

Recovery capacity, not simply more beds

The Irish rehabilitation, step-down and short-stay care opportunity

A market view for residential and community care providers, prepared by the Origin Care Group team

**3,745**

short-stay beds in Ireland, 2022

6,430–7,265

beds needed by 2040 (ESRI)

515

patients delayed in hospital today*

The central opportunity

Reposition a ring-fenced part of an existing care estate as an outcomes-led recovery service: rapid admission, daily therapy, measurable functional gain and a planned route home.

* HSE 8am national snapshot of delayed transfers of care, 27 July 2026. Market estimates and interpretations are explained in the sources and methodology on the final page.

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The market in one page

Ireland's short-stay rehabilitation market sits in the gap between acute hospitals, long-stay residential care and home support. It is already a sizeable market, but a loosely defined one: 'short stay' takes in step-down, rehabilitation, convalescence, respite and a range of other transitional placements. For providers, that looseness is both the opening and the risk. In our own work with rehabilitation and step-down services, the pattern is consistent: demand is not the problem — the services that win are the ones that can define what they do and prove it.

1 in 8 residential beds used short term	+2,685–3,520 extra beds implied by 2040	42,123 acute bed-days lost in Q1 2026
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Why this is moving now

- Ireland is ageing quickly. By 2040, one in five people here will be aged 65 or over, and the population aged 85 and over — the heaviest users of residential and step-down care — is projected to more than double.
- The pressure is visible in hospitals. Delayed transfers of care consumed 42,123 acute bed-days in the first quarter of 2026, up from 36,078 a year earlier — more than 450 beds out of action on an average day. By July 2026 the daily count of delayed patients had stayed above hospital thresholds for over 100 consecutive days, at an estimated cost of around €20 million a month.
- The State is building purchasing routes. In April 2026 the HSE went to market for a national panel of providers of community short-stay, therapy-supported beds — a direct commissioning route for exactly this kind of service.
- Policy is pushing care outwards. The HSE's 2026 National Service Plan commits to 428 new community beds alongside a broader shift of activity out of acute hospitals and into the community.

Commercial implication
The strongest proposition is not 'spare nursing-home beds'. It is a defined clinical service, sold on access, length of stay, outcomes and discharge reliability.

What the numbers say

Acute bed-days lost to delayed transfers of care, first quarter



Source: HSE data reported for Q1 2025 and Q1 2026. The rise is approximately 16.8%; published commentary rounded it to 15%. Separately, HSE figures released in July 2026 show roughly half of delayed transfers to end-April 2026 were attributed to a lack of nursing home or residential care support, with the average delay running to 24.8 days across acute hospitals in 2025.

A market heading towards 7,000 beds

The ESRI estimates that Ireland had 33,324 short- and long-stay residential beds in 2022. About 3,745 of these — roughly one in eight — were used for short-term care such as step-down and rehabilitation. By 2040, short-stay requirements are projected at 6,430 to 7,265 beds, growth of 72% to 94%.

Short-stay residential beds in Ireland, actual and projected requirement



Source: ESRI (2025), Hippocrates model. The range reflects demographic, healthy-ageing and policy scenarios. It is a requirement projection, not a funded procurement forecast.

Capacity translation

The projection implies another 2,685–3,520 short-stay beds by 2040 — approximately 0.98–1.28 million additional available bed-days each year. A 20-bed unit represents only 0.6%–0.7% of that incremental national requirement.

The regional pattern matters

HSE region	2022 short-stay beds	Signal for providers
Dublin & North East	1,024	Largest base and highest absolute 2040 increment: +661 to +893 beds.
Dublin & Midlands	468	Lowest baseline rate at 3.28 beds per 1,000 people aged 65+; a likely capacity gap.
Dublin & South East	783	Large private provision and a projected increment of +506 to +676 beds.
South West	469	Projected increment of +307 to +412 beds.
Mid West	311	Smallest base; projected increment of +211 to +282 beds.
West & North West	689	Projected increment of +433 to +580 beds; hospital-flow pressure is dispersed across the region.

Source: ESRI regional projections, Hippocrates model (2025). Regions are planning geographies; local opportunity still depends on referral origins, travel time, staffing and contract access.

Repositioning existing premises

The quickest route is normally a ring-fenced wing or small unit, not a whole-facility conversion. A credible service has its own admission criteria, therapy cadence, governance, outcome measures and discharge discipline — and can show all five to a referrer within minutes.

Model	Best-fit cohort	What must be different
Post-acute reablement	Deconditioning, falls, frailty; medically stable.	Daily functional goals, nurse-led monitoring, PT/OT access, 2–6 week target stay.
Orthopaedic recovery	Hip and knee surgery, fractures.	Seven-day mobilisation capability, pain and wound pathway, rapid referral from surgical teams.
Stroke / neuro step-down	Stable patients with defined rehabilitation potential.	Higher therapy intensity, SLT access, specialist competencies and stronger outcome evidence.
Respite-to-recovery	Carer breakdown or temporary loss of independence.	Prevention focus, medication and mobility review, explicit return-home plan.
Hybrid bed + home pathway	Patients able to leave earlier with support.	One care record, remote follow-up and a clean handover into home support or a virtual ward.

A practical 20-bed conversion

- **Estate.** Single rooms where possible; accessible bathrooms; a therapy area; dining and social space; a safe walking circuit; equipment storage; transport access.
- **Clinical model.** Named medical oversight, nursing competencies, therapy-led plans, medication management, escalation and hospital-transfer protocols.
- **Operating model.** Referral response in hours, seven-day admission capability where viable, and a live view of occupancy and expected discharges.
- **Evidence model.** Baseline and discharge measures: mobility, ADLs, frailty, falls risk, discharge destination, length of stay and readmission.

The unit economics hinge on flow

A 20-bed unit at 90% occupancy delivers 6,570 occupied bed-days a year. At a 28-day average stay, that is about 235 episodes — not simply 20 residents. Referral conversion and discharge reliability matter as much as the building.

CHALLENGES

Why apparently suitable beds still fail

The short-stay market is attractive precisely because it solves a hard coordination problem, and providers inherit part of that difficulty when they enter it. About half of current delayed transfers are attributed to a lack of residential support — yet plenty of nominally available beds still cannot admit.

Constraint	What goes wrong	Provider response
Workforce	A nominal bed cannot admit without nursing and therapy capacity; weekend gaps extend stays.	Secure core therapy capacity; cross-train staff; contract scarce disciplines; set a realistic acuity ceiling.
Contracting & price	Spot purchasing creates volatility; an inadequate rate makes higher therapy intensity uneconomic.	Seek block or minimum-volume commitments, indexation, clear inclusions and change control.
Referral quality	Late, incomplete or unsuitable referrals create rejection, delay and clinical risk.	Publish criteria; use a single digital referral pack; give rapid accept or defer decisions with reasons.
Discharge blockage	A short-stay bed becomes long stay when home support, equipment or family arrangements are late.	Plan the destination on day one; track barriers daily; integrate home-support and equipment partners.
Regulation & mix	A short-stay service can sit inside a regulated older-person centre, but scope, staffing and governance must match the resident profile.	Engage HIQA early; ring-fence the model; align the statement of purpose, policies, competencies and premises.
Data fragmentation	Hospitals and providers operate from different occupancy, referral and care records.	Run the pathway on one shared record: live capacity, referral status, expected discharge and outcomes reporting across all parties.

The strategic test

Reposition when...

the building is accessible; a hospital catchment has persistent discharge pressure; therapy can be secured; the provider can ring-fence the service; and the purchaser will support a viable rate and predictable flow.

Do not reposition when...

the plan relies only on empty rooms, agency staffing and ad-hoc referrals — or when long-stay demand is already stronger and more dependable at the same premises.

A sensible route to market

The opportunity is real, but the safest commercial move is staged. Prove the pathway before committing the whole estate.

1	Map the catchment Quantify delayed transfers, referral hospitals, competing units, travel time, local home-support capacity and likely cohorts.
2	Choose one pathway Start with a clinically coherent cohort — often frailty/deconditioning or orthopaedic recovery — rather than accepting every 'step-down' referral.
3	Co-design with purchasers Agree eligibility, response time, information set, escalation, outcomes, rate and minimum volume before capital works.
4	Pilot 12–20 beds Ring-fence staff and space; run a live bed, referral and discharge view; review flow weekly with hospital teams.
5	Scale on evidence Expand when occupancy, functional gain, discharge-home rate, length of stay and 30-day readmission support the model.

Bottom line

Ireland needs a larger recovery layer between hospital and home. Existing care providers are well placed to build it — but only if they sell a measurable, time-limited service rather than relabelling conventional beds.

The next build will be connected, not just bigger

Most of the constraints in this report — referral quality, discharge blockage, fragmented records, evidence for purchasers — are pathway problems before they are property problems. The next 3,000 beds will not be won by whoever converts fastest, but by whoever can show referrers and purchasers the whole journey: who is in the bed, why, what therapy they are receiving and when they are going home.



The rehabilitation journey mapped end to end on connects.health — every discipline, record and decision point on one connected pathway from referral to home, with AI-supported steps and patient engagement built in.

Where Origin fits

connects.health runs this pathway in live services today: referral triage, therapy cadence, clinical governance, occupancy and outcomes on one record. Providers planning the next generation of short-stay capacity design the digital pathway alongside the physical unit — so the service opens with its operating model and evidence base in place, rather than retrofitted after the first contract.

Sources and methodology

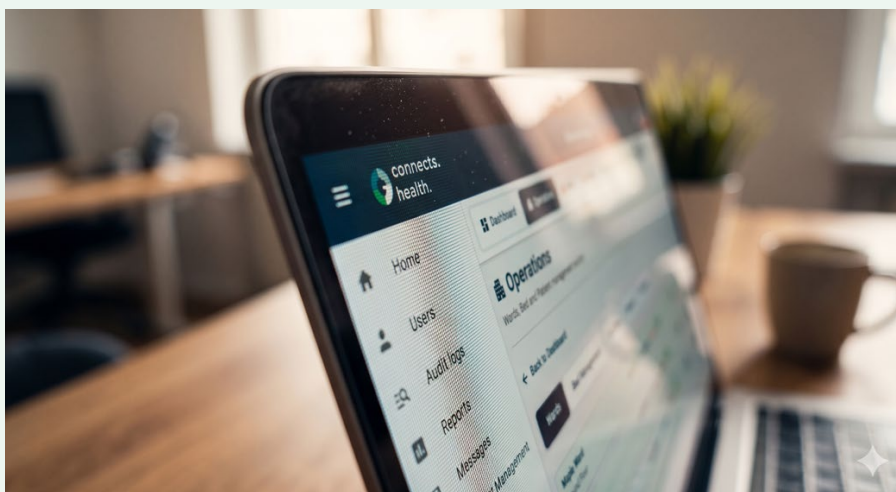
1. [ESRI \(2025\), projections of national demand and bed capacity requirements for older people's care in Ireland, 2022–2040.](#)
2. [ESRI \(2025\), regional demand and bed-capacity requirements, Hippocrates model \(SUSTAT 135\).](#)
3. [CSO \(2024\), Population and Labour Force Projections 2023–2057.](#)
4. [HSE, urgent and emergency care report, daily 8am snapshot \(27 July 2026\).](#)
5. [HSE / eTenders \(April 2026\), national panel for Community Short Stay Therapy Supported beds.](#)
6. [HSE National Service Plan 2026.](#)
7. [HSE delayed-transfer data reported for Q1 2025 and Q1 2026 \(c. 450 beds equivalent\).](#)
8. [HSE delayed-transfer figures released via parliamentary question, July 2026 \(cost, causes and average duration of delays\).](#)
9. [HIQA, guidance for designated centres for older people, version 3.1.](#)

Method note: capacity figures are ESRI modelled requirements, not guaranteed funded demand. 'Additional bed-days' equals incremental beds × 365 and does not assume occupancy. The 20-bed throughput example assumes 90% occupancy and a 28-day average length of stay. This document is strategic market analysis, not legal, regulatory or investment advice.



About Origin Care Group

Origin Care Group is an Irish digital health company. Our connects.health platform extends hospital-grade rehabilitation and step-down care beyond traditional settings, combining real-time clinical governance, therapy and outcomes tracking, AI-powered insights and age-friendly patient technology. We work with hospitals, rehabilitation units, step-down services and community care providers in Ireland and internationally — including on exactly the referral, occupancy and outcomes challenges described in this report.



connects.health operations — wards, beds and patient management in one live view.

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