Deliverables Report	Progress report	Considered with other Sláintecare reports as a body.
27	DoH[238] 2019	Sláintecare Action Plan Year-End Report 2019	Progress report	Considered with other Sláintecare reports as a body.
28	HSE[71] 2019	National adult critical care capacity and activity census report 2019	Report	Focused on quantitative data and not linked to policy.
29	ULHG[239] 2020	ULHG Annual Review 2020	Annual Review	Report of an annual review with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
30	DoH[240] 2020	Sláintecare Integration Fund Projects 2020	Report	Considered with other Sláintecare reports as a body.
31	HSE[72] 2020	National adult critical care capacity - census report 2020	Report	Focused on quantitative data and not linked to policy.
32	Government of Ireland[122] 2021	Sláintecare Implementation Strategy and Action Plan 2021-2023	Implementation strategy & action plan	Considered with other Sláintecare reports as a body.
33	DoH[241] 2021	Sláintecare mid-year Progress Report for 2021	Progress report	Considered with other Sláintecare reports as a body.
34	Government of Ireland[123] 2021	Sláintecare Action Plan 2022	Action plan	Considered with other Sláintecare reports as a body.
35	HSE[73] 2021	National adult critical care capacity Census 2021 report and resource allocation framework	Report	Focused on quantitative data and not linked to policy.
36	Government of Ireland[242] 2022	Sláintecare Progress Report 2021	Progress report	Considered with other Sláintecare reports as a body.
37	Government of Ireland[125] 2022	Business Case for the Implementation of Regional Health Areas	Business case	Considered with other Sláintecare reports as a body.

38	Government of Ireland[243] 2022	Sláintecare Progress Report 2022	Progress report	Considered with other Sláintecare reports as a body.
39	Government of Ireland[244] 2022	Sláintecare Integration Fund End of Programme Report 2022	Progress report	Considered with other Sláintecare reports as a body.
40	Government of Ireland[245] 2022	Sláintecare Healthy Communities Progress Report 2022	Progress Report	Considered with other Sláintecare reports as a body.
41	Government of Ireland[124] 2022	Sláintecare Action Plan 2023	Action plan	Considered with other Sláintecare reports as a body.
42	St. John's Hospital[246] 2022	St John's Hospital Strategy 2022-2027	Strategy	Strategy for a voluntary hospital in the region but with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region
43	HSE[128] 2022	Enhanced Community Care	Overview	Plan for community care initiative with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
44	DoH[247] 2023	Sláintecare 2023 Mid-Year Progress Report	Progress report	Considered with other Sláintecare reports as a body.
45	Royal College of Surgeons Ireland (RCSI)[248] 2023	The Report of the Short Life Working Group (SLWG) on the Provision of Emergency Surgery	Report	Provides information regarding emergency surgery for context. A number of the recommendations and issues outlined are similar to those seen in other reports.
46	RCSI[249] 2023	Creating the workforce for new surgical hubs	Report	Information captured in action.
47	Government of Ireland and HSE[49] 2023	Organisational Reform HSE Health Regions: Implementation Plan 2023	Implementation plan	Included in actions.
48	ULHG[142] 2023	ULHG Strategy 2018-2022 - Achievements Overview	Overview	Summary report of achievements in previous years but with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.

49	HIQA[250] 2023	Report of an inspection against the National Standards for Safer Better Healthcare (Ennis Hospital).	Inspection report	HIQA inspection report of a Model 2 hospital in the region with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
50	HSE[251] 2023	Infection Control Guiding Principles for Buildings Acute Hospitals and Community Healthcare Settings (Version 7)	Guidelines	Guidance document for infection control with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
51	HSE[252] 2023	Minimum Standards for Acute Surgical Assessment Units in Ireland – 2nd edition	Guidance	Similar contents to recommendations for AMUs (albeit in the surgical field).
52	HIQA[253] 2023	Report of an inspection against the National Standards for Safer Better Healthcare (Nenagh Hospital)	Inspection report	HIQA inspection report of a Model 2 hospital in the region with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
53	National Doctors Training and Planning (NDTP) and RCSI[254] 2023	Model 3 hospitals – consultant recruitment & retention report	Report	Report for Model 3 hospitals, which are not found in the region and therefore no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
54	DoH[133] 2023	Elective Hospitals Programme Overview	Report	Information for background but not key resource.
55	DoH[58] 2024	An Examination of Trends in Activity, Expenditure and Workforce in Publicly Funded Acute Hospitals in Ireland	Report	Heavily focused on data and not linked directly to policy.
56	Government of Ireland[150] 2024	Sláintecare Progress Report 2021-2023	Progress report	Considered with other Sláintecare reports as a body.
57	HSE[255] 2024	Our Service Plan 2024	Service plan	Countrywide service plan with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.

58	Irish Independent[256] 2024	University Hospital Limerick GP screening unit fails to tackle patient overcrowding crisis	News report providing evidence of action	Impact of an intervention that is already included in the key documents.
59	HSE NDTP[257] 2024	Surgery Medical Workforce in Ireland 2024-2038	Report	Information for background but not key resource.
60	Houses of the Oireachtas[37] 2024	Joint Committee on Health debate - Thursday, 10 Oct 2024	Dáil Debate	Committee debate summary with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
61	DoH[187] 2025	National Review of Adult Specialist Cardiac Services in Ireland	Review	Summary report of adult cardiac services across the country with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
62	HSE[147] 2025	The Third Report of the Structured Chronic Disease Management Treatment Programme in General Practice	Report	Summary report of achievements for the Chronic Disease Management Treatment Programme with no measurable impact specific to the urgent and emergency healthcare services in the Mid West Region.
63	Economic and Social Research Institute[148] 2025	Projections of national demand and workforce requirements for general practice in Ireland, 2023–2040: Based on the Hippocrates model	Report	Heavily focused on data and not linked directly to policy.
64	Government of Ireland[156] 2025	Sláintecare Implementation Progress Report 2024	Progress report	Considered with other Sláintecare reports as a body.
65	Government of Ireland[149] 2025	The Path to Universal Healthcare – Sláintecare & Programme for Government 2025+ (Sláintecare 2025+)	Plan	Considered with other Sláintecare reports as a body.

Key: A&E = Accident and Emergency; DoH = Department of Health; HIQA = Health Information and Quality Authority; HSE = Health Service Executive; NDTP = National Doctors Training and Planning; ULHG = University of Limerick Hospitals Group; RCSI = Royal College of Surgeons Ireland.

Appendix 3: All Sláintecare reports, plans and strategies (in chronological order by publication year)

Title [Reference] Year	Type of publication	Brief description
Sláintecare Report 2017[106]	Report	Initial report from the Oireachtas Committee on the Future of Healthcare. Recommendations for reorienting the healthcare system in five sections: 1. Population Health Profile 2. Entitlements and Access 3. Integrated Care 4. Funding 5. Implementation.
Sláintecare Implementation Strategy[34] 2018	Implementation strategy and action plan	Outlines actions to be taken in the first three years of Sláintecare's 10-year vision. Sets out 10 Strategic Actions under four overarching goals: 1. Deliver improved governance and sustain reform through a focus on implementation 2. Provide high quality, accessible and safe care that meets the needs of the population 3. Ensure the health system is financially sustainable 4. Enable the system to deliver its goals.
Sláintecare Action Plan 2019[127] 2018	Action plan	Sets out framework for implementation of "Citizen Care Masterplan". Identifies four workstreams, each with five main programmes and multiple projects: 1. Service redesign & supporting infrastructure, 2. Safe care, co-ordinated governance & value for money 3. Teams of the future 4. Sharing progress.
Sláintecare Action Plan 2019 Mid-Year Deliverables Report 2019[237]	Progress report	Updates on the status of 84 deliverables set out in the 2019 Action Plan for the first half of 2019, categorised into one of the four workstreams (98% on track). Identifies three enablers to success: 1. Implementation of Regional Health Areas (RHAs) 2. Capital funding for community and hospital beds 3. Clear direction on citizens' eligibility and entitlement.

Sláintecare Action Plan Year-End Report 2019[238] 2019	Progress report	Updates on status of 138 projects for the period up to December 2019 (112 on track, 24 minor challenges, 2 significant challenges). Details foundational government decisions made in 2019 that will influence Sláintecare progress, namely: 1. RHAs 2. Sláintecare Consultant contract (SCC) (by mid-2020) 3. Significant investment in GP services, including for chronic disease management 4. New HSE CEO and formal appointment of the Board.
Sláintecare Integration Fund Projects 2020[240] 2020	Report	Describes projects allocated funding under the Sláintecare Integration Fund (SIF) set out in Budget 2019 "to test and scale how services can be best delivered". Focus on projects in three categories: 1. Citizen empowerment and engagement 2. Best practices for chronic disease management and care of older people 3. Innovations in shifting care to the community or providing hospital avoidance measures.
Sláintecare Implementation Strategy and Action Plan 2021-2023[122] 2021	Implementation strategy & action plan	Sets out priorities and actions for the second 3-year phase of the programme. Restates commitment to Sláintecare vision "to achieve a universal single-tier health and social care system, where everyone has equitable access to services based on need, and not ability to pay". Identifies 2 new reform programmes: 1. Improving safe, timely access to care and promoting health & wellbeing - focus on waiting lists and capacity (7 projects) 2. Addressing health inequalities - towards universal healthcare (4 projects).
Sláintecare mid-year Progress Report for 2021[241] 2021	Progress report	Updates on status of 112 deliverables for first half of 2021 (84 on track, 25 minor challenges, 3 significant challenges). Challenges outlined include COVID-19 and cyberattack impacts, recruitment and capacity-building challenges, and issues identifying ownership of waiting lists action plan.
Sláintecare Action Plan 2022[123] 2021	Action plan	Aligns ongoing reform priorities with the Sláintecare Implementation Strategy & Action Plan 2021—2023, Programme for Government, Department of Health priorities and the HSE's National Service Plan 2022. Sets out 134 deliverables, with focus on: reducing waiting lists; shifting care to the community; innovation, enhanced capacity and access to care, implementing digital and eHealth solutions; introducing SCC; new elective capacity in Dublin, Cork, Galway; RHAs.

Sláintecare Progress Report 2021[242] 2022	Progress report	End of year updates on status of 228 deliverables (28 with significant challenges). Achievements include: progress on GP chronic disease management programme; national CIT coverage; GP direct access to diagnostics; Healthy Ireland strategic plan published; increased staffing and beds; eHealth developments (eprescribing and teleconsultations); 9 new primary care centres.
Business Case for the Implementation of Regional Health Areas (RHAs)[125] 2022	Business case	Details barriers to integration and transitions of care between community and acute health services. Sets out the case for six new Regional Health Areas (RHAs) to enable population-based resource allocation and provide integrated care.
Sláintecare Progress Report 2022[243] 2022	Progress report	Key achievements include: government approval on timelines for implementation of RHAs, reductions in waiting lists exceeding 2017 government targets, SCC approved by government, recruitment for Community Healthcare Networks (CHNs), with 94 of 96 CHNs now in place, increased acute and critical care bed capacity, framework for postnatal hubs agreed, additional medical student places, free contraception scheme launched, reduction in DPS monthly threshold. Of 120 deliverables, 20 were experiencing significant delays (4 of these due to external dependencies).
Sláintecare Integration Fund End of Programme Report 2022[244] 2022	Progress report	Outlines the progress made in the 123 projects funded in the initial round of the SIF. Main impacts include: reduction in acute referrals in favour of community or scheduled care; reduction in ED visits, admissions, and waiting times; reduction in ALOS; long term care avoidance; improved health literacy; patient and professional satisfaction; and cost reduction. 106 projects will continue to be funded annually and 13 have been completed.
Sláintecare Healthy Communities Progress Report 2022[245] 2022	Progress Report	Updates on Healthy Communities initiatives based in 19 areas of deprivation in Ireland, aimed at reducing health inequalities. Contains case studies of various projects and related outcomes. Falls under the Reform Programme 2 of Sláintecare Action Plan 2021-2023.
Sláintecare Action Plan 2023[124] 2022	Action plan	Sets out key priorities for 2023, based on the 2 Reform Programmes outlined in 2021-2023 Strategy and Action Plan, including: remaining CHNs to be established; Waiting List Plan to be actioned; progress towards RHAs; SCC introduced; workforce planning; develop 5 new surgical hubs; progress SIIF Round 2 projects and launch Round 3; publish Digital Health Strategic Framework; progress Electronic Health Record plans.

Sláintecare 2023 Mid-Year Progress Report[247] 2023	Progress report	Key achievements delivered from Jan - Jun 2023 include: completed recruitment of all approved posts for National Home Support Office; published Waiting List Action Plan; announced locations of 6 surgical hubs in advance of developing elective hospitals at Dublin, Cork and Galway; opened Major Trauma Centres at MMUH and CUH; increased GP training places; launched Health System Performance Assessment platform. Project updates and categorisation (e.g. significant (n=2) or minor (n=30) delays) and comment on delays (recruitment issues and sign-off of implementation plans described).
Organisational Reform, HSE Health Regions, Implementation plan July 2023[49] 2023	Implementation plan	Sets out a high level programme of work and timelines for Health Region (formerly known as RHAs) implementation. Aims for Health Regions to be operational by February 2024. Four themes of work identified: 1. Leadership, Vision, and People 2. Model of Integrated Care and Healthcare Governance 3. Planning and Finance 4. Infrastructure, including Capital, ICT and Supports
Sláintecare Progress Report 2021-2023[150] 2024	Progress report	Final progress report for the Strategy & Action Plan 2021-2023. Updates on progress of 11 projects associated with the 2 Reform Programmes, for example: implement the Health Service Capacity Review (2018) including Healthy Living, Enhanced Community Care and Hospital Productivity; implement the Sláintecare Consultant Contract; develop elective centres in Dublin, Cork and Galway; implement the digital health programme; develop HSE RHAs.
Sláintecare Implementation Progress Report 2024[156] 2025	Progress report	Updates on key milestones achieved in 2024, including: improving access, improving service quality, building capacity, and enabling reform. Highlights specific and targeted reforms, such as the HSE Health Regions and Digital Health Transformation Programme. Notes next steps to be included in Sláintecare 2025+.
The Path to Universal Healthcare – Sláintecare & Programme for Government 2025+ (Sláintecare 2025+)[149] 2025	Plan	Sets out a reform programme to be implemented over the period 2025–2027, recognising that some of these reforms will continue over a longer timeframe. States commitment to Sláintecare vision to provide universal, accessible, affordable, person-centred, safe and high-quality health and social care for all the people of Ireland. Sets out 23 individual Sláintecare Projects and milestone included on the path to achieving universal healthcare across three priority areas:

		1. Increase access to health and social care services 2. Improve service quality for patients and service users 3. Increase capacity of the health and social care system

Key: ALOS = average length of stay; ED = emergency department; CHN = Community Healthcare Network; DPS: Drug Payment Scheme; RHA = Regional Health Area; SCC = Sláintecare Consultant contract; SI(I)F = Sláintecare Integration (Innovation) Fund.

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