Irish Maternity Indicator System

National Report 2025

National Women and Infants Health Programme

May 2026

HSE

National Women & Infants Health Programme

Irish Maternity Indicator System
National Report, 2025

Produced by

The National Women and Infants Health Programme, HSE
In conjunction with staff at the 19 maternity hospitals/units in Ireland
(see *Appendix 2 for details)*

May 2026

Notes:

This report provides the definitions beneath the tables for each metric. Full detailed information is available on the IMIS Manual 2025, supplied by the NWIHP to the 19 maternity hospitals/ units. Data are correct at the time of publication, but it is possible that changes may arise at individual maternity hospitals/units.

Contents

IMIS 2014 – 2025

1 Background

In Ireland, as elsewhere, improving pregnancy outcomes is a national priority (HIQA 2016). The National Maternity Strategy 2016-2026 stated that the vision for maternity services was for "women and babies to have access to safe, high-quality care in a setting that is most appropriate to their needs […] parents are supported before, during and after pregnancy to allow them give their child the best possible start in life" (2016: 4).

The IMIS was developed in 2013-14 as the first national, data-driven management system for maternity hospitals/units in the Republic of Ireland. Its creation followed national recommendations for the "development of an agreed and defined dataset and standardised data definitions to support performance monitoring, evaluation and management of key patient outcome and experience indicators" (HIQA 2013; HSE NIMT 2013).

For over a decade, the IMIS has been operating across all 19 maternity hospitals/units as the national standardised system that serves within-hospital data collection, monthly monitoring, and regional and national oversight of activities and events (Appendix 4).

2 Methods and Data

The IMIS data are gathered by staff at the 19 maternity hospitals/units on a monthly basis. They are sent to the National Women and Infants health Programme (NWIHP) for validation and analysis.

The NWIHP prepares the annual National Report, which contains both longitudinal trends and annual hospital-level data on a series of funnel plots. The plots show rates for the 19 maternity hospitals/units, national average rates, and statistical control limits. The National report identifies outliers on specific metrics that may require local review.

It is important to stress, outliers do not necessarily imply poor performance. They are identified for *review* purposes, not ranking.

Caution is advised when dealing with small numbers, as the statistical calculations may be subject to distortion. Small-number effects explain many outliers in rare-event metrics, e.g., ectopic pregnancies transfused.

The funnel plots in the National Report are not risk-adjusted: they account for maternity hospital/unit size, but not complexity. Further, the data are aggregated at hospital/unit-level and do not facilitate analysis at the individual level.

The metrics comprise a selection of key elements, including obstetric emergencies and complications, neonatal care, hospital activities, infant feeding, and demographics. When reading this report, it is important to consider the metrics as a suite of interlinked activities, for example, the association between rates of Caesarean section and peripartum hysterectomy, or the links between neonatal metrics for neonatal encephalopathy (NE) and therapeutic hypothermia (TH) treatment. It is also important to bear in mind the variations in sizes of hospitals/units and the levels of activity, from under 800 births per annum to over 8,000.

3 Demographic and Activity Trends

Falling birth numbers: Total births nationally have fallen by over 19% over the past 12 years. The decline has been observed across all 19 maternity hospitals/units, irrespective of size. However, it has been particularly acute at smaller units. Units with under 2,000 births per annum have experienced an average decline of approximately a quarter total births per annum since 2014.

On first reading, the decline in birth numbers may suggest a sustained contraction in maternity activity. However, the raw numbers do not reveal any information about the increasing complexity and case-mix experienced at the maternity hospitals/units over the past decade. For example, the proportion of nulliparas has risen by over 10% nationally. First-time mothers are more likely to experience intervention.

Modes of birth and intrapartum care

Intervention rates generally have risen nationally. Rates of Caesarean section (CS) have risen sharply by 43% and Induction of labour has risen

by over 30% since 2014. These trends appear to be closely linked, particularly in first-time mothers. The decline in Assisted vaginal delivery (-14%) suggests a shift away from operative vaginal births towards CS in complex labours.

There has been a marked rise in Labour epidurals nationally among vaginal births (+24%). There has been a decline in General anaesthetic for Caesarean sections (-18%). These trends suggest improvements in access to regional anaesthesia, as well as evolving anaesthetic practice. More detailed data would be required to confirm these trends.

Maternal morbidity and safety

Stable indicators include Uterine rupture, PPH, and Blood transfusion rates. These trends suggest positive developments in haemorrhage prevention, management, and escalation pathways.

Concerning increases: Eclampsia, Peripartum hysterectomy, ectopic pregnancies. The rising trends on these metrics may reflect older maternal age, higher acuity, and may be associated with rising intervention rates.

Maternal death rates have fluctuated over the past decade. While the national rate has declined since 2014, there has been a slight upward trend over the past decade (average annual rate 1.67% since 2016).

Perinatal and Neonatal outcomes

Total perinatal death rates have fallen by approximately 11% since 2014, while the rate of perinatal death among infants weighing 2.5kg without a congenital anomaly has fallen by approximately 17%. These trends indicate overall improvements in perinatal survival, even despite the rising intervention rates.

The rate of NE appears to have increased by 18% since 2015, when data collection on the IMIS commenced. The rate of TH has largely remained stable. These trends may indicate changing risk patterns.

4 Funnel plots

In IMIS 2025, outliers beyond the 95% control limits occurred mainly in parity distribution, selected rare obstetric events/risks, birth intervention rates (e.g., Caesarean sections, Inductions of labour, Assisted vaginal deliveries), Postpartum haemorrhage (PPH), obstetric blood transfusions, and maternal critical care.

Maternal morbidity/Obstetric risks:

- Ectopic pregnancies requiring blood transfusion: Several outlying small units, but numbers are very small
- Eclampsia: While no visual outliers, several units show rates above the national average; funnel plot variability may be driven by very small numbers
- Uterine ruptures: Two outlying small units, very small numbers
- Peripartum hysterectomy: One large tertiary hospital outlier
- Pulmonary embolism: One outlier, small numbers
- Maternal sepsis: One outlying tertiary hospital with very low rate
- Maternal critical care (Level 2/Level 3): The general picture is large hospitals outlying above the 95% confidence level and smaller units below, reflecting the level of complexity managed at large tertiary hospitals
- Postpartum haemorrhage (PPH): Two small units outlying with high rates of PPH among vaginal deliveries; six small units have high rates of PPH among CS. The largest tertiary hospital and the smallest unit are high outliers on both PPH metrics
- Obstetric blood transfusions: Two outlying units with high rates. Three outlying units with low rates
- Severe perineal tears: Four outlying units with high rates: two of these have corresponding high rates of vaginal deliveries and high rates of episiotomy, while the two smaller units have low rates of vaginal deliveries and relatively low rates of episiotomy

- Multiple deliveries: There are policy agreements between the outlying hospitals with high rates and units with low outlying rates (i.e., GUH and PUH; CUMH and TippUH)
- Parity, Nulliparas: The three large tertiary maternity hospitals in Dublin have very high rates of nulliparas, with important implications for hospital planning and resources

Neonatal outcomes:

- Total perinatal deaths: One tertiary hospital with high rate
- TH: One outlying unit (this unit has been working closely with the NWIHP during 2026 to review all TH cases and procedures)
- Brachial plexus injury: Two high outliers (one large tertiary hospital and one small unit)
- Neonatal sepsis: Two outliers (one large tertiary hospital and one mid-sized unit). Note, one tertiary hospital does not fulfil the requirement of returning dat aon this metric

Deliveries and intrapartum care:

- Assisted vaginal deliveries: Two small units and one large hospital have outlying high rates. Five small/mid-sized units and one tertiary hospital with outlying low rates
- Inductions of labour: Two large tertiary hospitals and two mid-sized units with outlying high rates (these hospitals have correspondingly low CS rates). Range 15.4% nationally
- Caesarean sections: One large hospital, two mid-sized units, and three small units with outlying high rates. Range 18% nationally
- CS at full dilatation: Three outlying units (two of which also have high rates of PPH among CS)
- VBAC: Low outliers include one tertiary hospital and two small units (these also have high CS rates). Three small units with high rates

It is important to note that many of these statistical outliers arise from small numbers and rare events and, furthermore, note that no risk adjustment is applied to the funnel plots. Outliers are signals for conducting local reviews, they are not performance judgements.

5 Conclusion

The IMIS 2025 National Report describes a maternity network that is smaller in terms of birth numbers than it was slightly over a decade previously. However, it is a system that is more intervention-intensive, as depicted by rising CS and IOL rates. It is generally 'safe', as evidenced by improving mortality rates. However, there are morbidity metrics that warrant attention, particularly for first-time mothers/nulliparas.

Key System-level trends include:

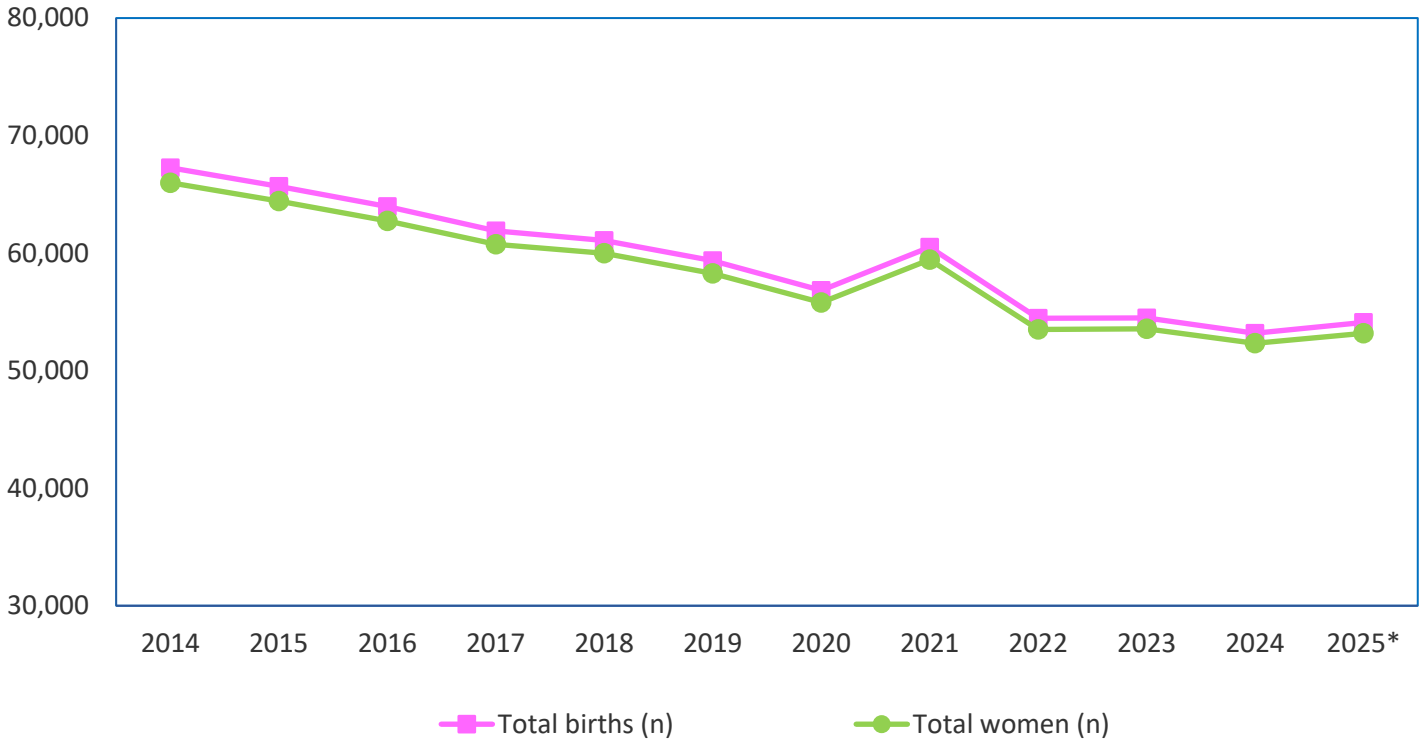
- Fewer births/fewer women delivering, more nulliparas
- Higher rates of Induction of labour and CS deliveries
- A declining rate of Assisted vaginal deliveries
- Generally stable or improving safety indicators, but at higher intervention intensity
- Large inter-hospital/unit variation persists on many metrics
- Funnel plots highlight outliers, but lack of risk-adjustment limits direct performance comparisons across hospitals/units

The IMIS is a strong quality-improvement and surveillance tool for maternity hospital/unit and system management. It is not intended as and should not be used as a league table.

National Women and Infants Health Programme
Kilian McGrane, National Programme Director
Dr Cliona Murphy, National Clinical Director
Dr Léan E McMahon, IMIS Data Manager

May 2026

1. National longitudinal trends 2014-25: Total births and Total women delivered

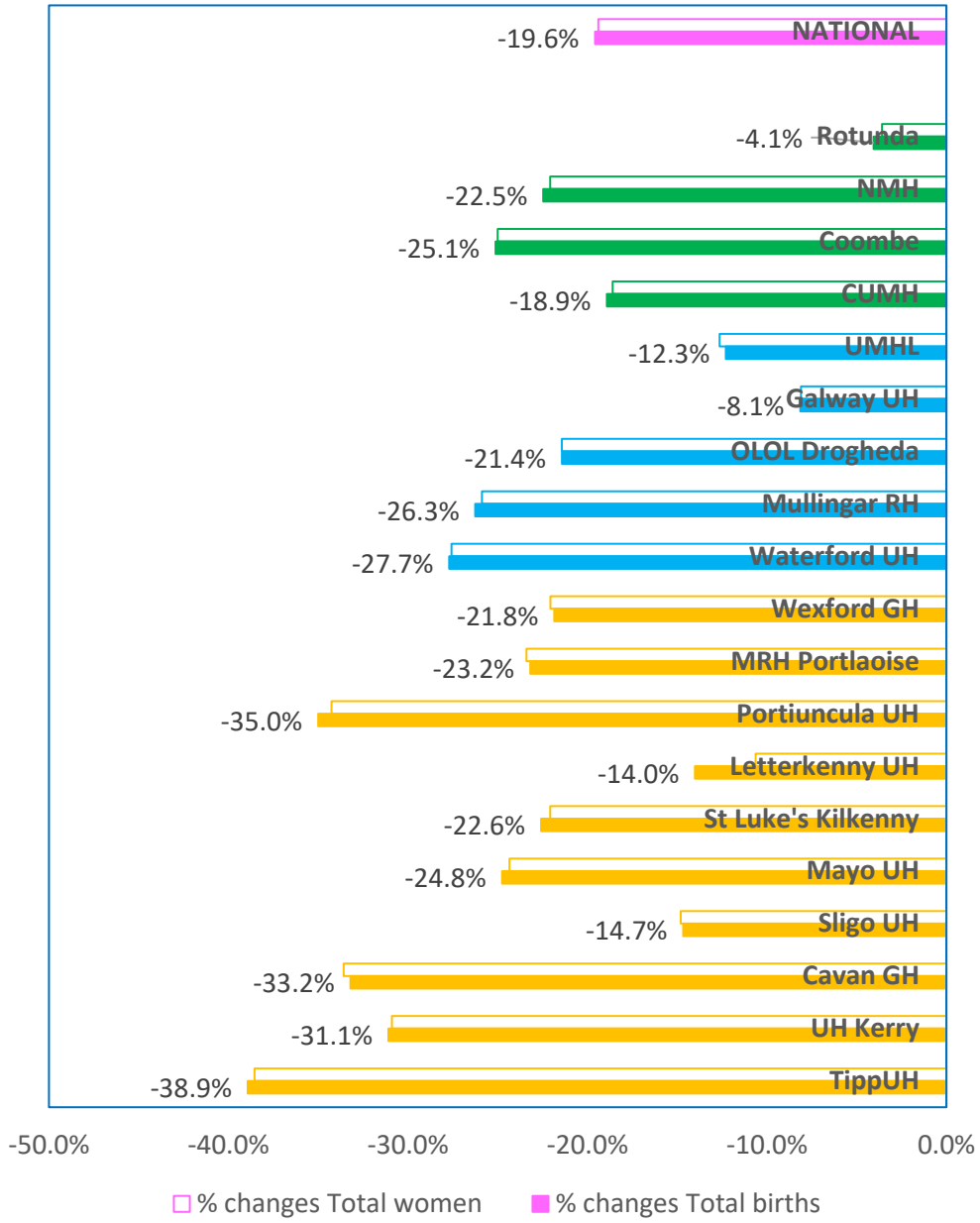


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025*	Annual rate of change over 12 years	Total change
Total births (n)	67263	65680	63964	61902	61084	59352	56833	60492	54456	54488	53185	54097	-1.80%	-19.6%
Total women (n)	65987	64435	62736	60744	59981	58272	55799	59443	53495	53558	52328	53191	-1.78%	-19.4%

Source: IMIS 2014-25. Definitions (2014-24): Total women giving birth/Total births weighing ≥500g, including live birth and stillbirths.

*2025: Total women giving birth/Total births weighing ≥400g and/or with a gestational age of ≥23 weeks. (Total births excluding TOP in 2025, n=54,046)

Changes in numbers of Total women delivered/Total births, 2014 to 2025



Over the past 12 years, since 2014, there has been a decline nationally in the numbers of Total births/Total women delivering of over 19%.

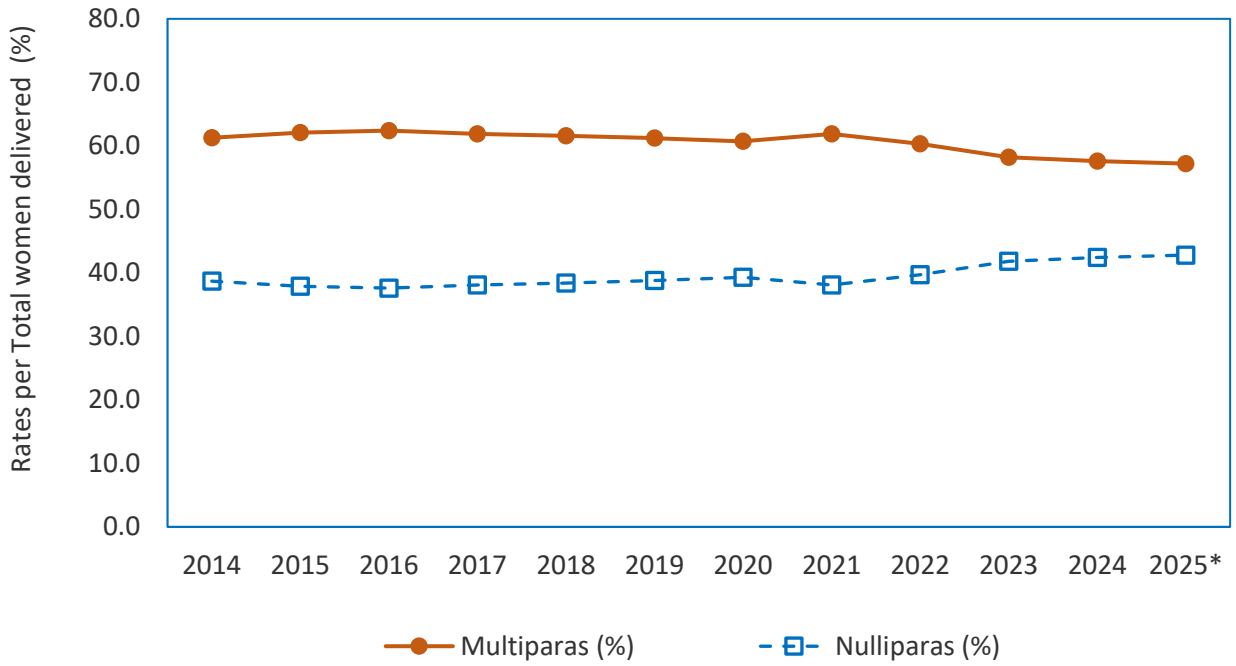
The decline has been observed across all 19 maternity hospitals/units, irrespective of size.

On average, the four large tertiary hospitals have had a drop of -17.6% since 2014. The decline has been unevenly distributed across the four hospitals, with falling numbers varying from -4% (Rotunda) to -25% (Coombe).

The five 'mid-sized' hospitals (i.e., from around 2,000 to over 4,000 births per annum) have seen an average drop of -19.2%.

Smaller units, with total births below 2,000 per annum, have on average dropped by over a quarter since 2014 (-25.9%).

2. National longitudinal trends 2014-25: Total Multiparas and Nulliparas

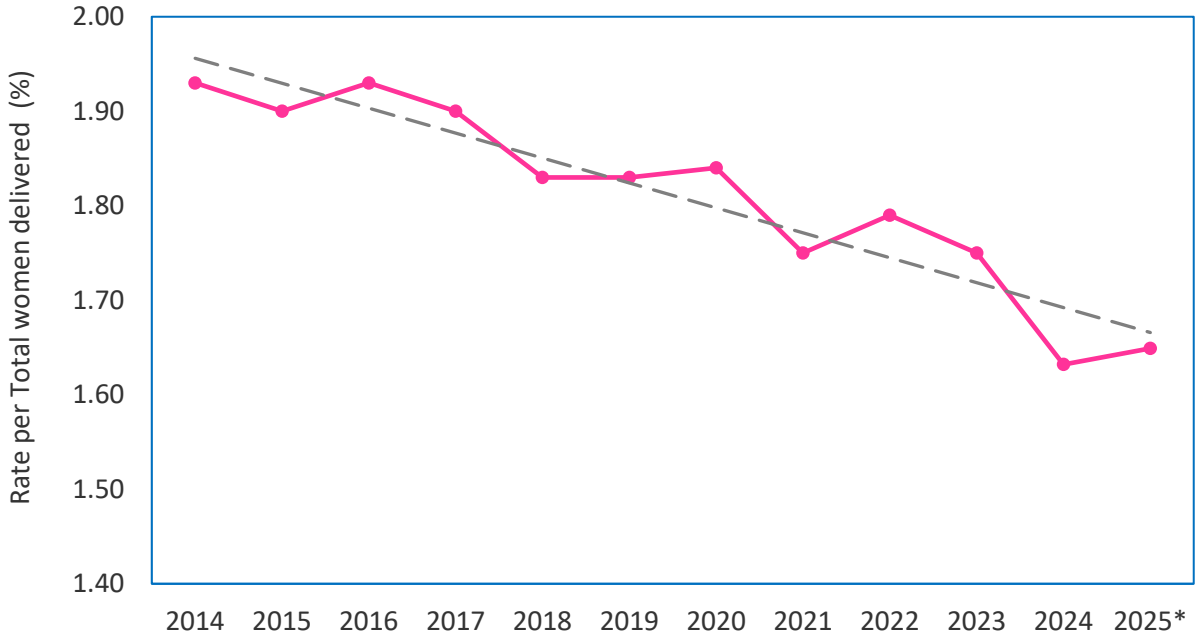


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025*	Average annual rate	Total change
Multiparas *(%)*	61.3%	62.1%	62.4%	61.9%	61.6%	61.2%	60.7%	61.9%	60.3%	58.2%	57.6%	57.2%	-0.58%	-6.7%
Nulliparas *(%)*	38.7%	37.9%	37.6%	38.1%	38.4%	38.8%	39.3%	38.1%	39.7%	41.8%	42.4%	42.8%	+0.84%	+10.6%

Source: IMIS 2014-2025. Definitions: Nulliparas: Women who have never had a previous pregnancy resulting in a live birth or stillbirth. Multiparas: Women who have had at least one previous pregnancy resulting in a live birth or stillbirth.

*2025: Total women giving birth/Total births weighing ≥400g and/or with a gestational age of ≥23 weeks

3. National longitudinal trends 2014-25: Total Multiple deliveries

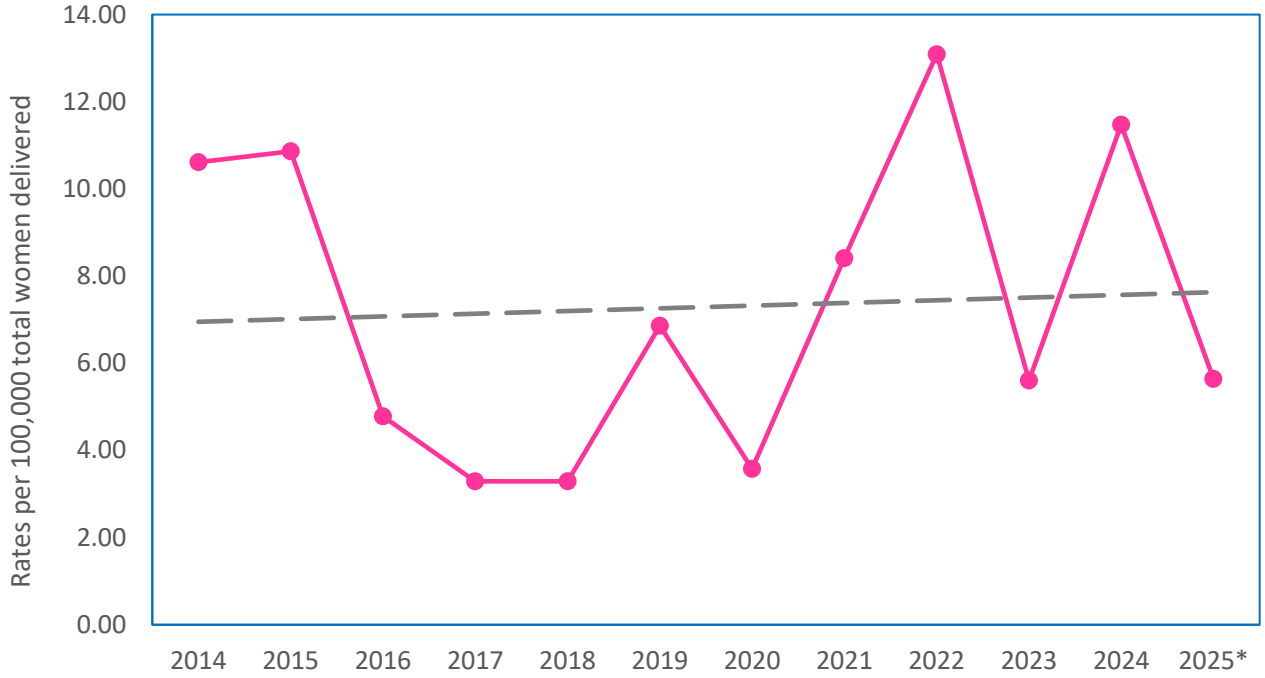


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025*	Average annual rate	Total change
Multiple deliveries *(%)*	1.93%	1.90%	1.93%	1.90%	1.83%	1.83%	1.84%	1.75%	1.79%	1.75%	1.63%	1.65%	-1.30%	-14.5%

Source: IMIS 2014-2025. Definition: Women with multiple births (not the number of babies delivered) occurring during the current month.

*2025: Total women giving birth/Total births weighing ≥400g and/or with a gestational age of ≥23 weeks. Where one of the babies is a 'stillborn child', include where birthweight is ≥200g.

4. National longitudinal trends, 2014-25: Maternal deaths



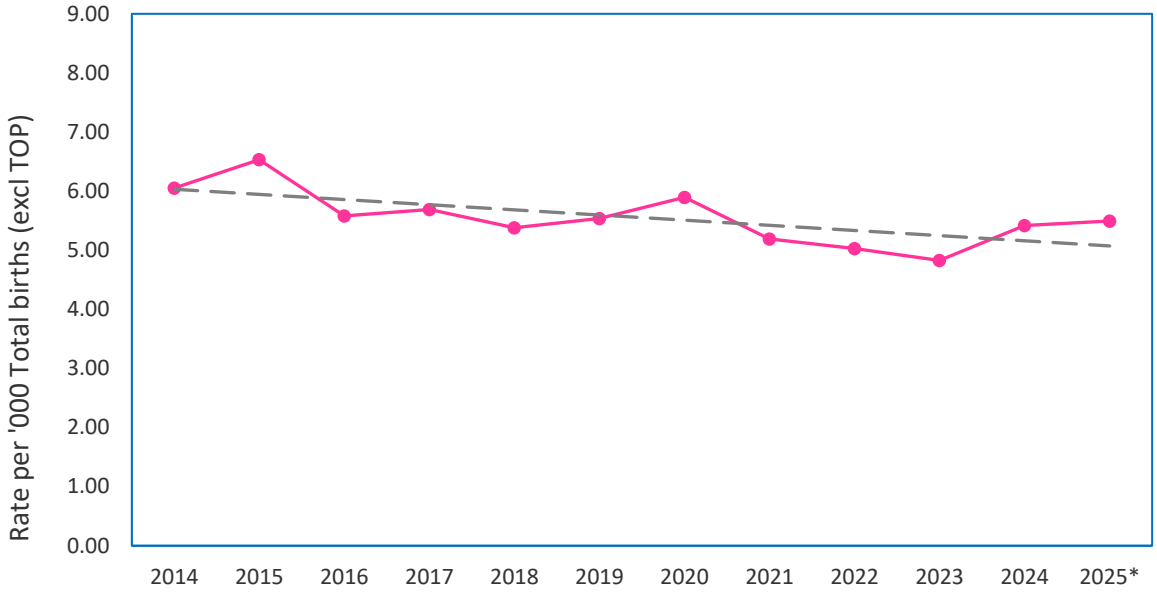
Note:

Maternal death rates have fluctuated over the past decade. There has been a slight upward trend over the past decade (average annual rate 1.67% since 2016), but the numbers are extremely small for statistical calculations.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025*
Maternal deaths *N*	7	7	3	2	2	4	2	5	7	3	6	3
Rate per 100,000 total women delivered	10.61	10.86	4.78	3.29	3.29	6.86	3.58	8.41	13.09	5.6	11.47	5.64

Source: IMIS 2014-2025. Definition: Total number of deaths of women while pregnant or within 42 days of the end of the pregnancy (includes giving birth, ectopic pregnancy, miscarriage, or termination of pregnancy), from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (based on WHO 2010 definition and Confidential Maternal Death Enquiry 2016: 10). For the purposes of the IMIS, count both direct and indirect maternal deaths. Exclude late maternal deaths and 'coincidental' maternal deaths.

5. National longitudinal trends 2014-25: (Total) Perinatal Deaths



Note:

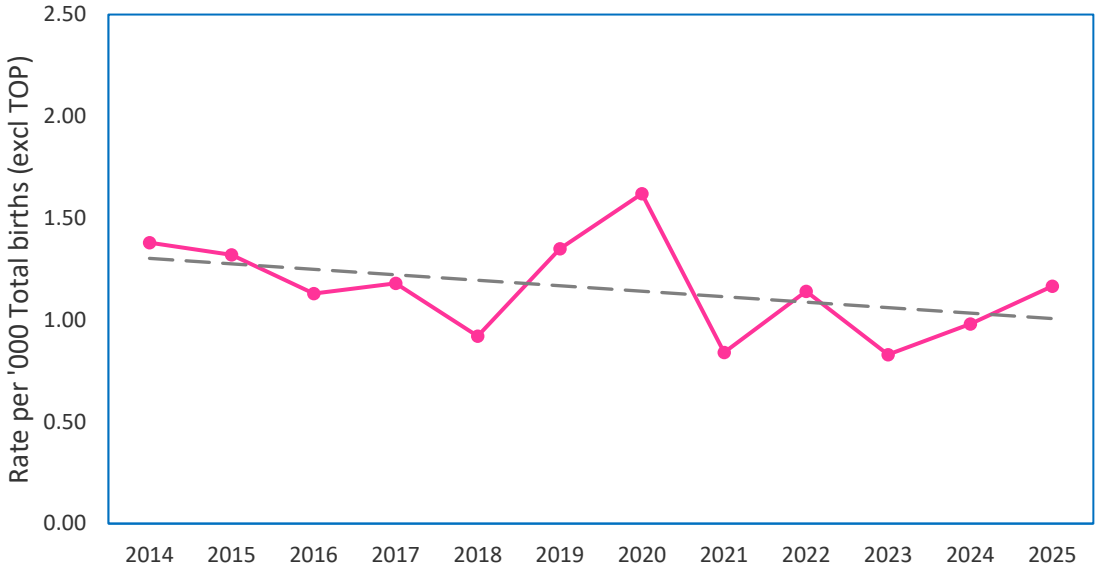
The rate of total perinatal deaths has declined since 2014 by -9.4%. Despite year-on-year fluctuations, the average annual rate of decline has been -0.82%.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025*	Average annual rate	Total change
(Total) Perinatal Deaths *('000)*	6.05	6.53	5.58	5.69	5.38	5.64	5.89	5.19	5.03	4.83	5.42	5.48	-0.82%	-9.42%

Source: IMIS 2014-2025. Definition: Number of deaths, including stillbirths and early neonatal deaths from delivery to six completed days. This metric is not adjusted to exclude congenital anomalies.

*2025: Total women giving birth/Total births weighing ≥400g and/or with a gestational age of ≥23 weeks. Where one of the babies is a 'stillborn child', include where birthweight is ≥200g. The national rate in 2025 is calculated per total births excluding Terminations of pregnancy (TOP).

6. National longitudinal trends 2014-25: (Adjusted) Perinatal Deaths



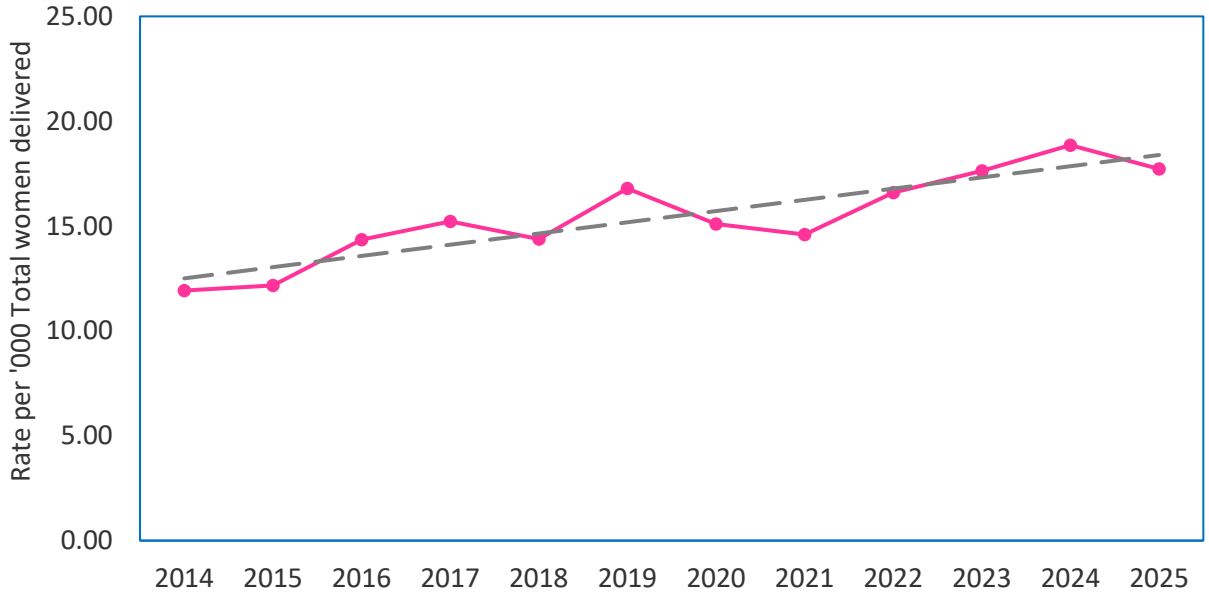
Note:

The rate of perinatal deaths among infants weighing 2.5kg or more without a congenital anomaly has declined since 2014, on average by an annual drop of -1.37%.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
(Adjusted) Perinatal Deaths *(per '000)*	1.38	1.32	1.13	1.18	0.92	1.35	1.62	0.84	1.14	0.83	0.98	1.17	-1.37%	-15.22%

Source: IMIS 2014-2025. Rates calculated per '000 Total births (in 2025, rates calculated per '000 Total births excluding Termination of pregnancy (TOP)). Definition: Number of perinatal deaths (stillbirths and early neonatal deaths) weighing 2.5kg or more without physiological or structural abnormalities that develop at or before birth and are present at the time of birth.

7. National longitudinal trends 2014-25: Ectopic pregnancy



Note:

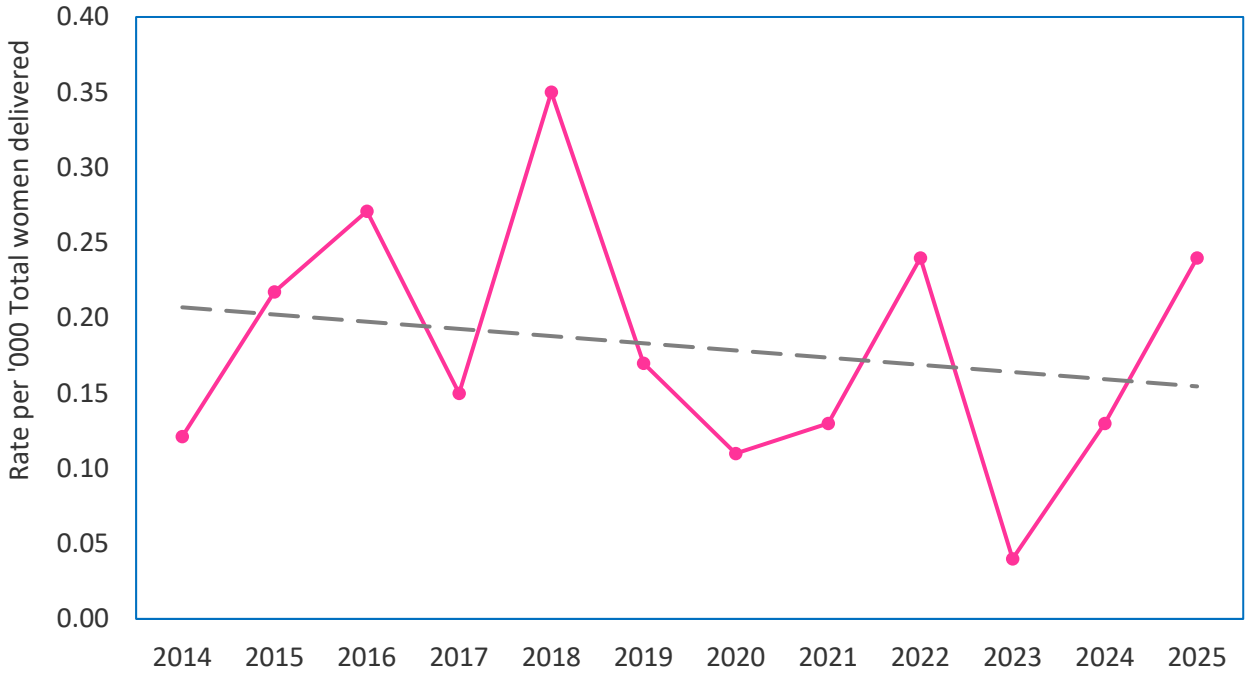
There is a rising trend in rates of ectopic pregnancy over the past 12 years. Similar trends are observed in other European countries. Women of reproductive ages should be educated about the risk factors and warning symptoms of ectopic pregnancy (Gogoi et al 2024). Epidemiological study on ectopic pregnancy in a tertiary care centre | European Journal of Cardiovascular Medicine

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Ectopic pregnancy *('000)*	11.9	12.2	14.3	15.2	14.4	16.8	15.1	14.6	16.6	17.6	18.9	17.7	+3.22%	+46.2%

Source: IMIS 2014-2025

Definition: Number of women diagnosed during the current month with an ectopic pregnancy, including abdominal pregnancy, tubal pregnancy, ovarian pregnancy, and other/unspecified pregnancy.

8. National longitudinal trends 2014-25: Eclampsia



Note:

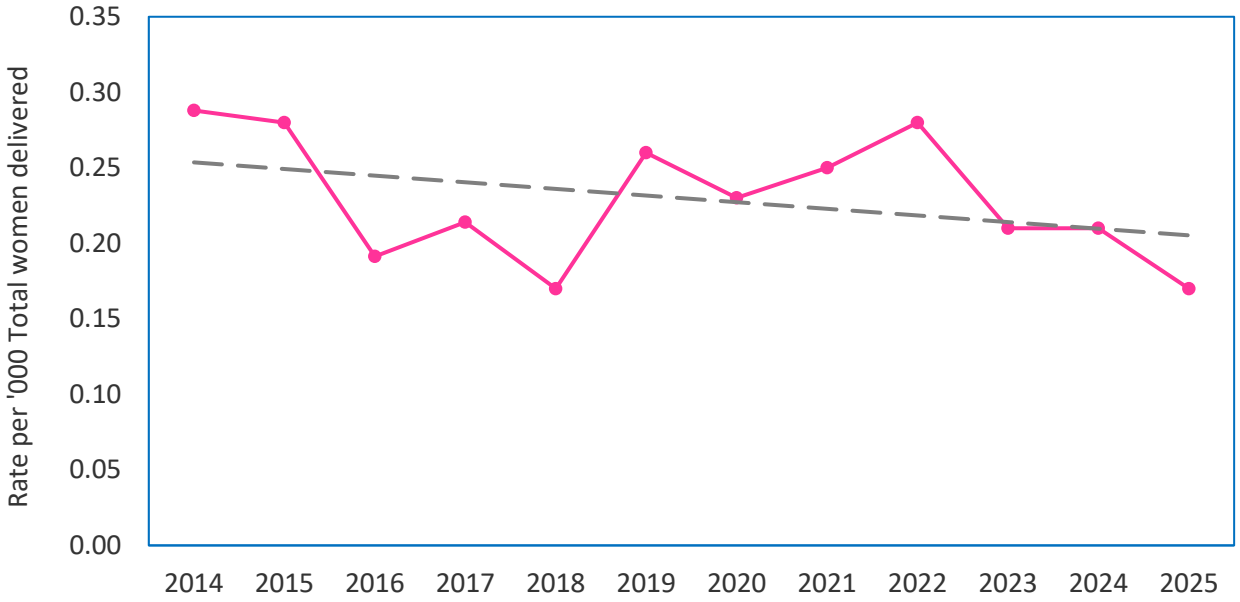
The declining incidence of eclampsia may be attributed to enhanced management, supported by ongoing audits and confidential enquiries.

The observed rise in the past two years is very concerning and suggests greater attention is required around clinical characteristics of eclampsia, including diagnosis of preeclampsia and premonitory symptoms such as headache, epigastric pain, nausea/vomiting and blood pressure.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Eclampsia *('000)*	0.12	0.22	0.27	0.15	0.35	0.17	0.11	0.13	0.24	0.04	0.13	0.24	+5.94%	+100.0%

Source: IMIS 2014-2025. Definition: Number of women with eclampsia during any antenatal hospital event or at delivery, including eclampsia in pregnancy, in labour, in the puerperium, and eclampsia unspecified as to time period. Exclude severe pre-eclampsia. Seizure associated with antepartum, intrapartum or postpartum symptoms and signs of pre-eclampsia.

9. National longitudinal trends 2014-25: Uterine rupture



Note:

The risk of Uterine rupture may be associated with prior CS, previous uterine surgery, high parity, multiple gestation, and prolonged labour.

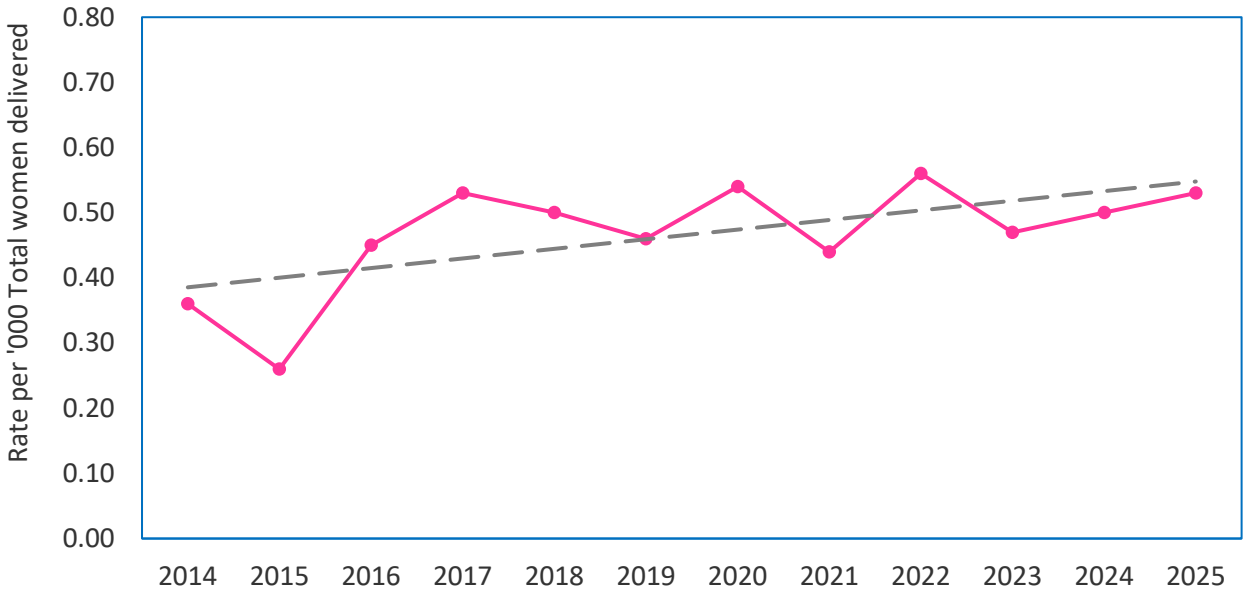
This metric should be assessed in conjunction with VBAC and Peripartum hysterectomy.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Uterine rupture *('000)*	0.29	0.28	0.19	0.21	0.17	0.26	0.23	0.25	0.28	0.21	0.21	0.17	-4.35%	-41.4%

Source: IMIS 2014-2025

Definition: Number of women with rupture of uterus before onset of labour or during labour, including cases that may not be diagnosed until after delivery. Rupture implies complete separation of the wall of the pregnant uterus, with or without expulsion of the fetus, involving rupture of membranes at the site of the uterine rupture or extension into uterine muscle separate from any previous scar, and endangering the life of the mother or fetus. Exclude any asymptomatic palpable or visualised defect (e.g., dehiscence noted incidentally at Caesarean section delivery.

10. National longitudinal trends 2014-25: Peripartum hysterectomy



Note:

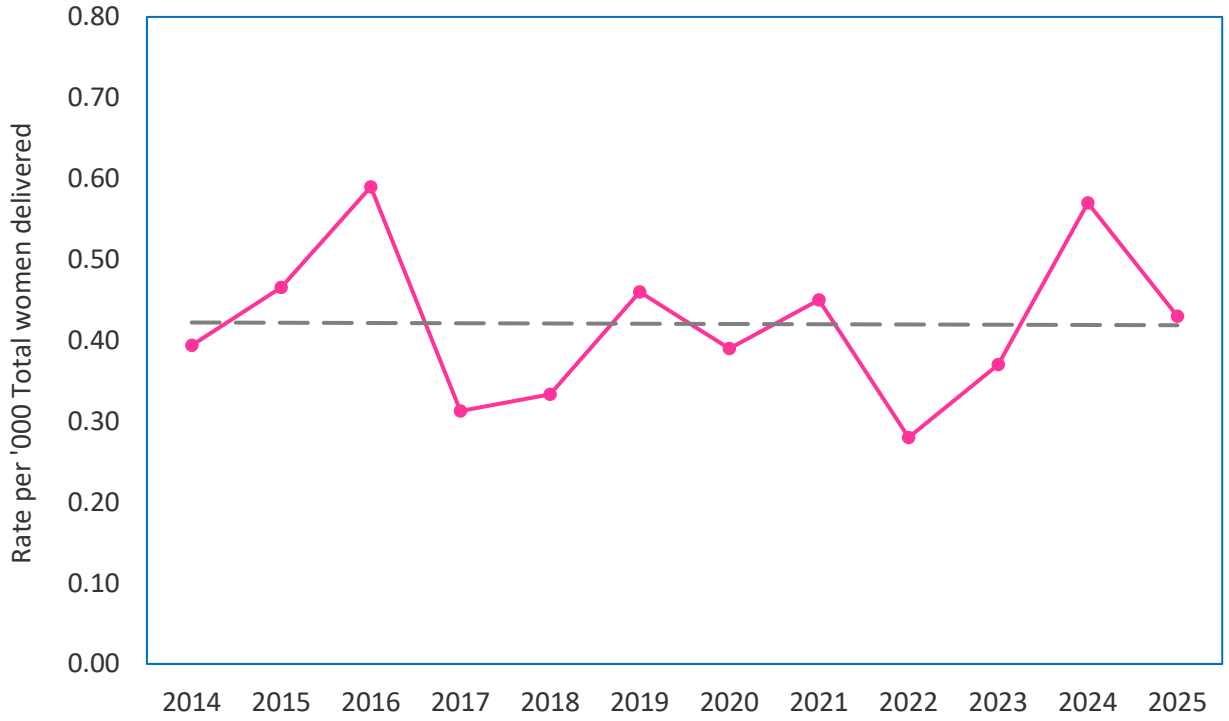
The increasing incidence of Peripartum hysterectomy is linked to the rising rate of Caesarean section. The relationship is driven by the need to address life-threatening conditions such as placenta accrete spectrum, which is a leading cause of Caesarean hysterectomy (McKeown et al 2024, IMJ.) Peripartum-hysterectomy.pdf

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Peripartum hysterectomy *('000)*	0.36	0.26	0.45	0.53	0.50	0.46	0.54	0.44	0.56	0.47	0.50	0.53	+3.28%	+47.2%

Source: IMIS 2014-2025

Definition: Total number of hysterectomy procedures performed during pregnancy and/or within seven completed days after delivery.

11. National longitudinal trends 2014-25: Pulmonary embolism



Note:

Where there are fluctuations in the rates of PE over the past 12 years, the overall trend is relatively stable.

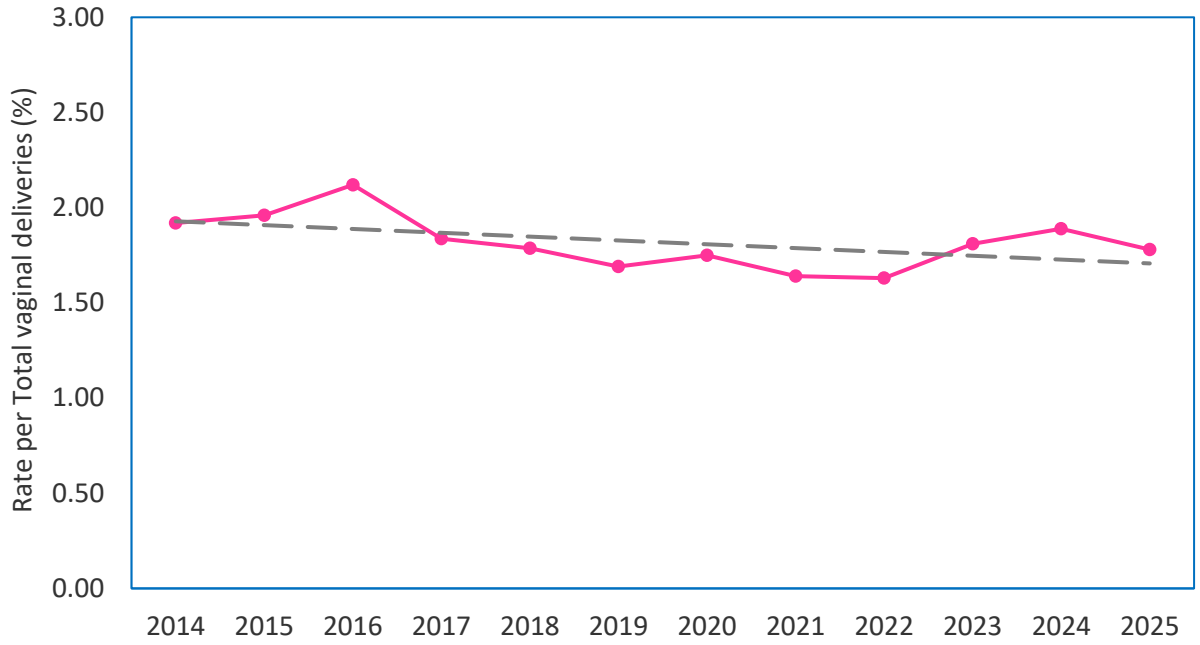
A new National Guideline is scheduled for publication later this year. Guidelines around PE take into consideration the challenges in diagnosing PE (as early signs and symptoms may overlap with physiological changes of pregnancy) and emphasise the importance of long-term management to optimise patient outcomes.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Pulmonary embolism *('000)*	0.39	0.47	0.59	0.31	0.33	0.46	0.39	0.45	0.28	0.37	0.57	0.43	+0.82%	+10.26%

Source: IMIS 2014-2024

Definition: Number of women with obstetric pulmonary embolism, including pulmonary emboli in pregnancy and/or the puerperium. Exclude embolism complicating abortion or ectopic or molar pregnancy.

12. National longitudinal trends 2014-25: Perineal tears, third- and fourth-degree



Note:

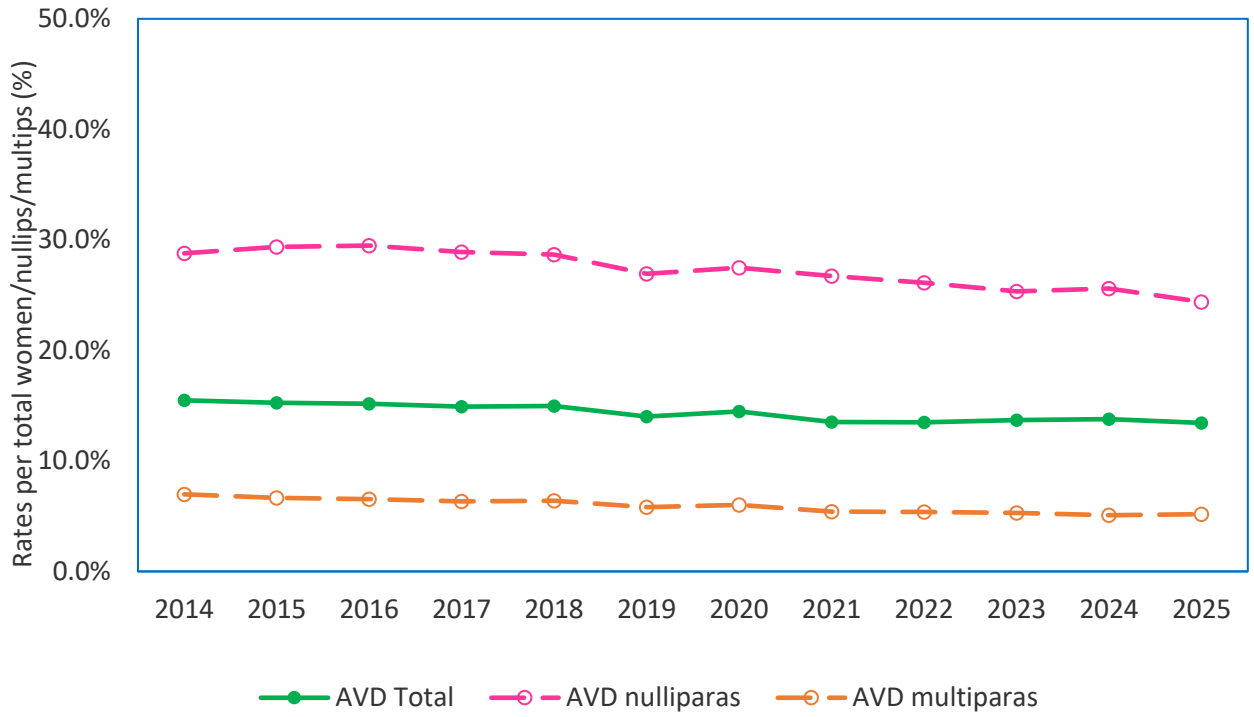
The declining trend in severe third and/or fourth degree perineal tears may be associated with lower rates of spontaneous vaginal deliveries, higher rates of CS, relatively low rates of VBAC.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Perineal tears (%) (Rate per Total vaginal deliveries)	1.92%	1.96%	2.12%	1.84%	1.79%	1.69%	1.75%	1.64%	1.63%	1.81%	1.89%	1.78%	-0.63%	-7.3%

Source: IMIS 2014-2024

Definition: Number of third-degree and/or fourth-degree perineal lacerations diagnosed during the current month, including tears in the vaginal tissue, perineal skin, and perineal muscles that extend into the anal sphincter and/or go through the anal sphincter and the tissue underneath it.

13. National longitudinal trends 2014-25: Assisted vaginal deliveries (AVD)



Note:

The trend for falling AVD rates in Ireland, as well as other western countries globally, is of concern. There is a decline in the use of obstetric forceps and an increase in Caesarean section rates. These changes raise questions about skillsets for AVD procedures and preference for CS deliveries.

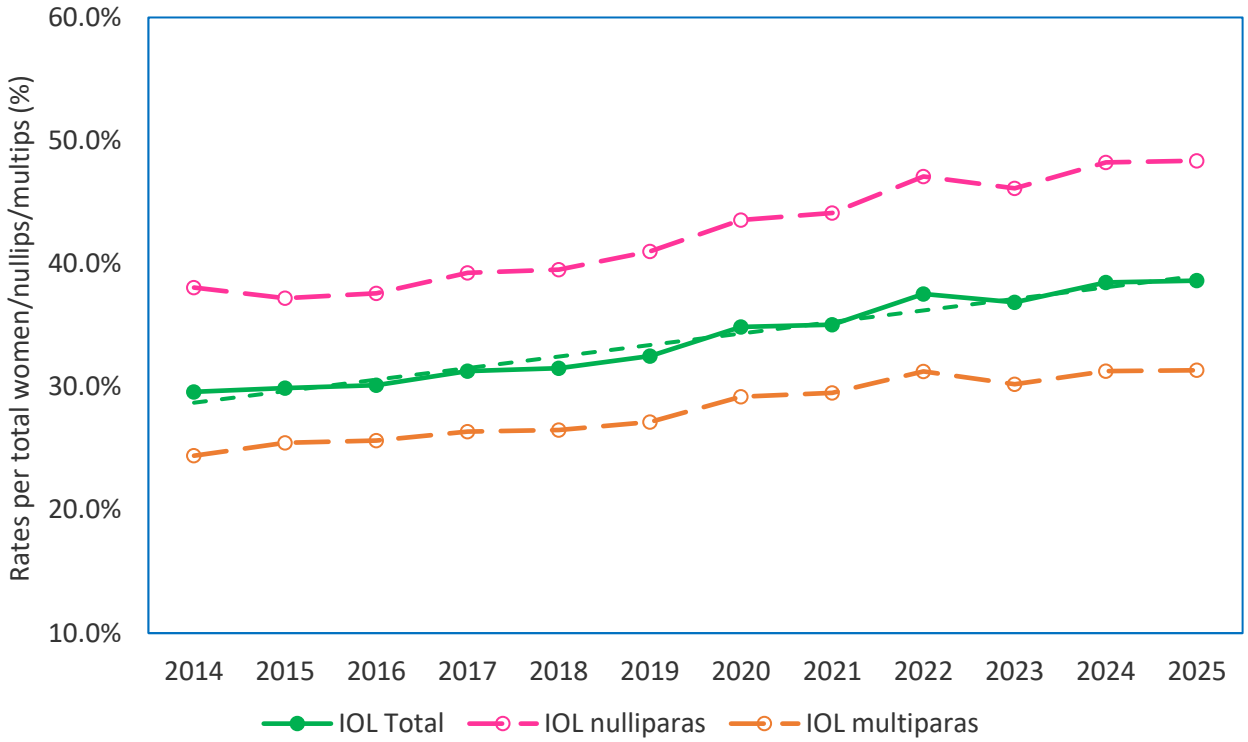
These trends may herald a need for renewed staff training and education around assisted deliveries and use of forceps.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
AVD Total *(%)*	15.5%	15.3%	15.2%	14.9%	15.0%	14.0%	14.5%	13.5%	13.5%	13.7%	13.8%	13.4%	-1.21%	-13.6%
AVD nulliparas *(%)*	28.8%	29.4%	29.5%	28.9%	28.7%	26.9%	27.5%	26.7%	26.1%	25.3%	25.6%	24.4%	-1.37%	-15.3%
AVD multiparas *(%)*	7.0%	6.7%	6.5%	6.3%	6.4%	5.8%	6.0%	5.4%	5.4%	5.3%	5.1%	5.2%	-2.45%	-25.7%

Source: IMIS 2014-2025

Definition: Number of women undergoing Assisted vaginal delivery (AVD), also known as instrumental or operative delivery.

14. National longitudinal trends 2014-25: Induction of labour (IOL)



Note:

The rising trend in Induction of labour may be explained by changes in women's medical conditions, such as gestational diabetes, hypertensive disorders, and prolonged pregnancies, as well as policy changes and cultural expectations.

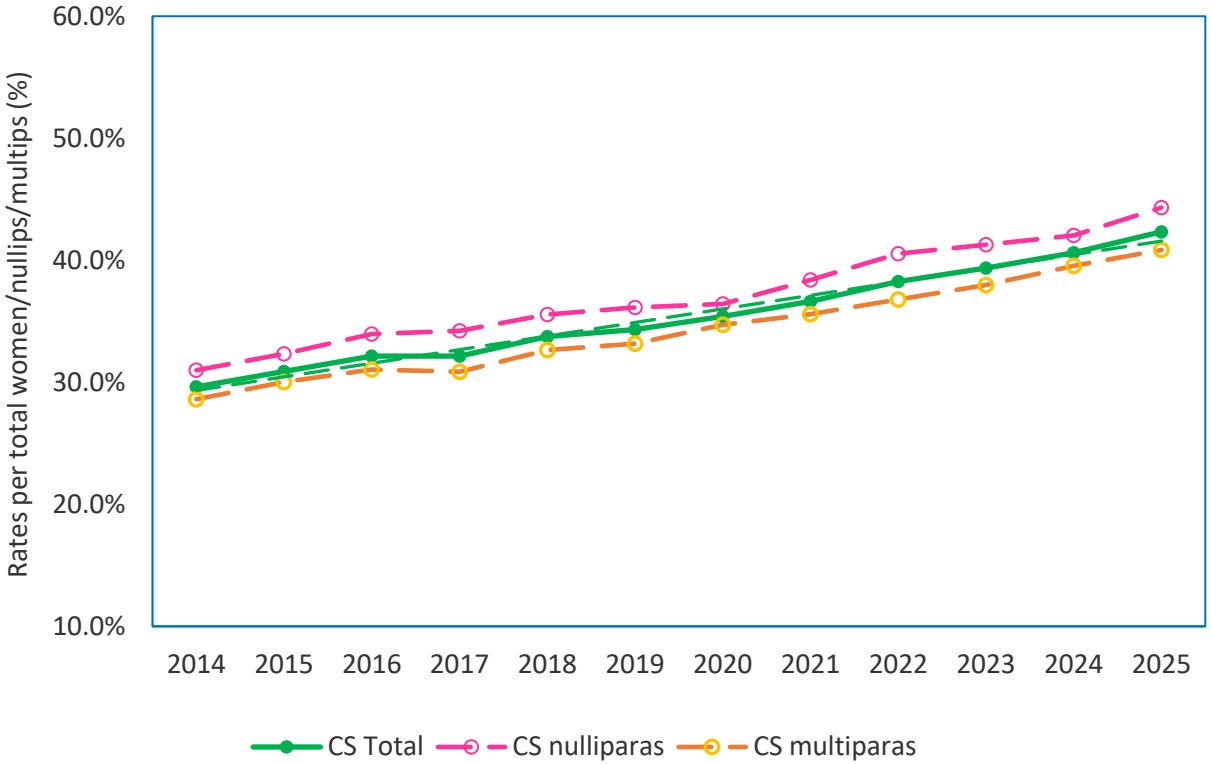
The rising trend, particularly among nulliparous women, may have unintended consequences for maternity services, including increased care challenges for women and increased workloads for staff.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
IOL Total *(%)*	29.6%	29.9%	30.1%	31.3%	31.5%	32.5%	34.9%	35.1%	37.5%	36.9%	38.5%	38.6%	+2.24%	+30.4%
IOL nulliparas *(%)*	38.1%	37.2%	37.6%	39.3%	39.5%	41.0%	43.5%	44.1%	47.1%	46.1%	48.2%	48.4%	+2.01%	+27.1%
IOL multiparas *(%)*	24.4%	25.5%	25.6%	26.4%	26.5%	27.1%	29.2%	29.5%	31.3%	30.2%	31.3%	31.4%	+2.12%	+28.7%

Source: IMIS 2014-2025

Definition: Number of women undergoing induction of labour, including medical induction (oxytocin/prostaglandin/other) and/or surgical induction (AROM/other).

15. National longitudinal trends 2014-25: Caesarean sections (CS)



Note:

The rising trend in Caesarean sections in Ireland reflects global trends in rising CS rates. The rise is attributed to various factors, such as later maternal age, increasing use of reproductive technologies, smaller family sizes, and the need for timely access to care.

There is variation in CS rates across different countries: Ireland rates among the countries with higher prevalence, at over 40%. C-section rates by country OECD| Statista

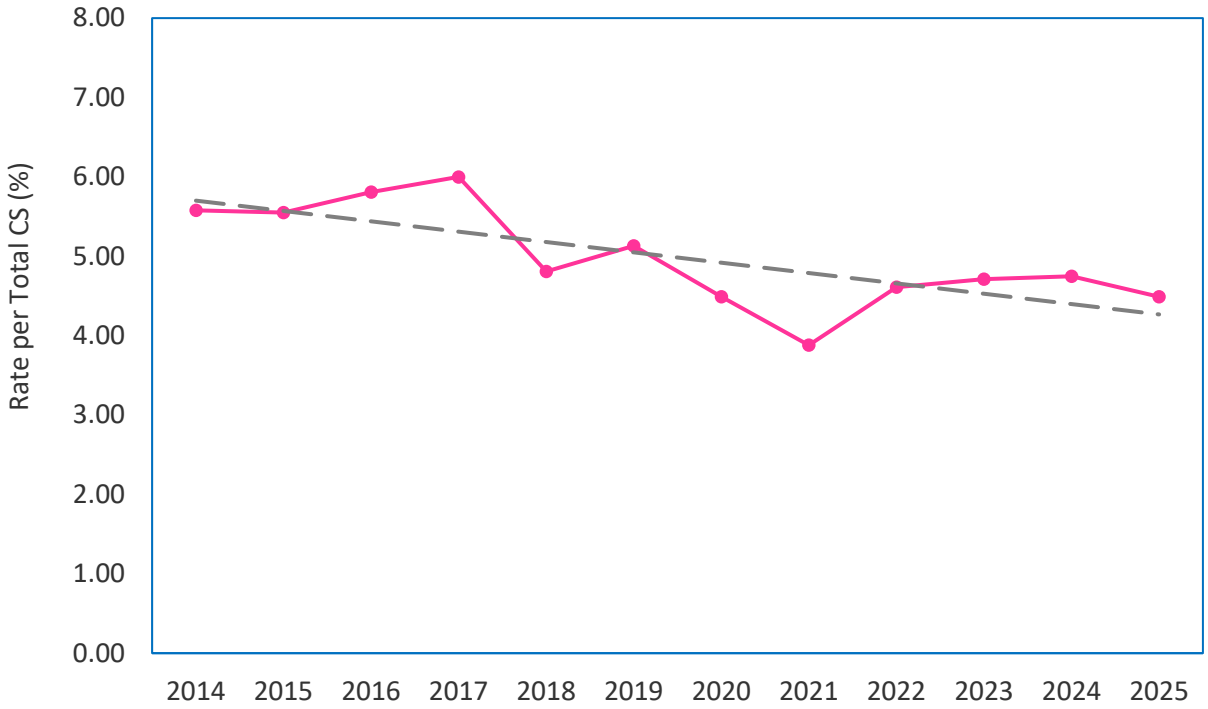
There is variability in CS rates across the 19 maternity hospitals/units in Ireland.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
CS Total *(%)*	29.6%	30.9%	32.1%	32.1%	33.8%	34.3%	35.4%	36.6%	38.3%	39.4%	40.6%	42.3%	+3.02%	+42.9%
CS nulliparas *(%)*	31.0%	32.3%	34.0%	34.2%	35.6%	36.1%	36.4%	38.4%	40.5%	41.3%	42.1%	44.3%	+3.02%	+42.9%
CS multiparas *(%)*	28.6%	30.0%	31.0%	30.9%	32.6%	33.2%	34.7%	35.6%	36.8%	38.0%	39.6%	40.9%	+3.03%	+43.0%

Source: IMIS 2014-2025

Definition: Number of women giving birth by Caesarean section, including elective and/or emergency Caesarean sections.

16. National longitudinal trends 2014-25: General anaesthetic for Caesarean sections



Note:

Usually reserved for CS when rapid unconscious is required or regional anaesthesia is not suitable, the rate of GA for CS has fallen over the past 12 years.

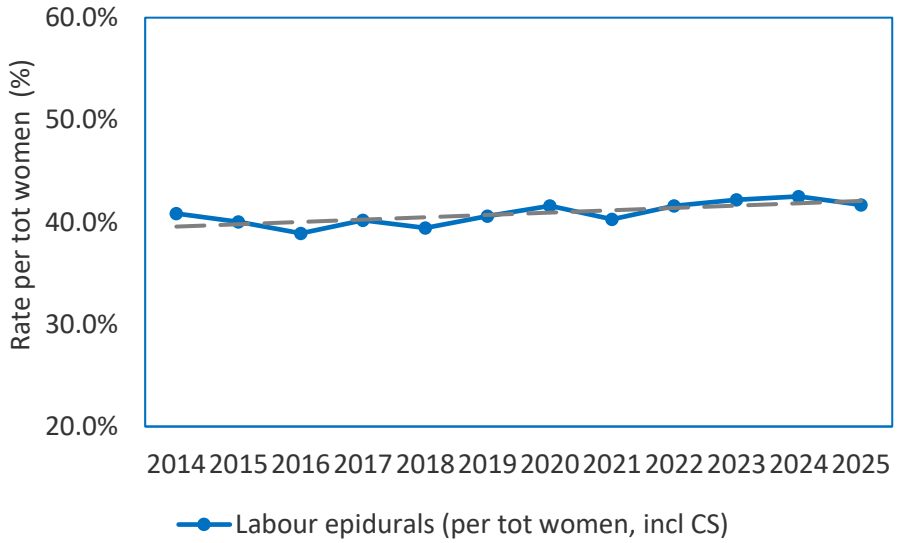
It carries specific risks in pregnant women, including airway complications and maternal hypotension. It also carries neonatal risks.

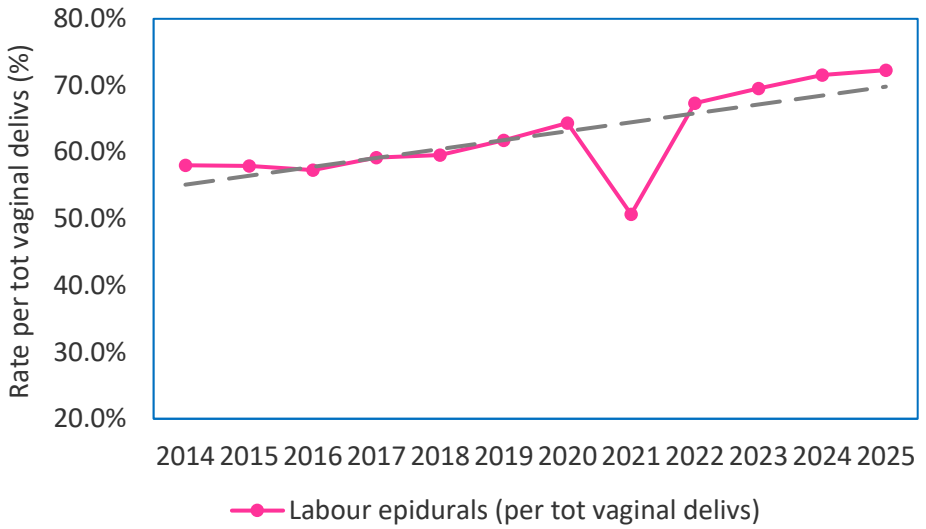
	2014	2015	2016	2017	2018	2019	2020	2021*	2022	2023	2024	2025	Average annual rate	Total change
GA for CS *(% Total CS)*	5.58%	5.55%	5.81%	6.00%	4.81%	5.13%	4.49%	3.88%	4.61%	4.71%	4.75%	4.49%	-1.79%	-19.5%

*Source: IMIS 2014-2025. *Missing data in 2021.*

Definition: Number of women who underwent a CS and were administered a general anaesthetic (GA), including primary GA and conversion to GA from regional anaesthetic (epidural or spinal).

17. National longitudinal trends 2014-25: Labour epidurals



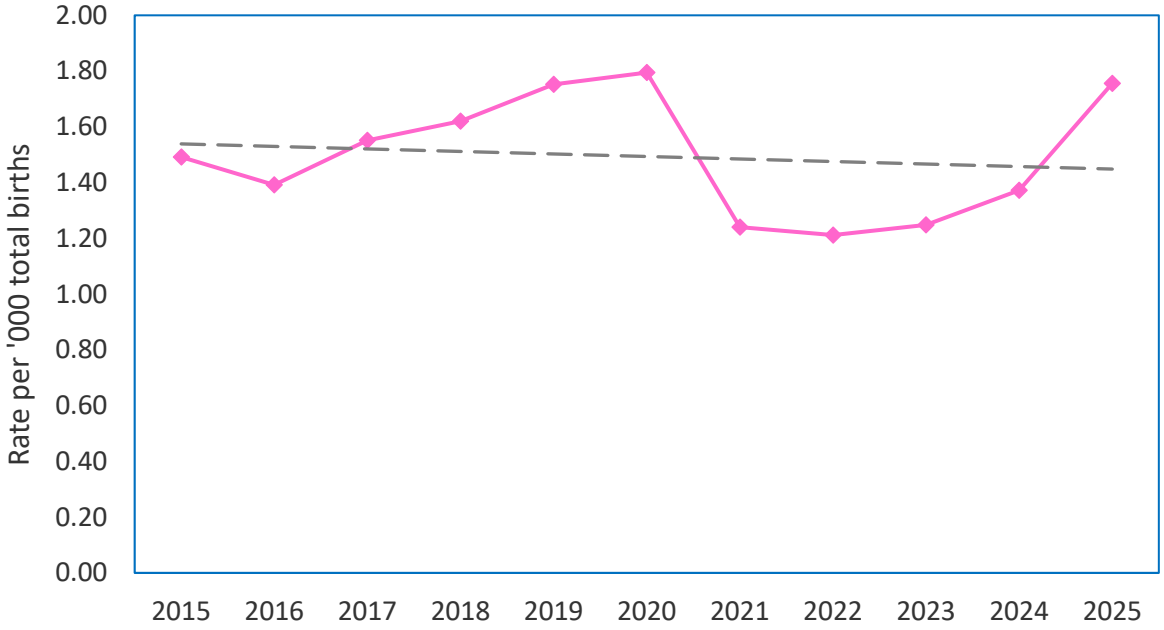


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
Labour epidurals *(% total women)*	40.8%	40.0%	38.9%	40.2%	39.4%	40.6%	41.6%	40.3%	41.6%	42.2%	42.5%	41.7%	+0.18%	+2.21%
Labour epidurals *(% vaginal deliveries)*	58.1%	57.9%	57.3%	59.2%	59.5%	61.8%	64.4%	50.7%	67.4%	69.6%	71.6%	72.3%	+1.84%	+24.4%

Source: IMIS 2014-2025. (Missing data in 2021)

Definition: Number of women for whom labour epidurals were administered, incl Neuraxial block during labour and Neuraxial block during labour and delivery procedure. Does not refer to spinal anaesthesia. May include women with emergency CS.

18. National longitudinal trends 2015-24: Neonatal encephalopathy (NE)



Note:

The fall in rates of NE in Ireland reflects a decline in incidence globally and good progress made in reducing NE.

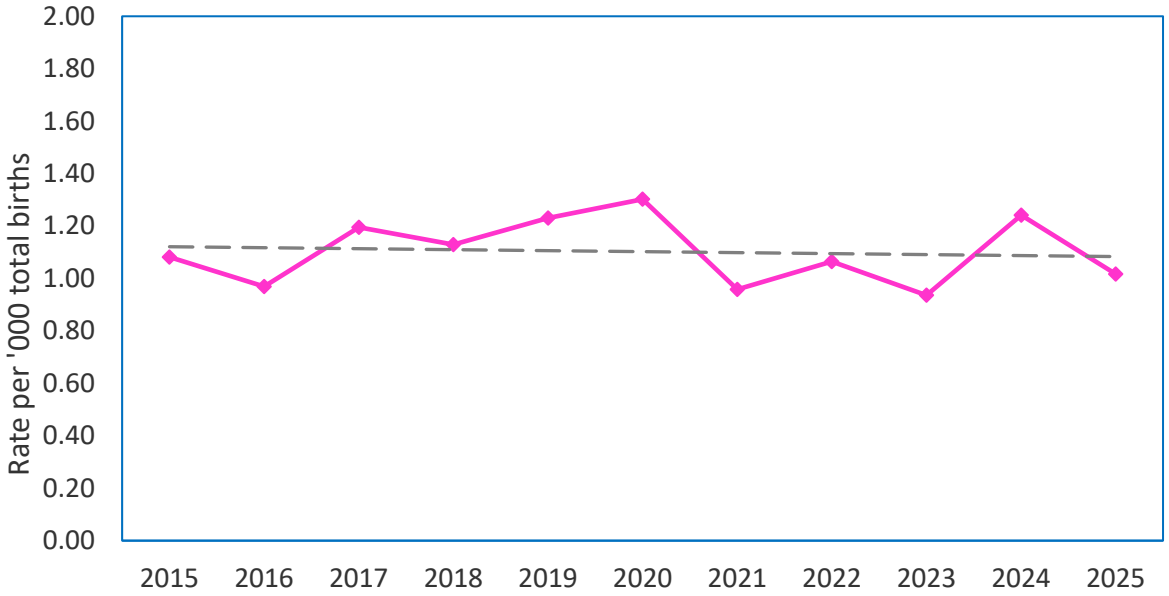
However, the upturn in the last four years highlights the need for continued monitoring and targeted interventions including MRI, biomarkers, and clinical assessment.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
NE *(per '000 total births)*	--	1.49	1.39	1.55	1.62	1.75	1.79	1.24	1.21	1.25	1.37	1.78	+0.18%	+2.21%

Source: IMIS 2015-2025

Definition in 2024: Number of infants diagnosed with NE (moderate-to-severe). (Note: Hypoxic ischaemic encephalopathy (HIE) is the most common cause of NE, but not all NE cases have HIE.)

19. National longitudinal trends 2014-25: Therapeutic hypothermia (TH)



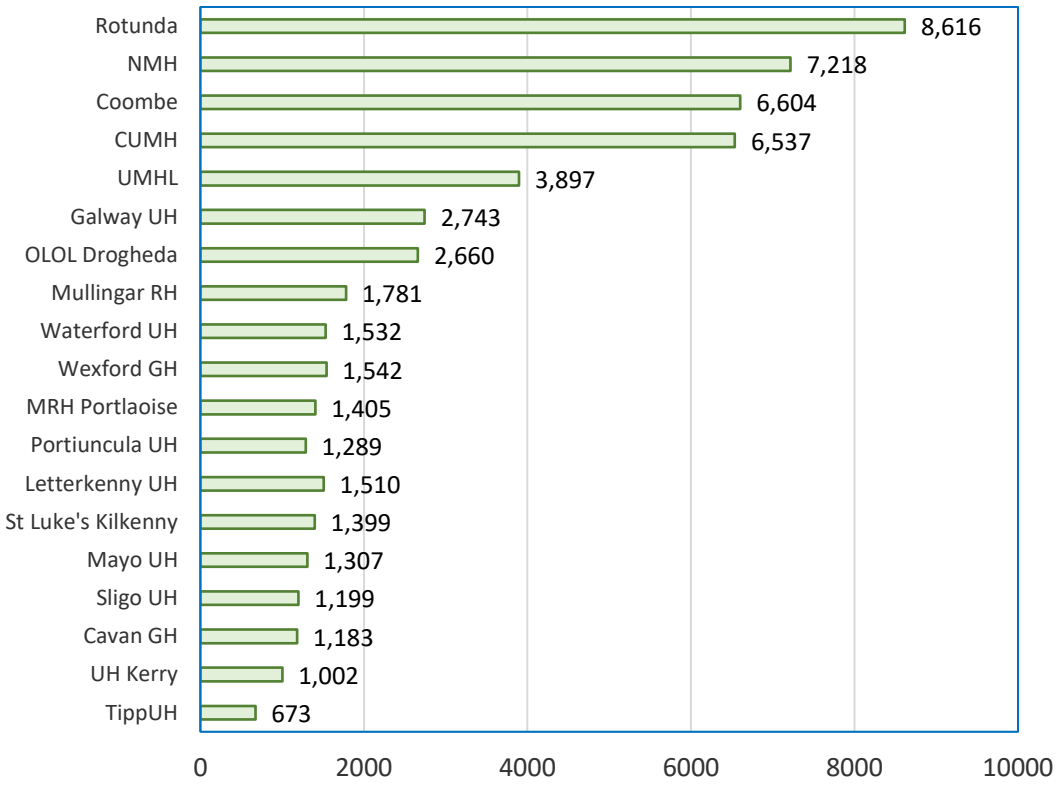
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average annual rate	Total change
TH *(per '000 total births)*	--	1.08	0.97	1.20	1.13	1.23	1.30	0.96	1.06	0.94	1.24	1.02	-0.52%	-5.56%

Source: IMIS 2015-2025

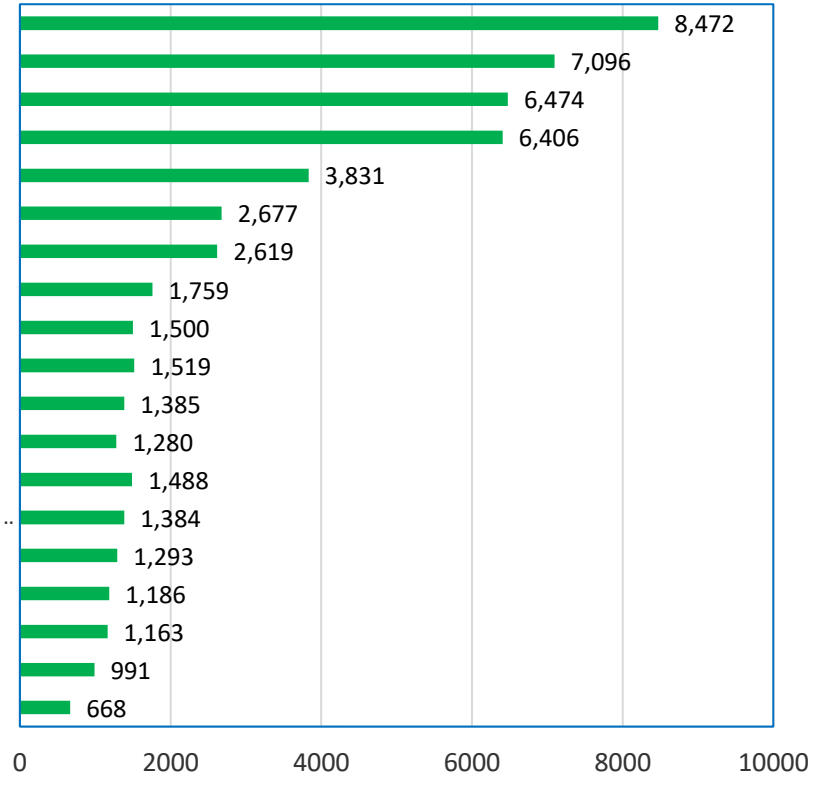
Definition: Neonatal therapeutic cooling administered during current birth episode as treatment for NE. Aligns with Neonatal Therapeutic Hypothermia in Ireland Annual Report, 2020 (2022: 15).

IMIS 2025: Demographics

Total births



Total women delivered

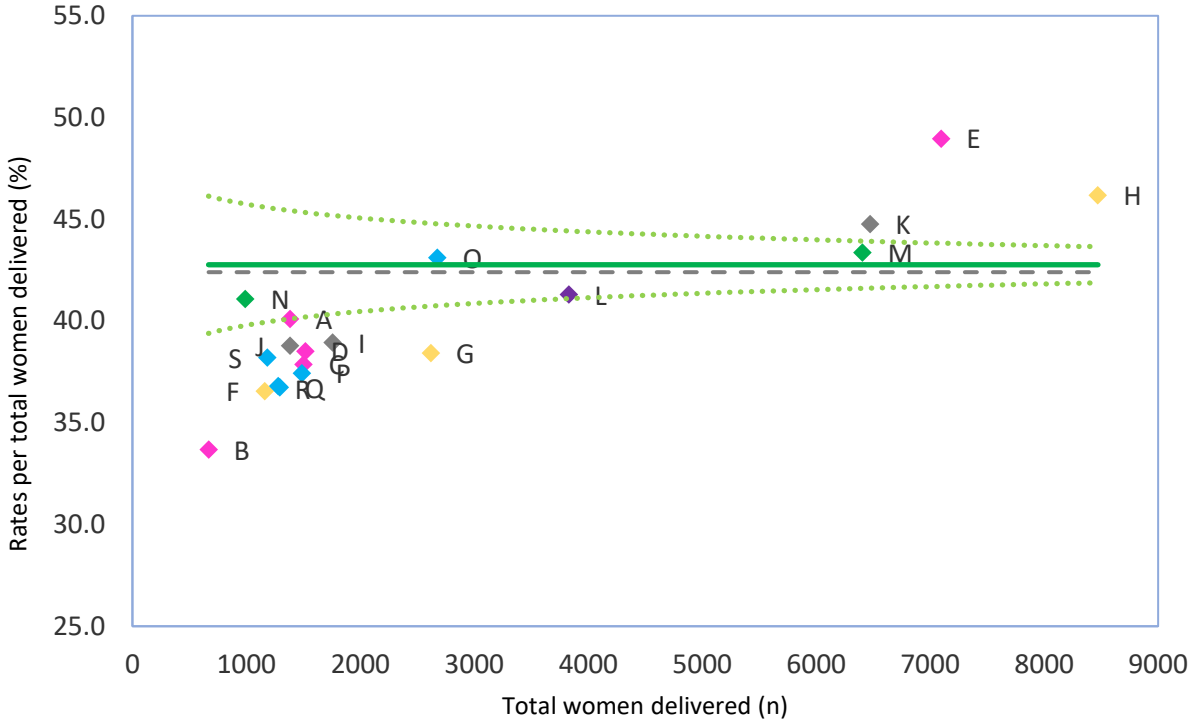


	2024	2025
Total births (n)	53,185	54,097
Range (n)	675-8,457	673-8,616

	2024	2025
Total women (n)	52,328	53,191
Range (n)	672-8,324	668-8,472

Definitions: In 2024, the following definitions applied: Total live births and stillbirths, weighing ≥500g/Total women giving birth to babies ≥500g. In 2025, definitions: Total births/Total women giving birth to baby weighing ≥400g and/or with a gestational age of ≥23 weeks. [Total births excluding Termination of pregnancy in 2025=54,046.]

Nulliparas



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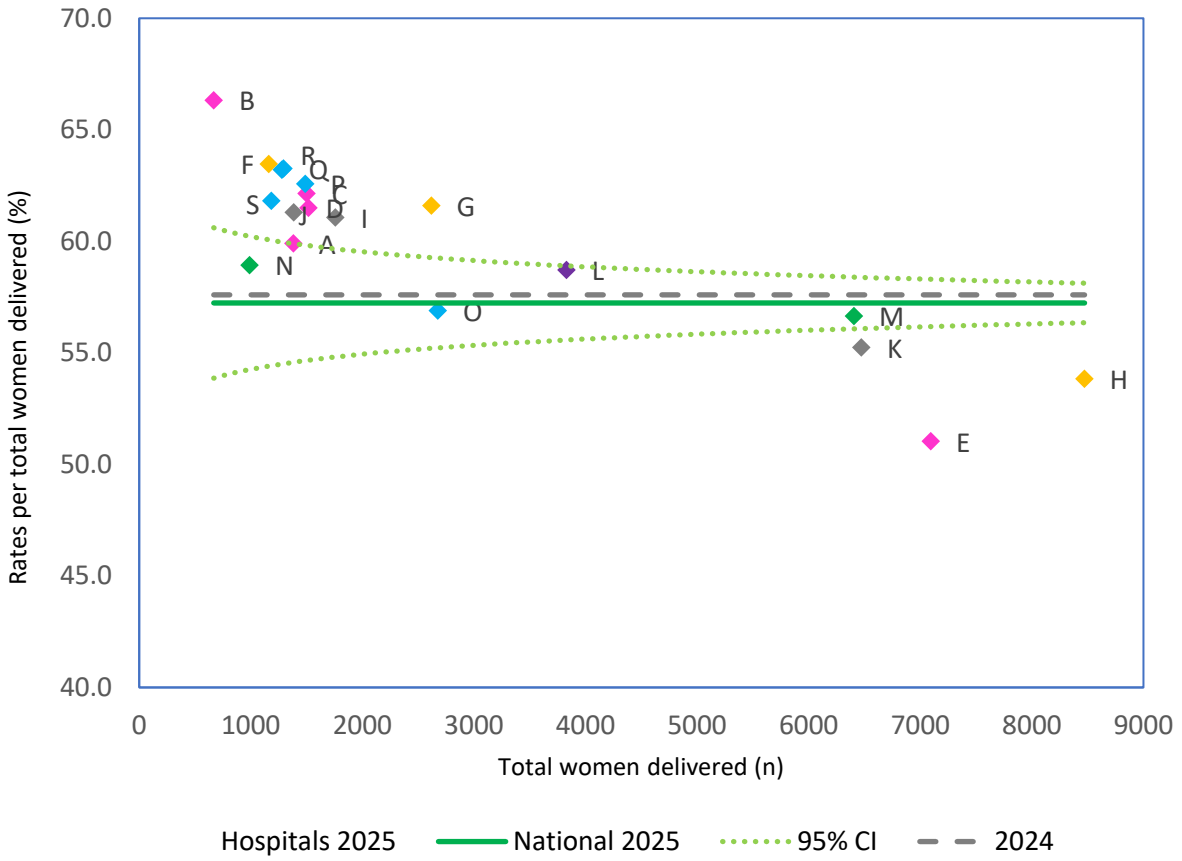
	2024	2025*
Rate *(% total women delivered)*	42.4%	42.8%
95% Confidence interval (CI)	42.0%-42.9%	42.3%-43.2%
Range	32.0%-48.0%	33.7%-49.0%
Nulliparas (n)	22,207	22,747
Total women delivered (n)	52,328	53,191

Definition: Women delivering a baby (live birth or stillbirth) ≥500 grams who never had a previous pregnancy resulting in a live birth or stillbirth.

**2025*: Total women giving birth/Total births weighing ≥400g and/or with a gestational age of ≥23 weeks.

Multiparas



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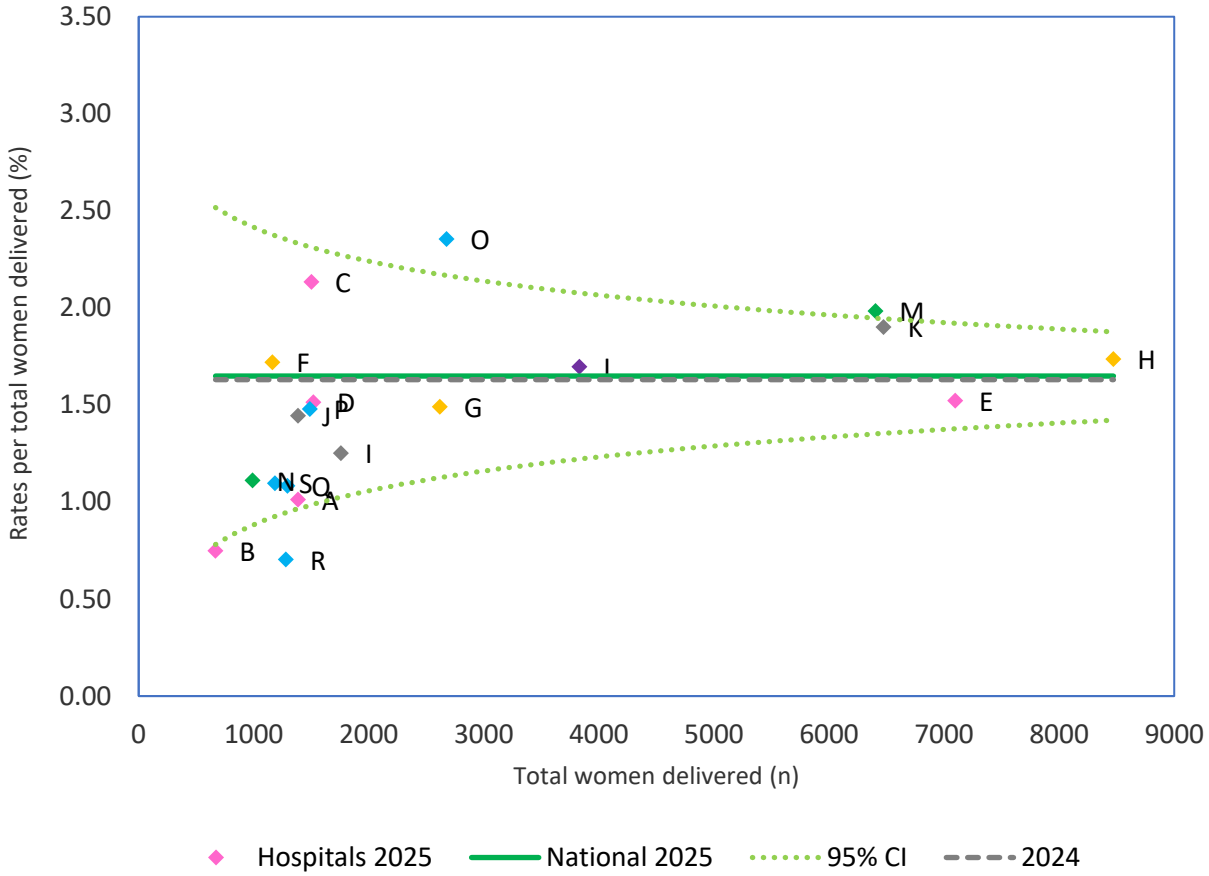
	2024	2025
Rate *(% total women delivered)*	57.6%	57.2%
95% Confidence interval (CI)	57.1%-58.0%	56.8%-57.7%
Range	52.0%-68.0%	51.0%-66.3%
Multiparas (n)	30,121	30,445
Total women delivered (n)	52,328	53,191

Definition: Women delivering a baby (live birth or stillbirth) ≥500 grams who had at least one previous pregnancy resulting in a live birth or stillbirth.

Multiple deliveries



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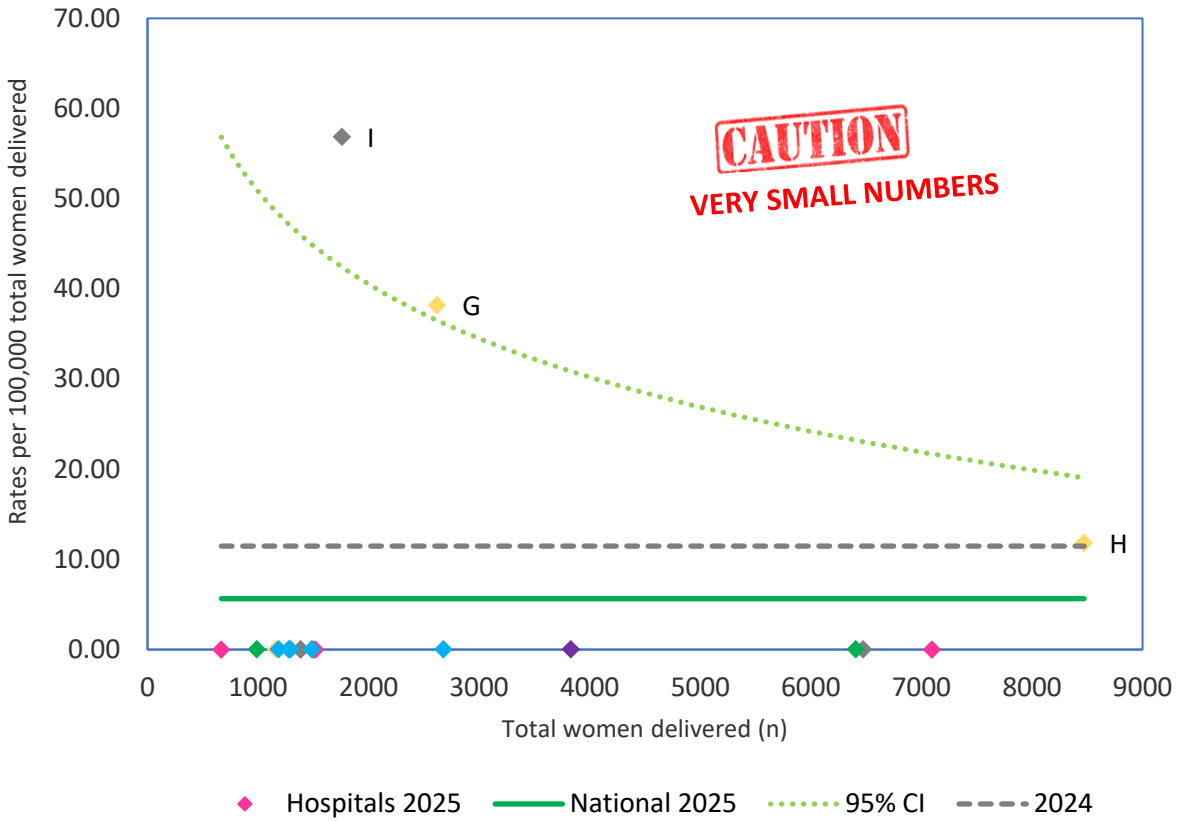
	2024	2025
Rate *(% total women delivered)*	1.63%	1.65%
95% Confidence interval (CI)	1.52%-1.74%	1.54%-1.76%
Range	0.45%-2.32%	0.70%-2.35%
Multiple deliveries (n)	854	877
Total women delivered (n)	52,328	53,191

Definition: Women delivering more than one baby (live births or stillbirths) ≥500 grams from a single pregnancy.

Note:

As part of the ongoing integration of Maternity services at University Hospital Galway (UHG) and Portiuncula University Hospital (PUH), the transfer of high-risk cases from PUH to GUH was expanded in March 2025 to include women with multiple pregnancies.

Maternal deaths



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	2024	2025
Rate *(per 100,000 women delivered)*	11.47	5.64
95% Confidence interval (CI)	0.00-20.64	0.00-12.02
Maternal deaths (n)	6	3
Total women delivered (n)	52,328	53,191

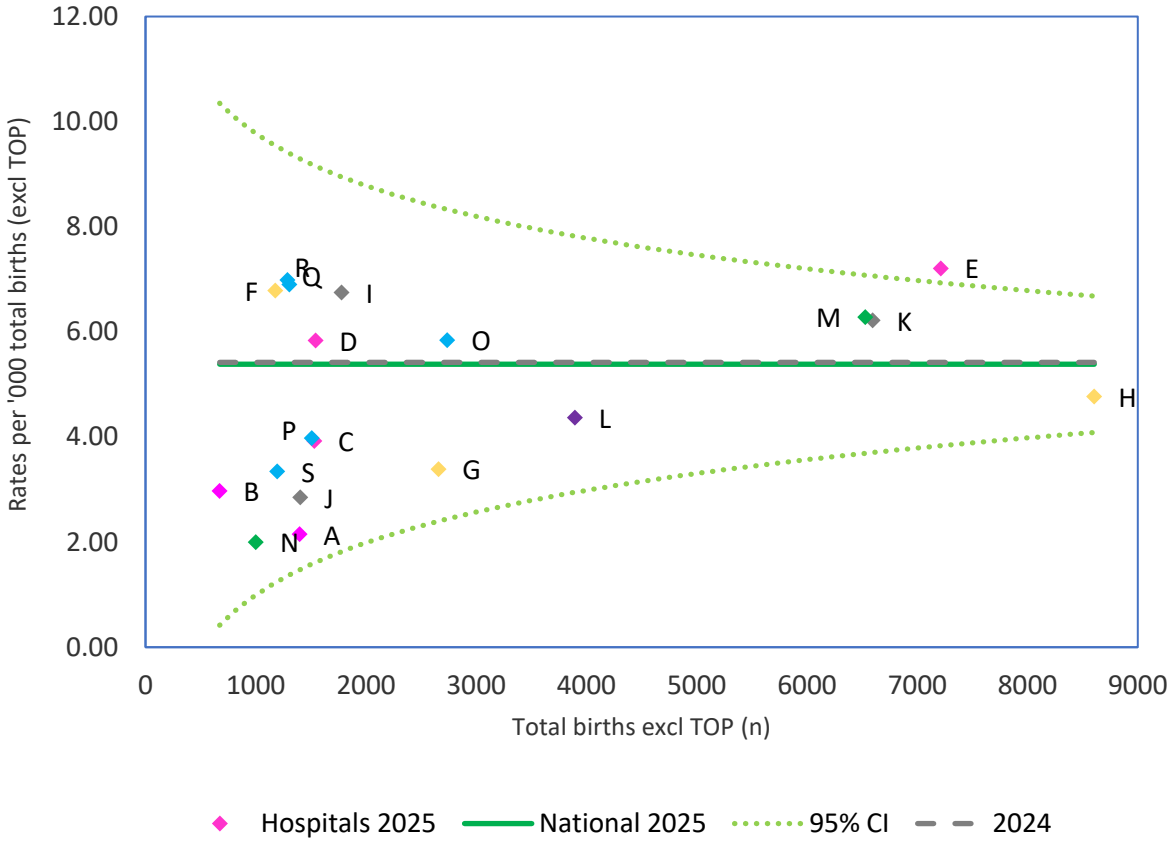
CAUTION

Caution is advised when dealing with small numbers:

they can distort the rate calculations.

Definition: Deaths of women while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (based on WHO 2010 definition and Confidential Maternal Death Enquiry 2016: 10). Include direct and indirect maternal deaths. Exclude late maternal deaths.

Perinatal Deaths – Total



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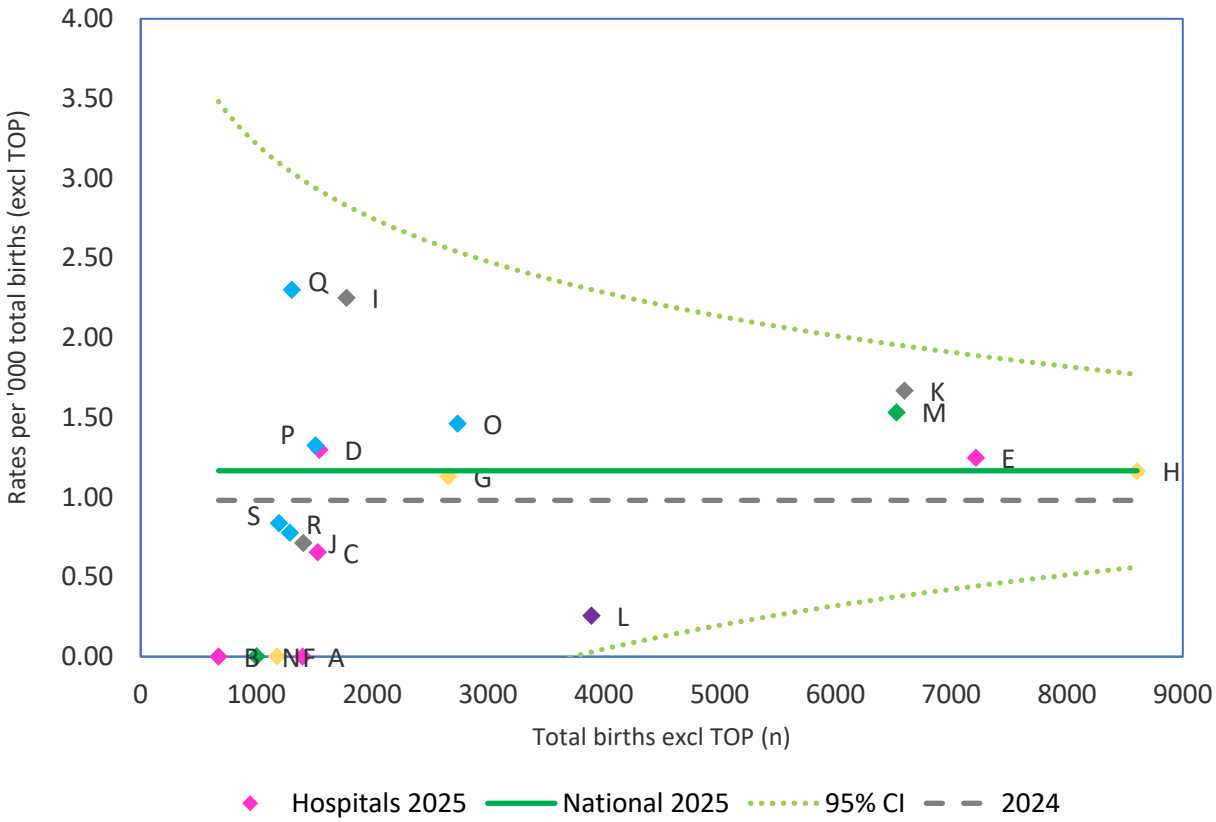
	2024	2025
Rate *(per '000 total births / excl TOP)*	5.42	5.48
95% Confidence interval (CI)	4.79-6.04	4.85-6.10
Range	1.88-6.68	2.00-7.49
Total perinatal deaths (n)	288	296
Total births / Total births excl TOP (n)	53,185	54,046

Definition: Total infant deaths, incl stillbirths and early neonatal deaths 500 grams or more. Rates for 2024 are based on Total births; 2025 are based on Total births excluding TOP.

Note: The metric includes In utero transfers at the four tertiary hospitals.

Perinatal Deaths – Adjusted



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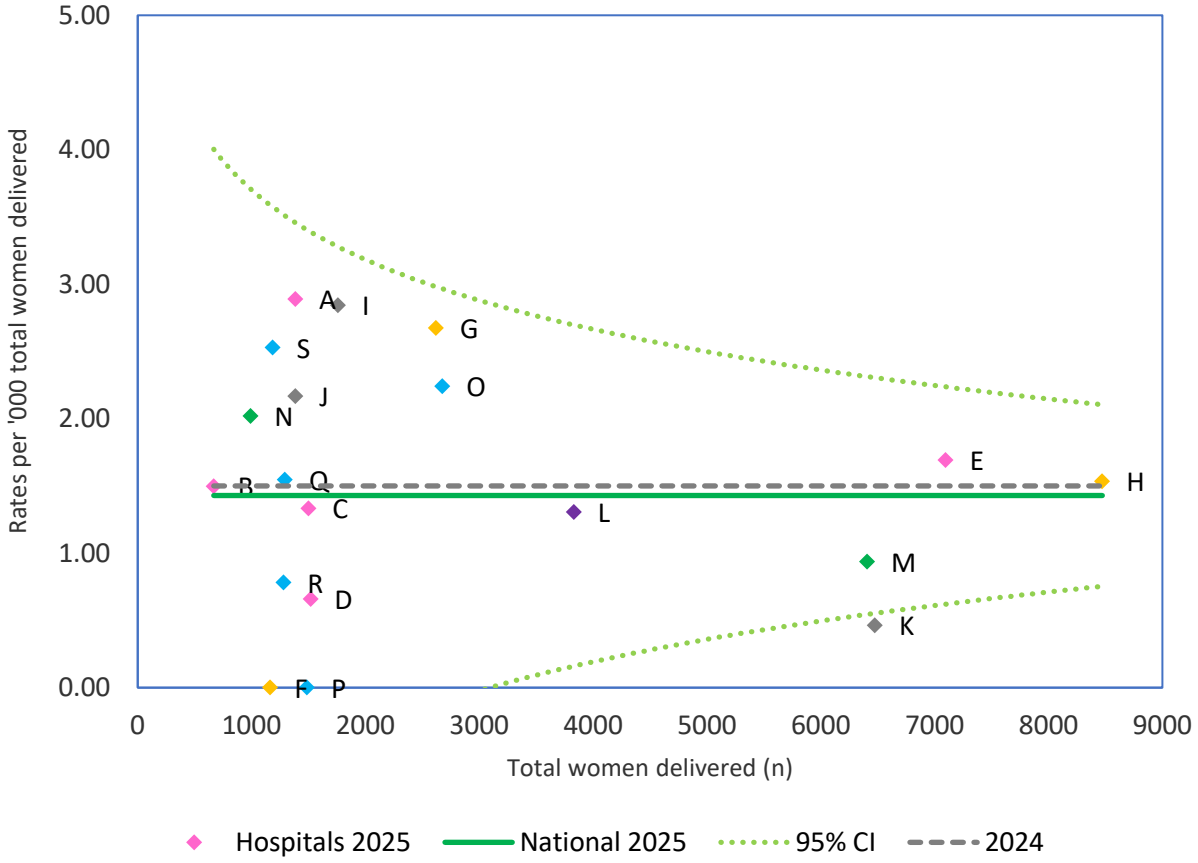
	2024	2025
Rate *(per '000 total births excl TOP)*	0.98	1.17
95% Confidence interval (CI)	0.71-1.24	0.88-1.45
Range	0.00-3.04	0.00-2.30
Adjusted perinatal deaths (n)	52	63
Total births / Total births (excl TOP) (n)	53,185	54,046

Definition: Stillbirths and early neonatal deaths combined, weighing 2.5kg or more without a congenital anomaly. Rates for 2024 are based on Total births; 2025 are based on Total births excluding termination of pregnancy. Note: The metric includes In utero transfers at the four tertiary hospitals.

IMIS 2024: Obstetric risks and complications

Maternal sepsis



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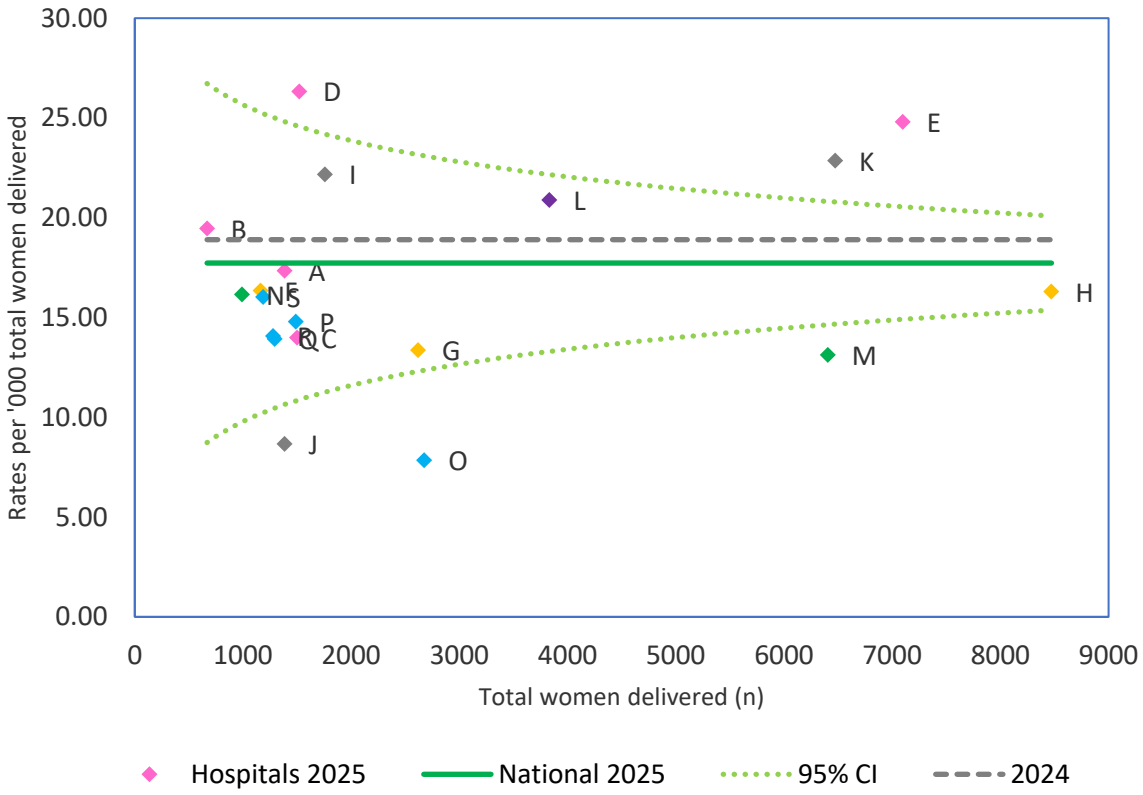
	2024	2025
Rate *(per '000 women delivered)*	1.50	1.43
95% CI	1.15-1.86	1.11-1.75
Range	0.00-4.70	0.00-2.89
Maternal sepsis (n)	69	76
Total women delivered (n)	45,857*	53,191

*Definition: Women with maternal sepsis: Organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion, or postpartum period (WHO 2016). *Missing data from CUMH in 2024*

Ectopic pregnancies



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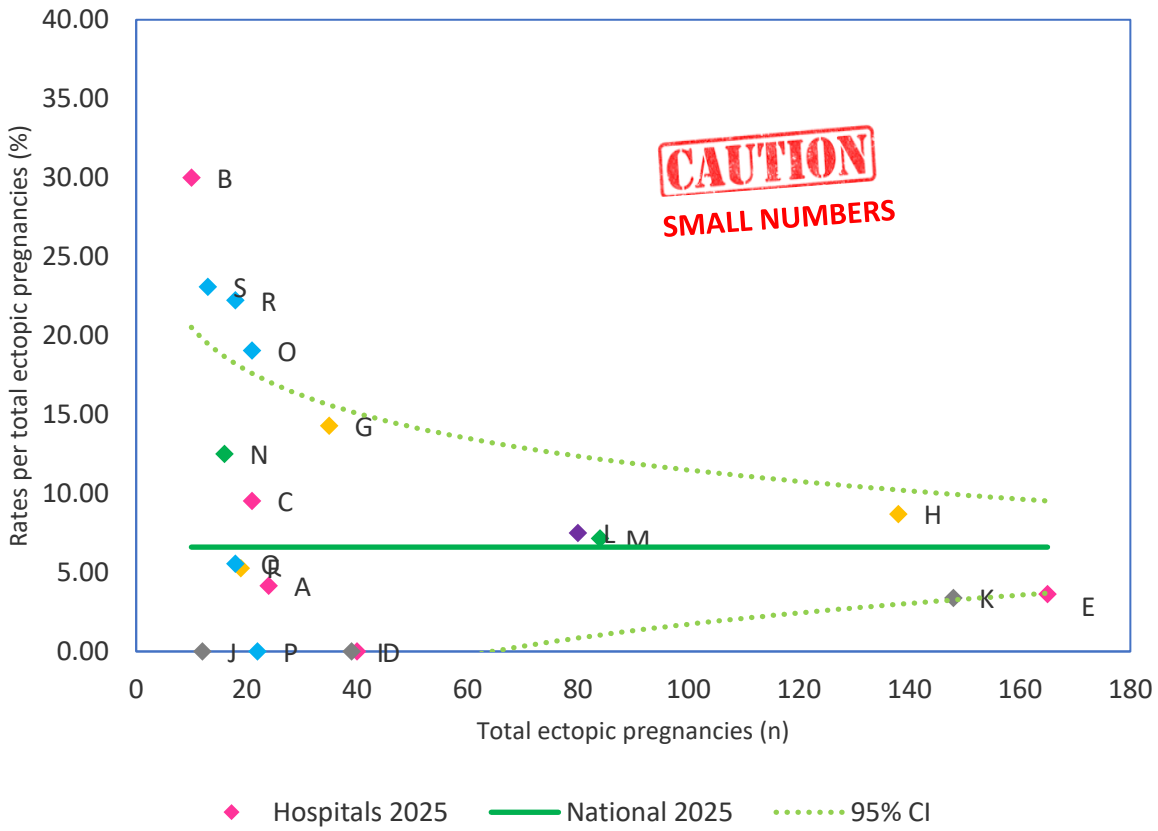
	2024	2025
Rate *(per '000 women delivered)*	18.9	17.7
95% CI	17.7-20.0	16.6-18.9
Range	7.4-26.7	7.8-26.3
Ectopic pregnancies (n)	987	943
Total women delivered (n)	52,328	53,191

Definition: Women with an ectopic pregnancy. Refers to women who present at maternity hospitals/units only.

Ectopic pregnancies transfused (sub-metric)



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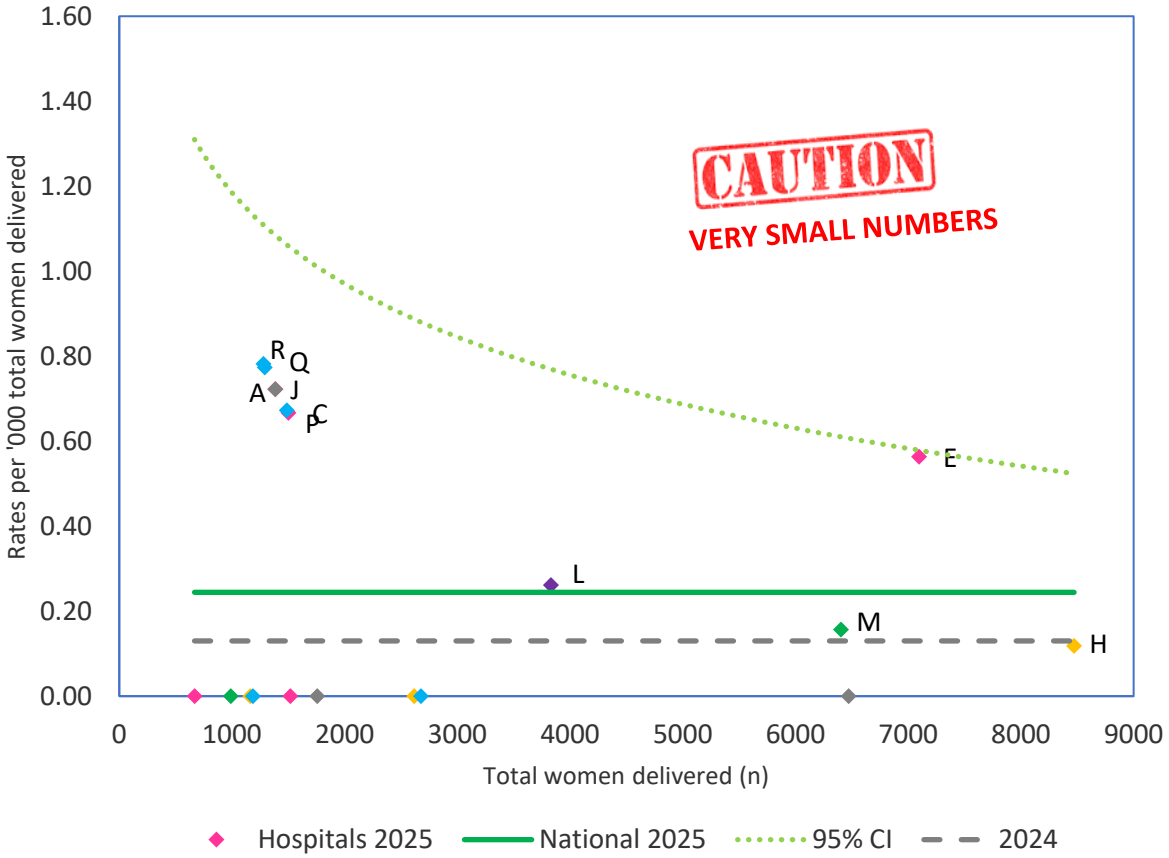
	2024	2025
Rate *(% of ectopic pregnancies)*	5.67%	6.61%
95% CI	4.23%-7.12%	5.01%-8.21%
Range	1.21%-40.00%	0.00%-30.00%
Ectopic pregnancies transfused (n)	56	61
Total ectopic pregnancies (n)	987	923

SMALL NUMBERS: The outlying unit on the left-hand-side of the funnel plot reflects the small number of ectopic pregnancies (n=10), of which n=4 received blood transfusions.

CAUTION

Definition: Ectopic pregnancies requiring blood transfusion (sub-metric). Include initial haemoglobin and hCG levels, abnormal bleeding on presentation.

Eclampsia



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	2024	2025
Rates *(per '000 women delivered)*	0.13	0.24
95% CI	0.03-0.23	0.11-0.38
Range	0.00-1.19	0.00-0.78
Eclampsia (n)	7	13
Total women delivered (n)	52,328	53,191

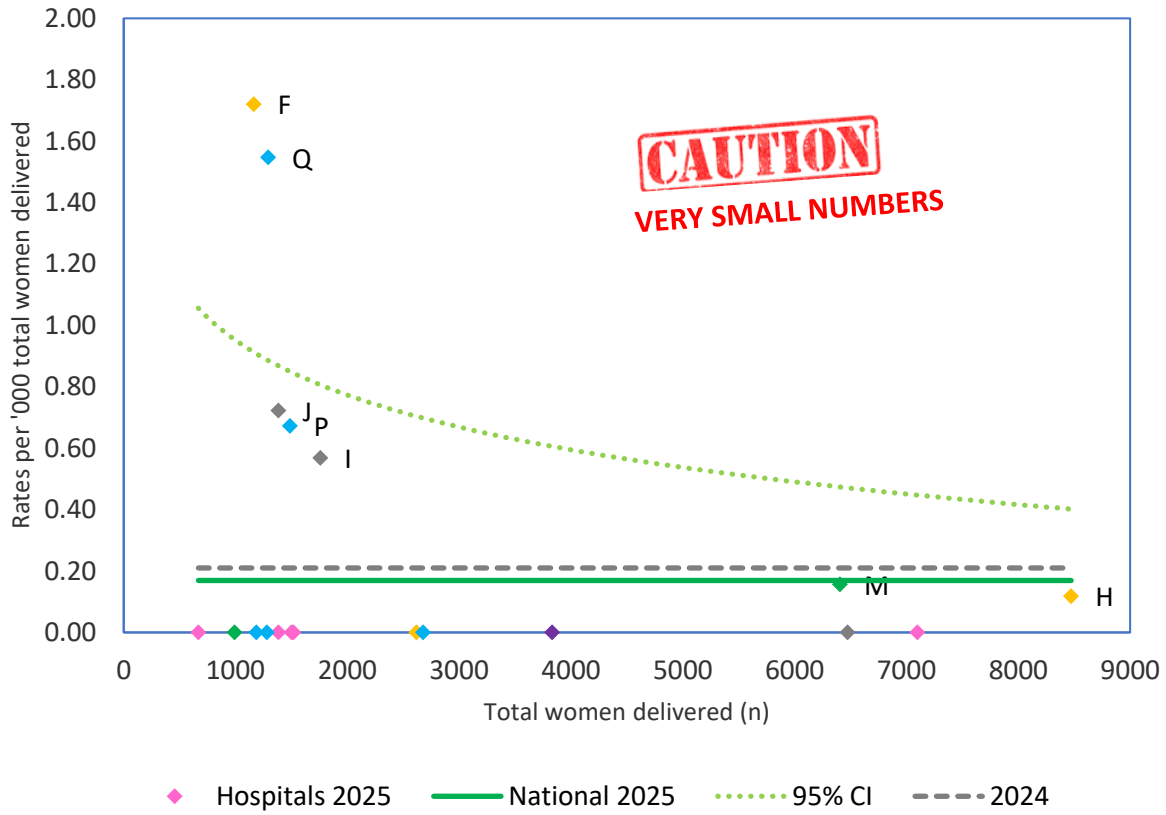
CAUTION

SMALL NUMBERS

The national rate has been increasing in recent years. In 2025, it was almost double that of the previous year. Funnel plot variability here is largely driven by very small numbers.

Definition: Women with eclampsia during any antenatal hospital event or at delivery. The metric does not include severe pre-eclampsia.

Uterine ruptures



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	2024	2025
Rates *(per '000 women delivered)*	0.21	0.17
95% CI	0.09-0.33	0.06-0.28
Range	0.00-0.69	0.00-1.72
Uterine ruptures (n)	11	9
Total women delivered (n)	52,328	53,191

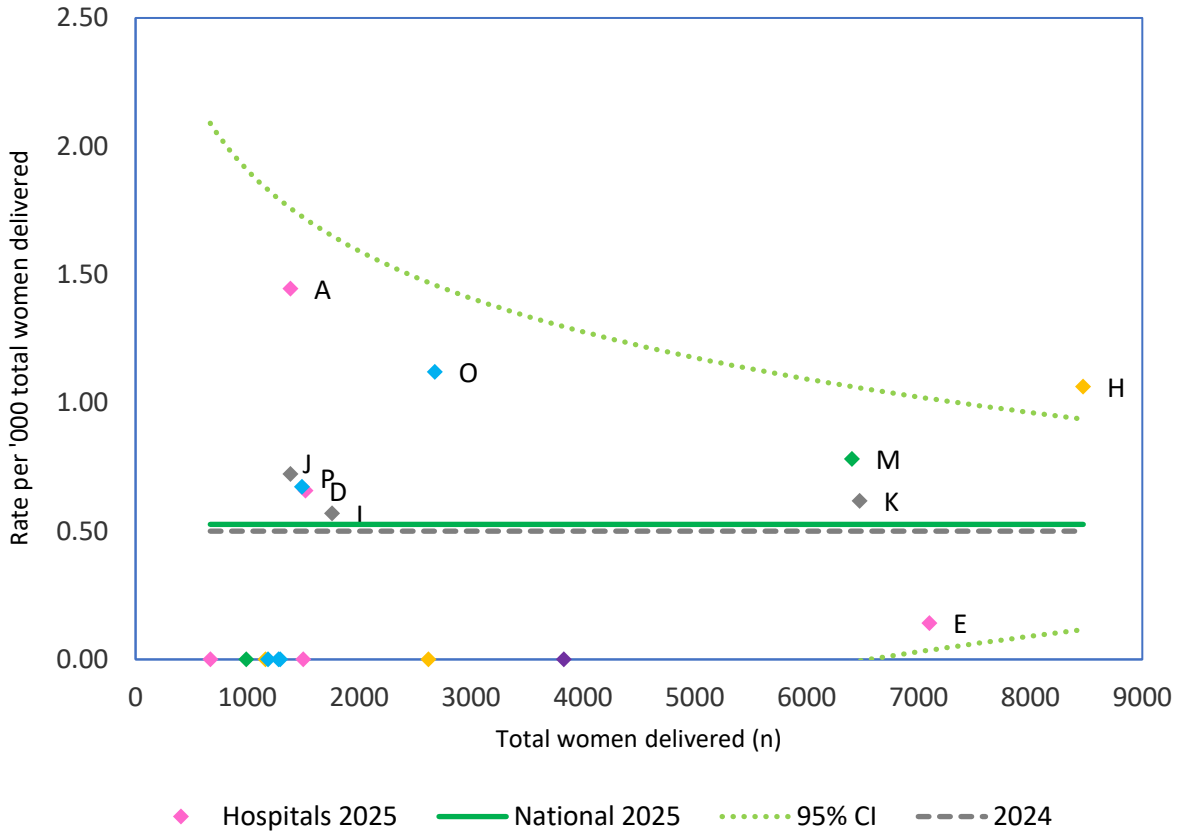
Note:

The two outlying units both saw n=2 cases of uterine rupture.

Almost half of all national cases occurred in women with a previous Caesarean section (i.e., four women of the nine with UR).

Definition: Women with complete rupture of uterus before onset of labour or during labour, including cases that may not be diagnosed until after delivery.

Peripartum hysterectomy



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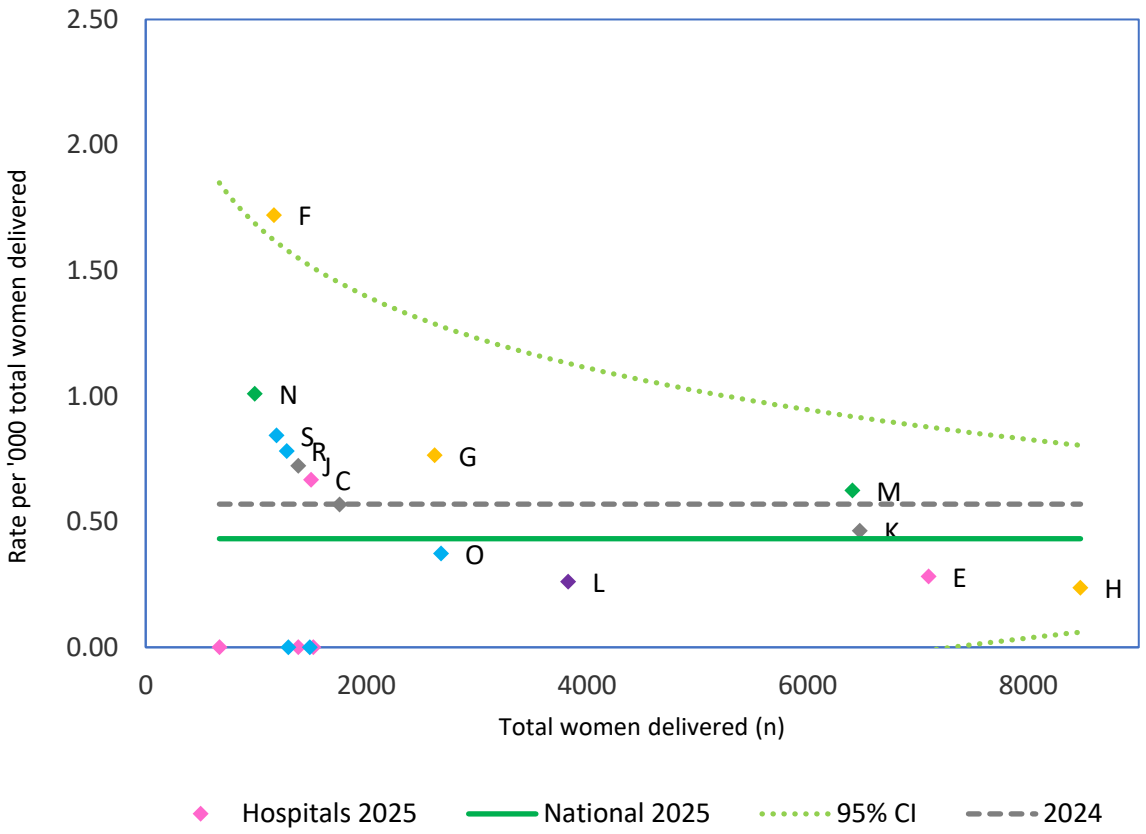
	2024	2025
Rates *(per '000 women delivered)*	0.50	0.53
95% CI	0.31-0.69	0.33-0.72
Range	0.00-2.71	0.00-1.45
Peripartum hysterectomy (n)	26	28
Total women delivered (n)	52,328	53,191

Definition: Hysterectomy procedures performed during pregnancy and/or within seven completed days after delivery.

Pulmonary embolism



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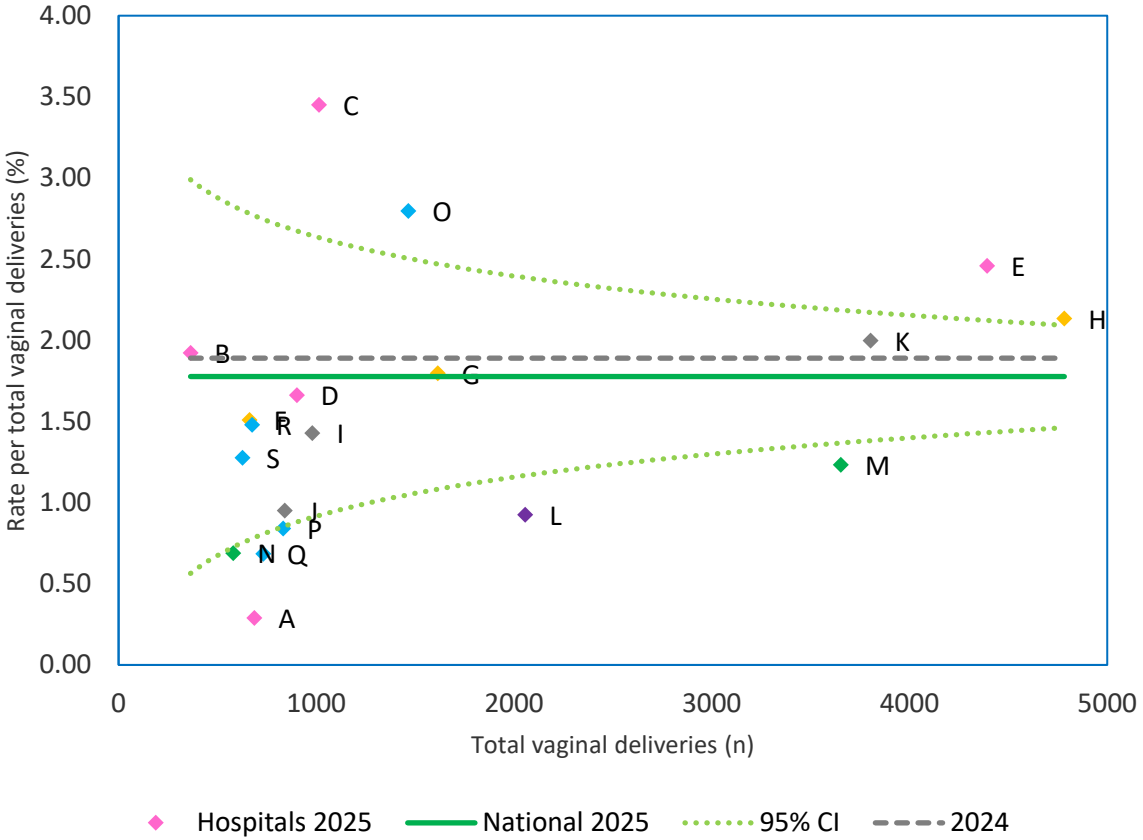
	2024	2025
Rates *(per '000 women delivered)*	0.57	0.43
95% CI	0.37-0.78	0.26-0.61
Range	0.00-1.90	0.00-1.72
Pulmonary embolism (n)	30	23
Total women delivered (n)	52,328	53,191

Definition: Women with obstetric pulmonary embolism, including pulmonary emboli during the pregnancy and up to 42 days following pregnancy end.

Perineal tears (third- and/or fourth-degree)



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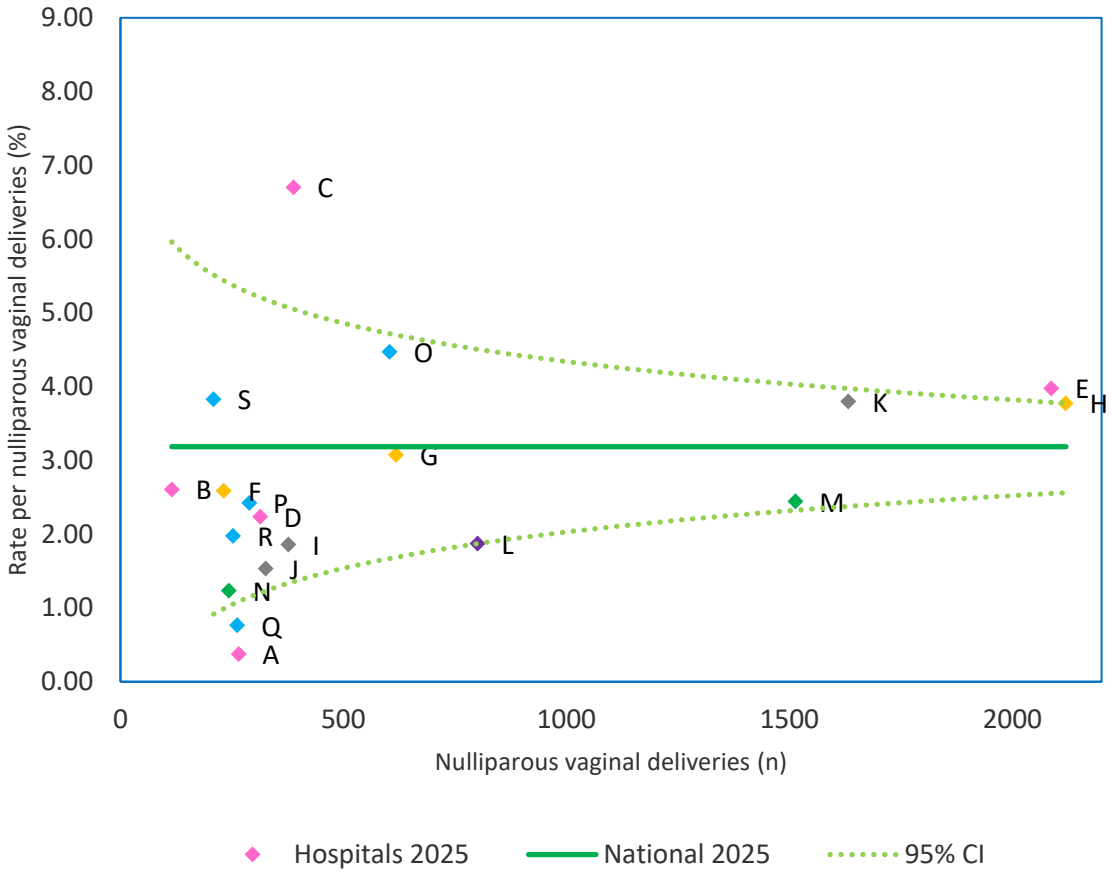
	2024	2025
Rates *(% total vaginal deliveries)*	1.89%	1.78%
95% CI	1.74%-2.04%	1.64%-1.93%
Range	0.81%-2.41%	0.29%-3.45%
Perineal tears (n)	588	547
Total vaginal deliveries (n)	31,082	30,673

Definition: Third-degree and/or fourth-degree lacerations, incl tears in the vaginal tissue, perineal skin, and perineal muscles that extend into the anal sphincter and/or go through the anal sphincter and tissue underneath

Perineal tears, Nulliparas



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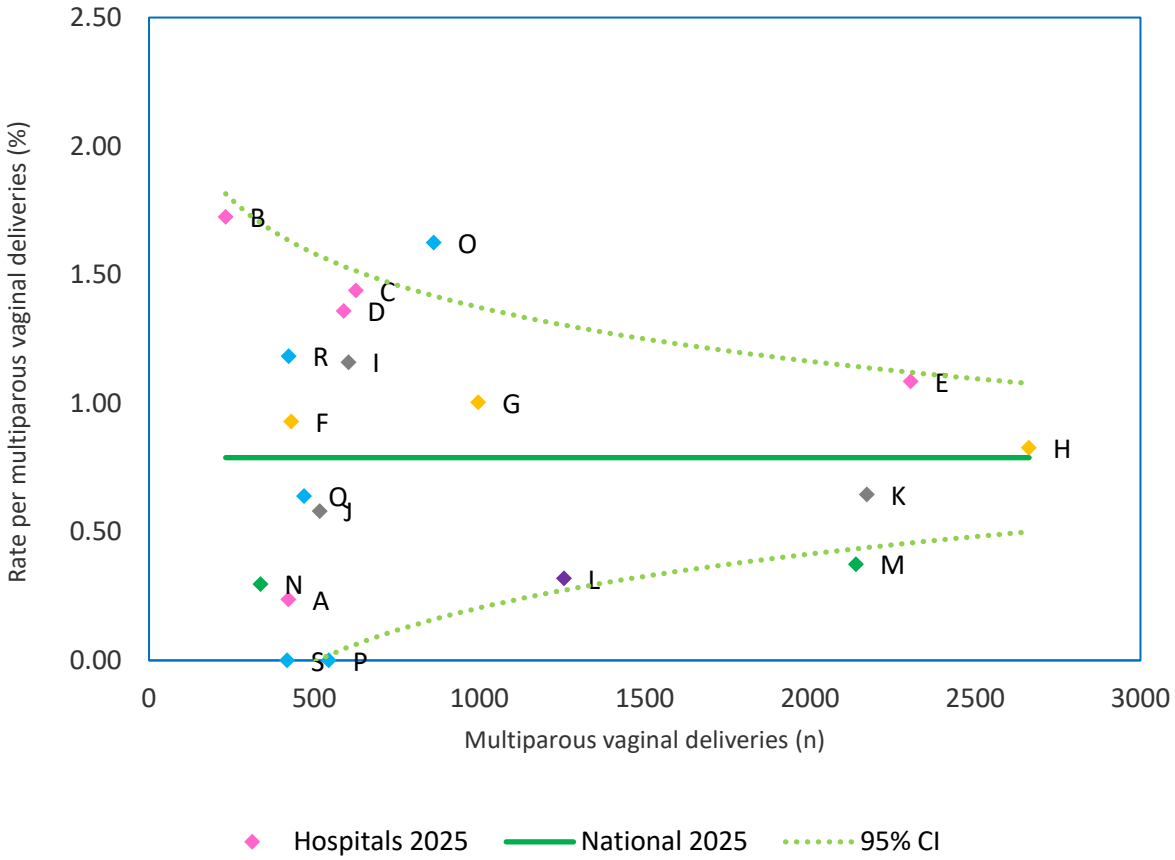
	2024	2025
Rates *(% Nulliparous vaginal deliveries)*	--	3.20%
95% CI	--	2.89%-3.50%
Range	--	0.38%-6.70%
Perineal tears, Nulliparas (n)	--	405
Nulliparous Vaginal deliveries (n)	--	12,665

Perineal tears, Multiparas



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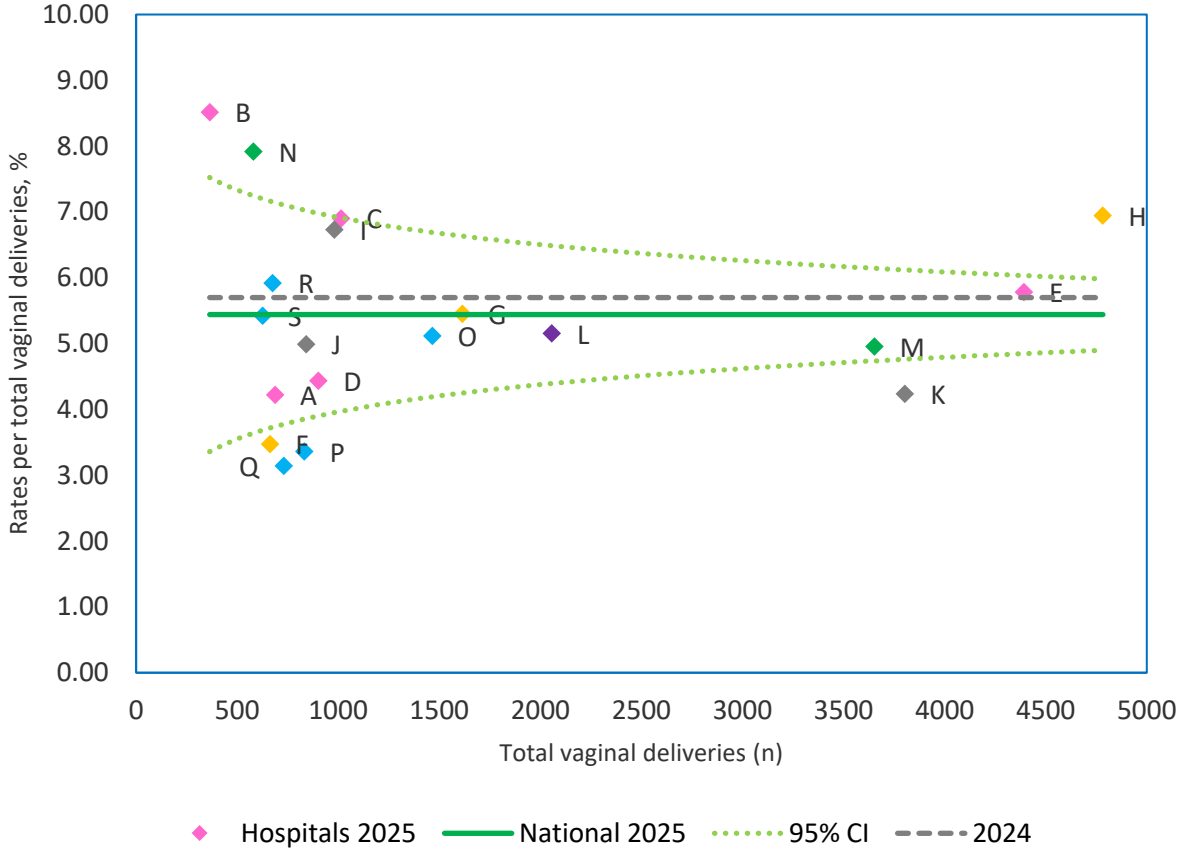
	2024	2025
Rates *(% Multiparous vaginal deliveries)*	--	0.79%
95% CI	--	0.66%-0.92%
Range	--	0.00%-1.72%
Perineal tears, Multiparas (n)	--	142
Multiparous Vaginal deliveries (n)	--	18,009

PPH, vaginal deliveries



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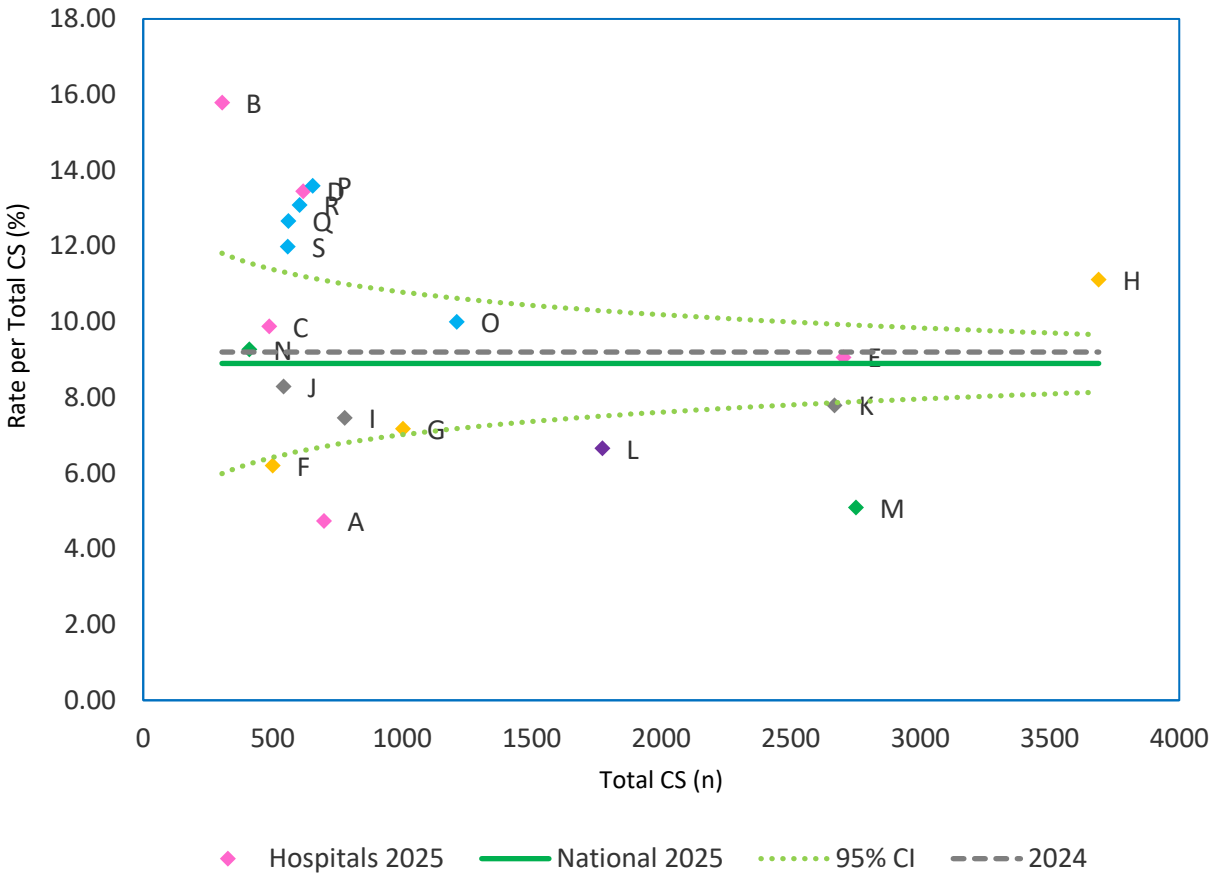
	2024	2025
Rates *(% total vaginal deliveries)*	5.7%	5.4%
95% CI	5.4%-5.9%	5.2%-5.7%
Range	2.6%-8.6%	3.1%-8.5%
PPH per total vaginal deliveries (n)	1,767	1,669
Total vaginal deliveries (n)	31,084	30,673

Definition: Women with blood loss of ≥1,000mL following vaginal delivery within 24 hours of delivery (or, where relevant, prior to discharge from the labour ward). Exclude ectopic pregnancies and molar pregnancies. Discount/exclude liquor from the measurement of blood loss.

PPH, Caesarean sections



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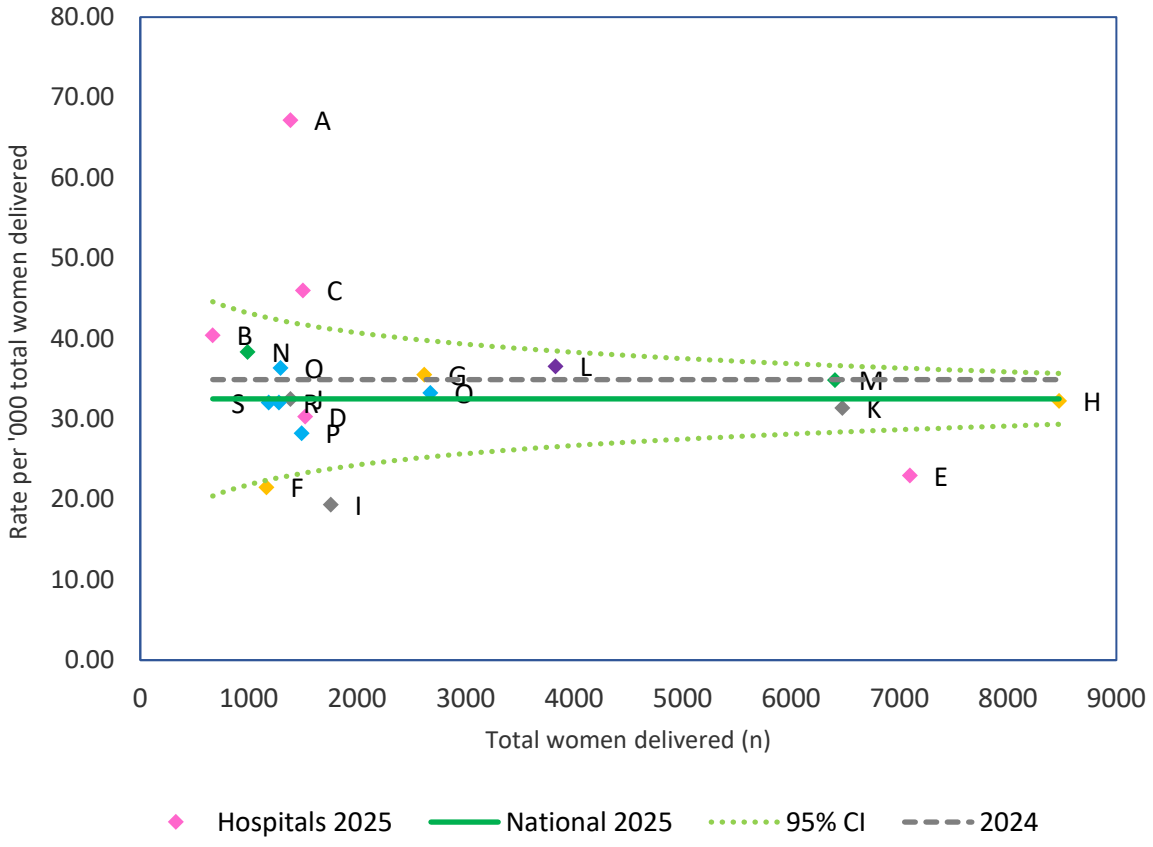
	2024	2025
Rates *(% total CS)*	9.2%	8.9%
95% CI	8.8%-9.6%	8.5%-9.3%
Range	3.8%-16.0%	4.7%-15.8%
PPH per total Caesarean sections (n)	1,951	2,004
Total CS (n)	21,248	22,518

Definition: Women with blood loss of ≥1,000mL following Caesarean section within 24 hours of delivery.

Obstetric blood transfusions



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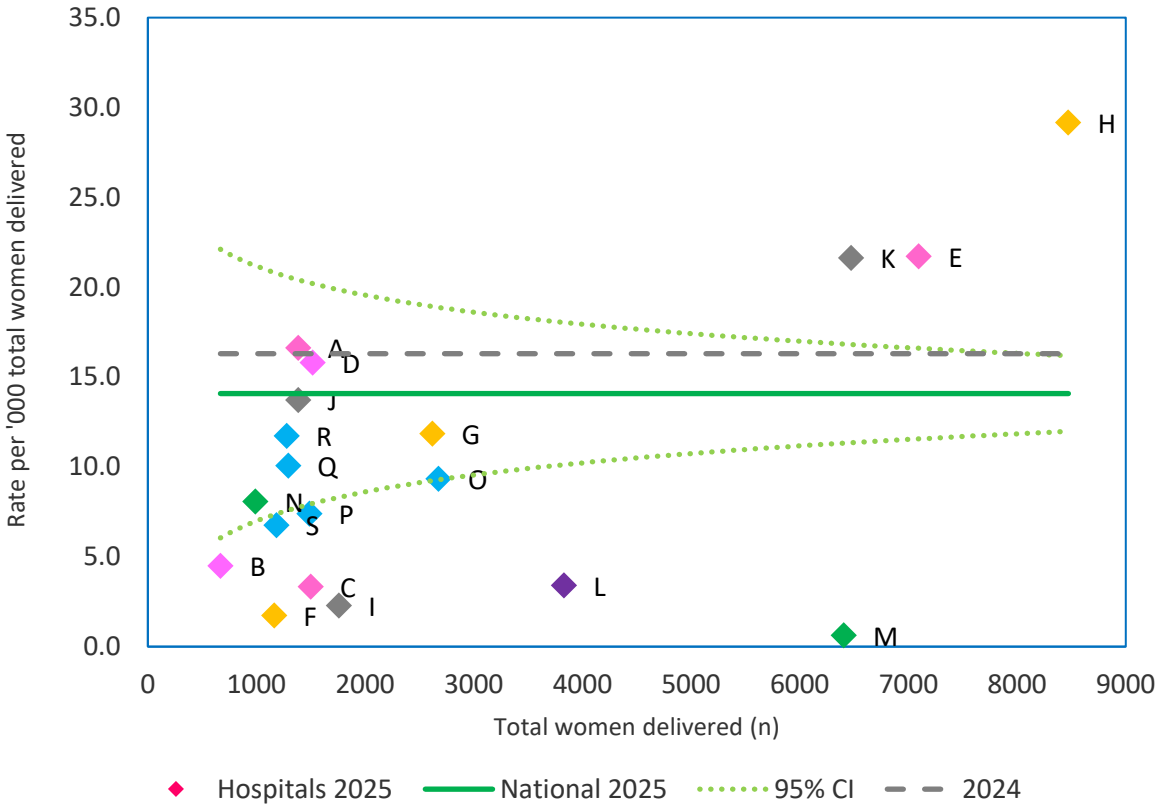
	2024	2025
Rate *(per '000 women delivered)*	34.9	32.5
95% CI	33.3-36.5	31.0-34.0
Range	20.3-64.5	19.3-67.2
Obstetric blood transfusions (n)	1,827	1,729
Total women delivered (n)	52,328	53,191

Definition: Obstetric patients who receive one or more units of blood components/ products (including red cells, plasma, platelets, etc.), not including clotting factors or recombinant products. If a patient is transfused twice during her hospital stay, count as ONE transfusion

Maternal critical care (Level 2 / Level 3)



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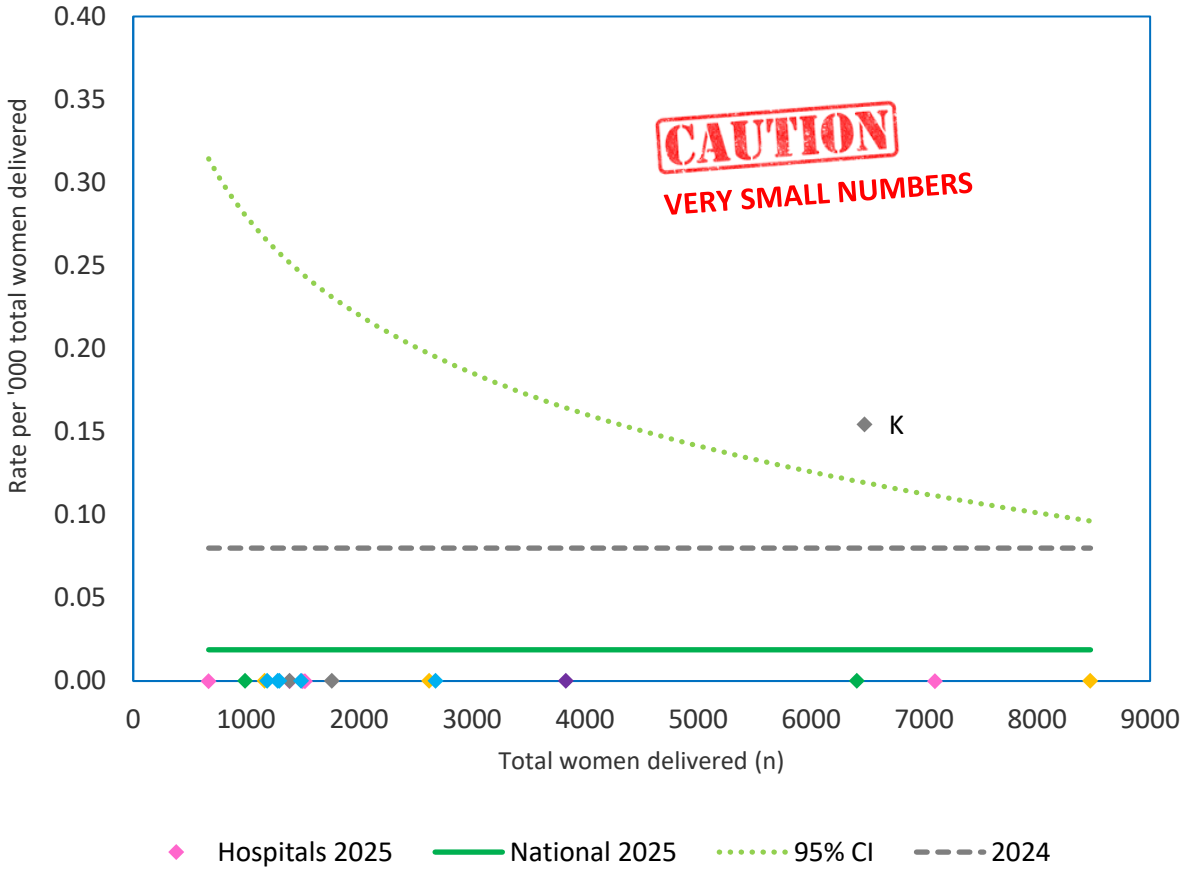
	2024*	2025
Rates *(per '000 women delivered)*	18.54	14.08
95% CI	17.30-19.77	13.08-15.08
Maternal critical care (n)	850	749
Total women delivered (n)	45,857	53,191

Definition: Number of women admitted/transferred to Intensive Care Unit/Coronary Care Unit (ICU/CCU) or High Dependency Unit (HDU) who required Level 2 and/or Level 3 care (not Level 1).

**Missing data from CUMH in 2024. This metric is under review with CUMH in 2025.*

Miscarriage misdiagnosis



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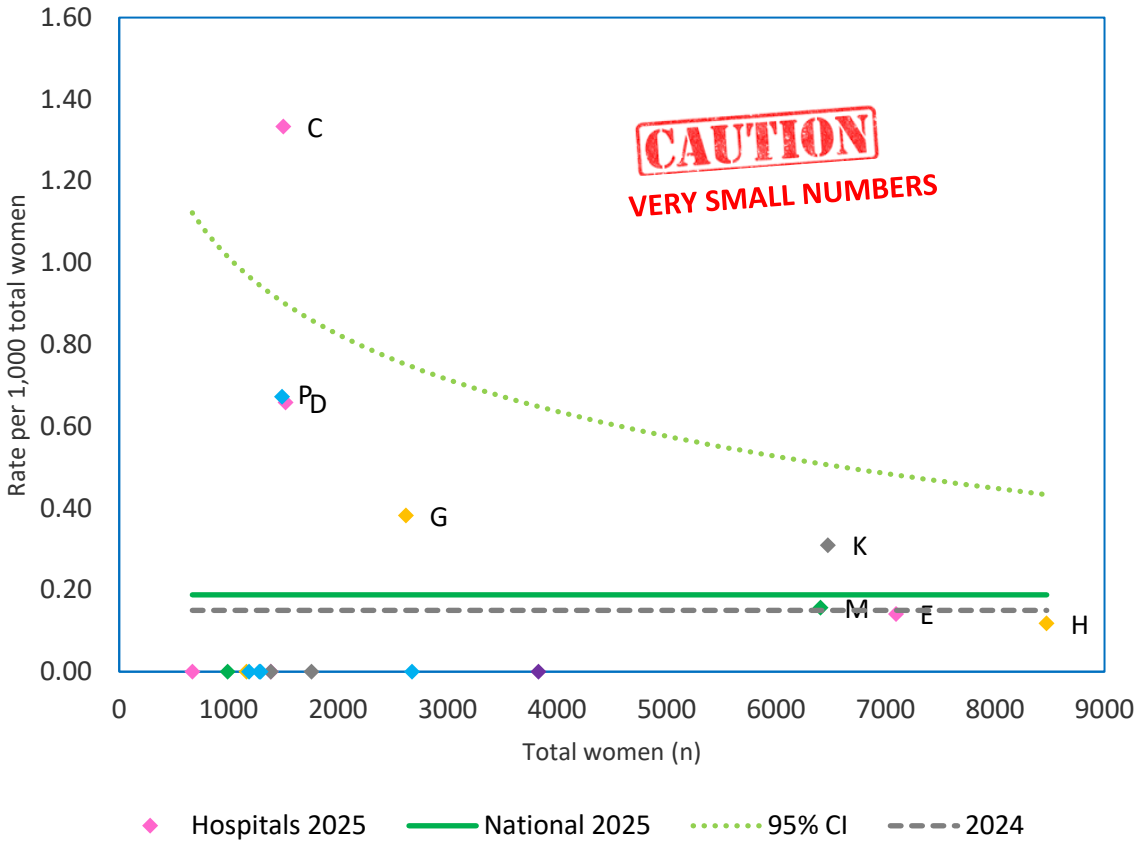
	2024	2025
Rates *(per '000 women delivered)*	0.08	0.02
95% CI	0.00-0.15	0.00-0.06
Miscarriage misdiagnosis (n)	4	1
Total women delivered (n)	52,328	53,191

Definition: Women diagnosed with a spontaneous miscarriage but a subsequent ultrasound confirms an ongoing pregnancy.

Retained swabs



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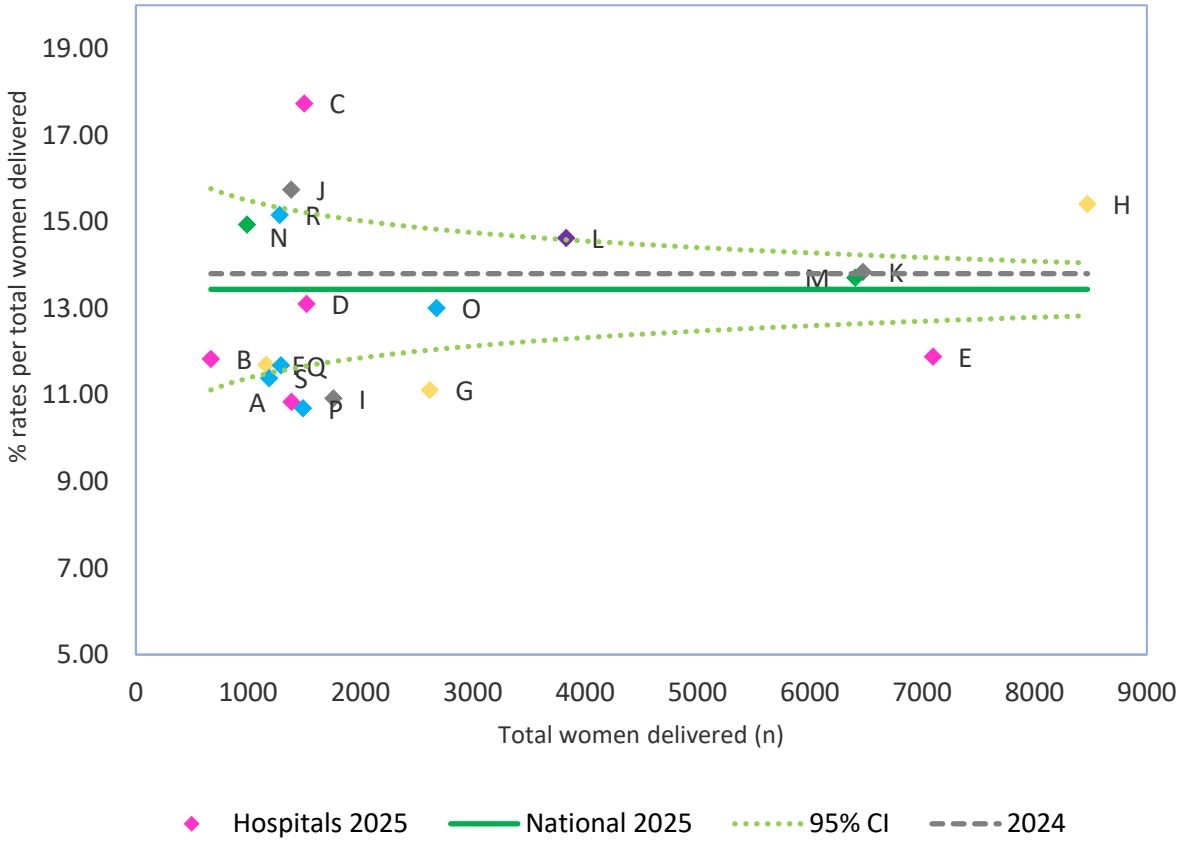
	2024	2025
Rates *(per '000 women delivered)*	0.15	0.19
95% CI	0.05-0.26	0.07-0.31
Retained swabs (n)	8	10
Total women delivered (n)	52,328	53,191

Definition: Women with a swab (for cleansing and to absorb blood and other fluids) retained unintentionally in the vagina after a vaginal delivery.

IMIS 2024: Deliveries and Anaesthesia

Assisted vaginal deliveries (AVD), Total



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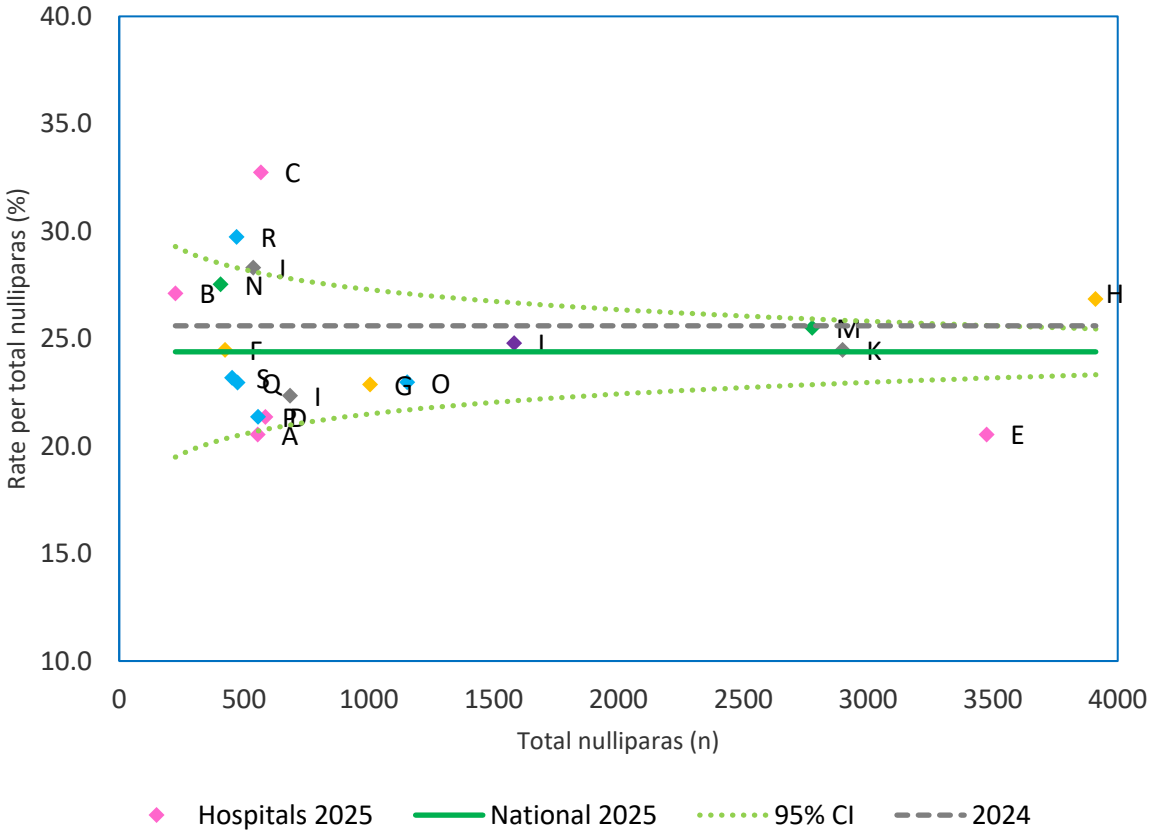
	2024	2025
Rates *(% total women delivered)*	13.8%	13.4%
95% CI	16.5%-14.1%	13.2%-13.7%
Range	10.2%-17.4%	10.7%-17.7%
Assisted vaginal deliveries (AVD) (n)	7,212	7,150
Total women delivered (n)	52,328	53,191

Definition: Women undergoing assisted vaginal delivery (previously, Operative vaginal delivery), incl forceps and vacuum extraction

AVD among nulliparas



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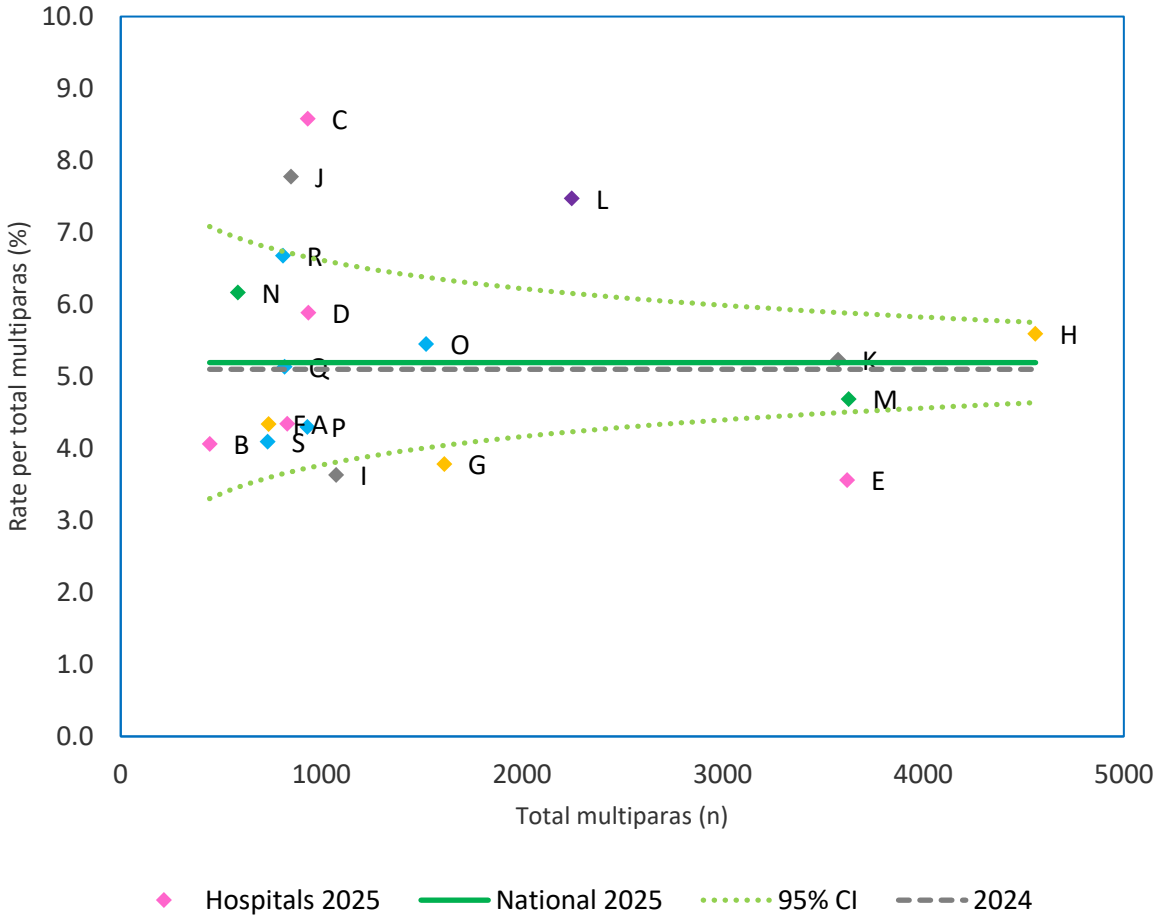
	2024	2025
Rates *(% nulliparas)*	25.6%	24.4%
95% CI	25.0%-26.2%	23.8%-25.0%
Range	18.3%-31.5%	20.5%-32.8%
AVD among nulliparas (n)	5,687	5,549
Total nulliparas (n)	22,207	22,747

AVD among multiparas



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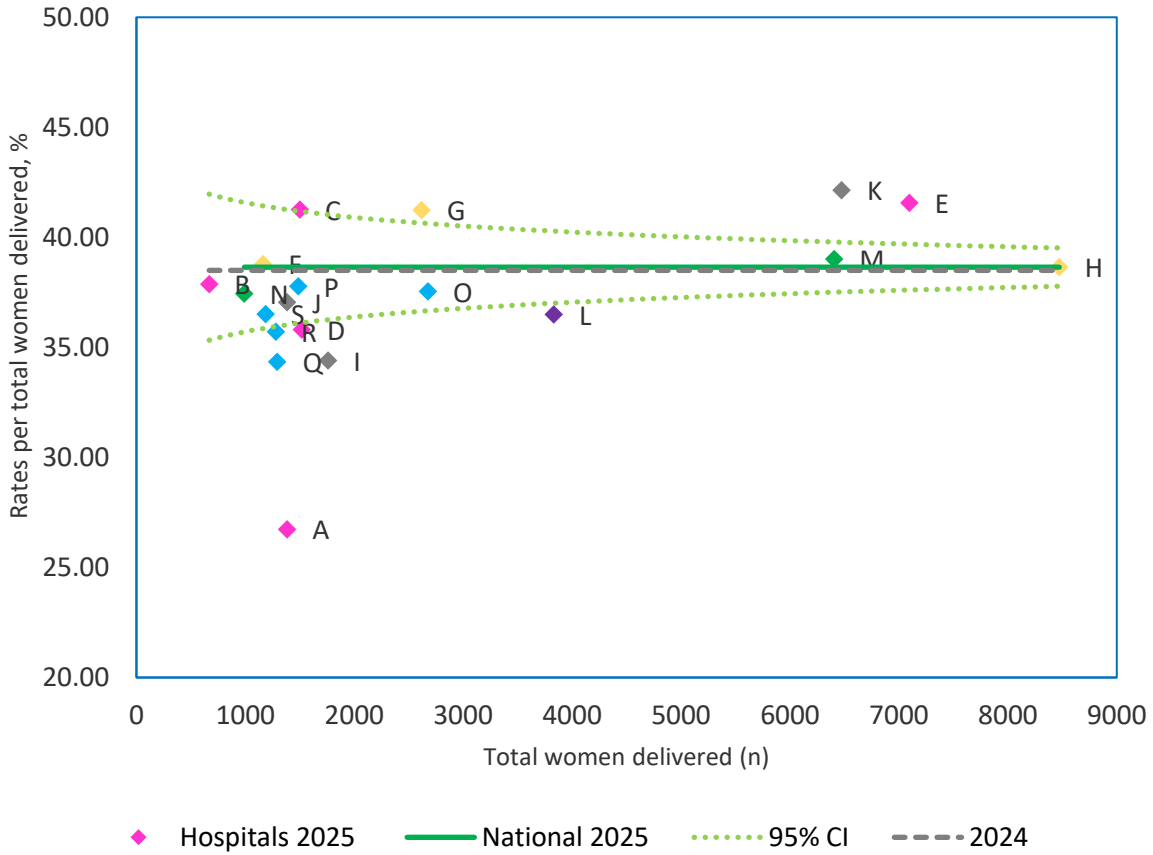
	2024	2025
Rates *(% multiparas)*	5.1%	5.2%
95% CI	4.8%-5.3%	5.0%-5.5%
Range	3.1%-8.5%	3.6%-8.9%
AVD among multiparas (n)	1,532	1,582
Total multiparas (n)	30,121	30,445

Induction of labour (IOL)



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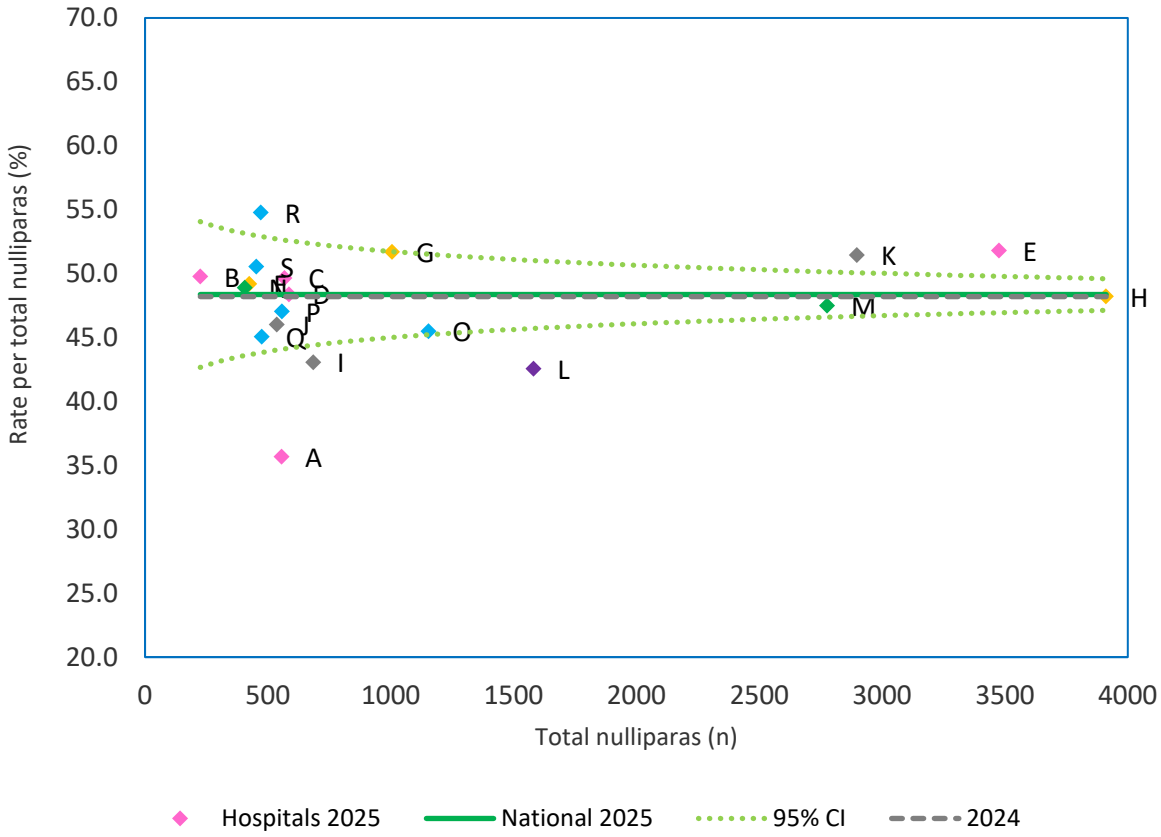
	2024	2025
Rates *(% total women delivered)*	38.5%	38.7%
95% CI	38.2%-38.9%	38.2%-39.0%
Range	24.9%-44.5%	26.7%-42.1%
Induction of labour (n)	20,132	20,556
Total women delivered (n)	52,328	53,191

Definition: Women undergoing inductions of labour, incl medical induction (with oxytocin or prostaglandin or other) and/or surgical induction by artificial rupture of membranes or other.

IOL among nulliparas



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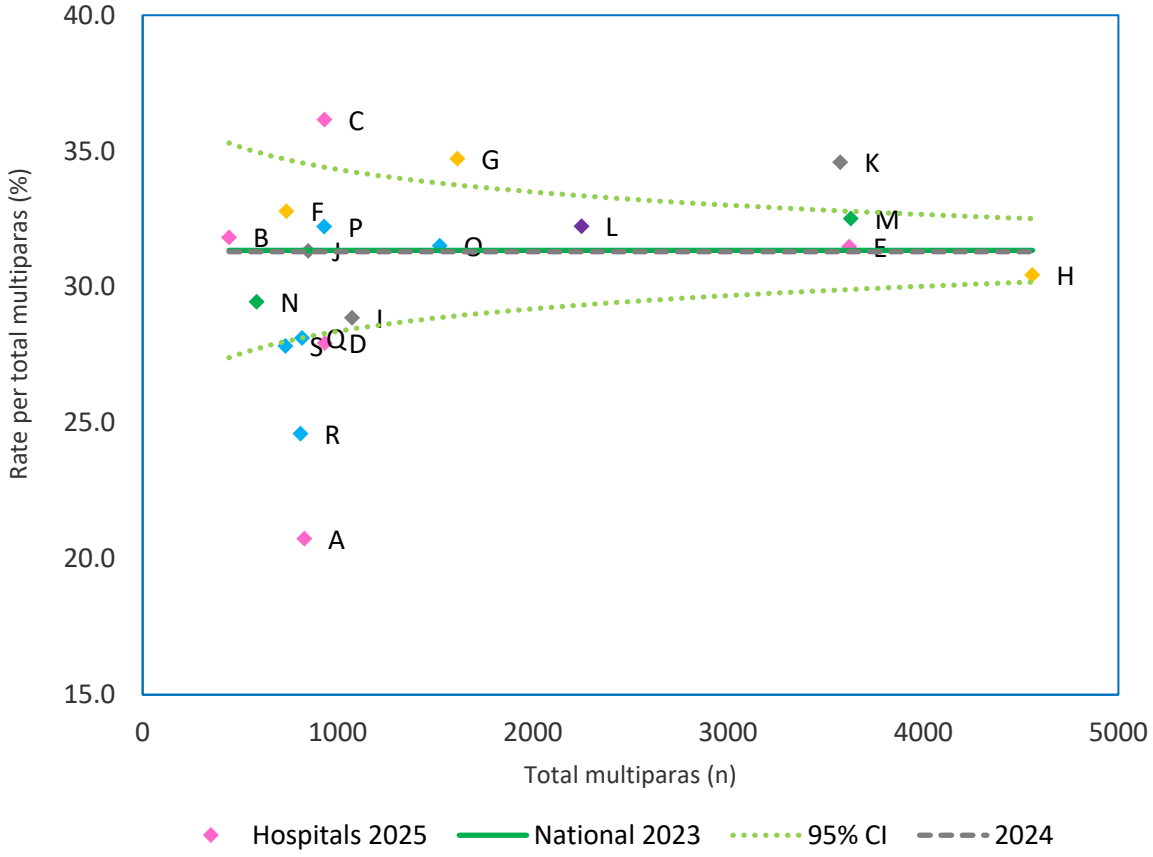
	2024	2025
Rate *(% nulliparas)*	48.2%	48.4%
95% CI	47.6%-48.9%	47.7%-49.0%
Range	29.6%-54.0%	42.5%-54.8%
IOL among nulliparas (n)	10,710	11,008
Total nulliparas (n)	22,207	22,747

IOL among multiparas



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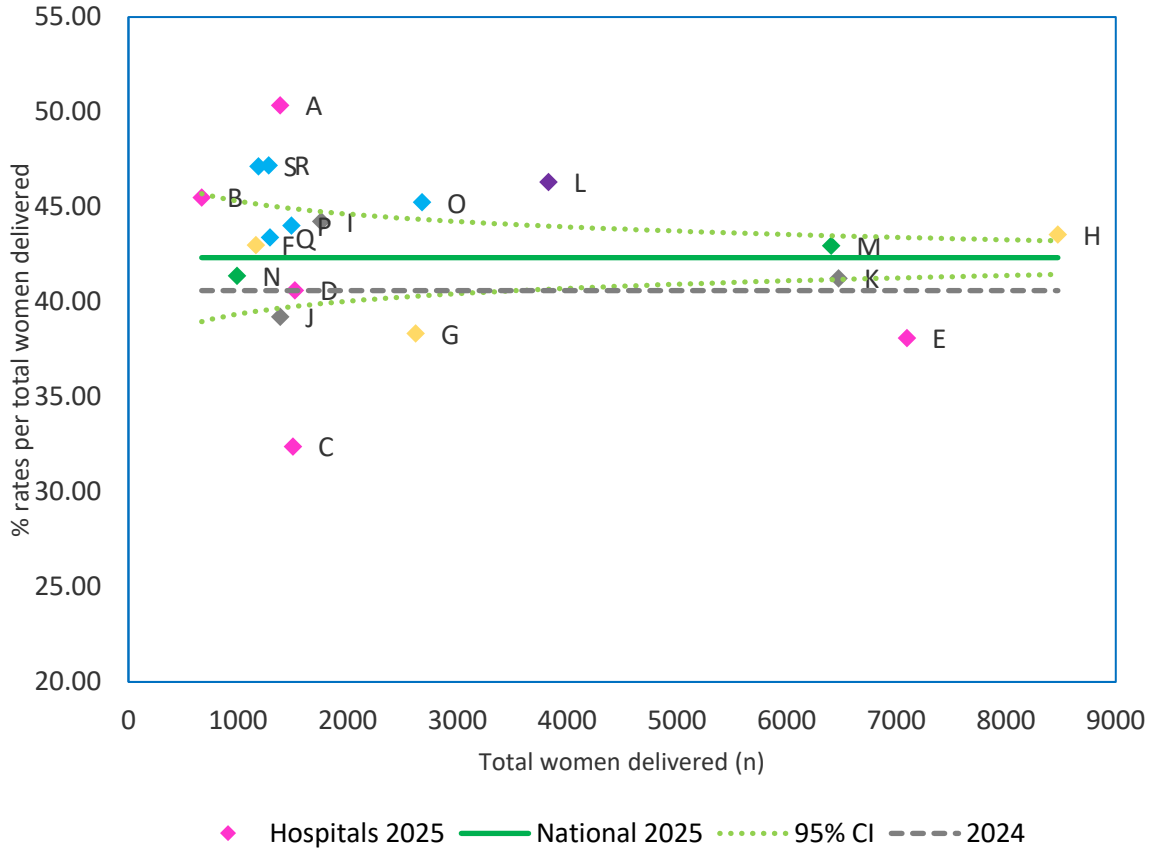
	2024	2025
Rate *(% multiparas)*	31.3%	31.4%
95% CI	30.8%-31.8%	30.8%-31.9%
Range	21.9%-37.9%	20.8%-36.2%
IOL among multiparas (n)	9,422	9,548
Total multiparas (n)	30,121	30,445

Total Caesarean sections (CS)



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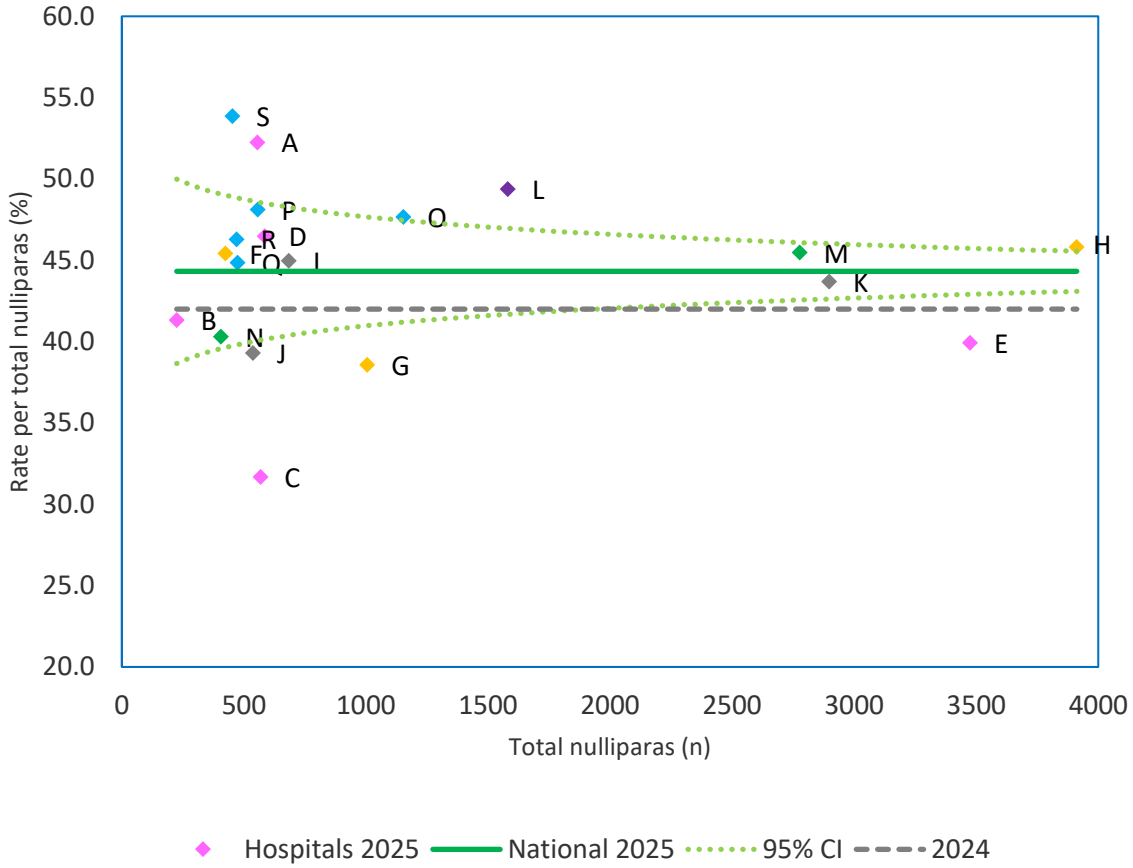
	2024	2025
Rate *(% total women delivered)*	40.6%	42.3%
95% CI	40.2%-41.0%	41.9%-42.8%
Range	34.1%-48.5%	32.4%-50.4%
Caesarean sections (n)	21,250	22,518
Total women delivered (n)	52,328	53,191

Note:

The CS rate for UHG includes women who were transferred in-utero and admitted and who subsequently gave birth in GUH (3.0%). The CS rate for woman who were initially booked and delivered at GUH (i.e., excluding the in-utero transferred women) was 42.2%, which is not a statistical outlier.

Definition: Women giving birth by Caesarean section, incl elective and emergency classical CS, and elective and emergency lower CS.

Caesarean sections among nulliparas



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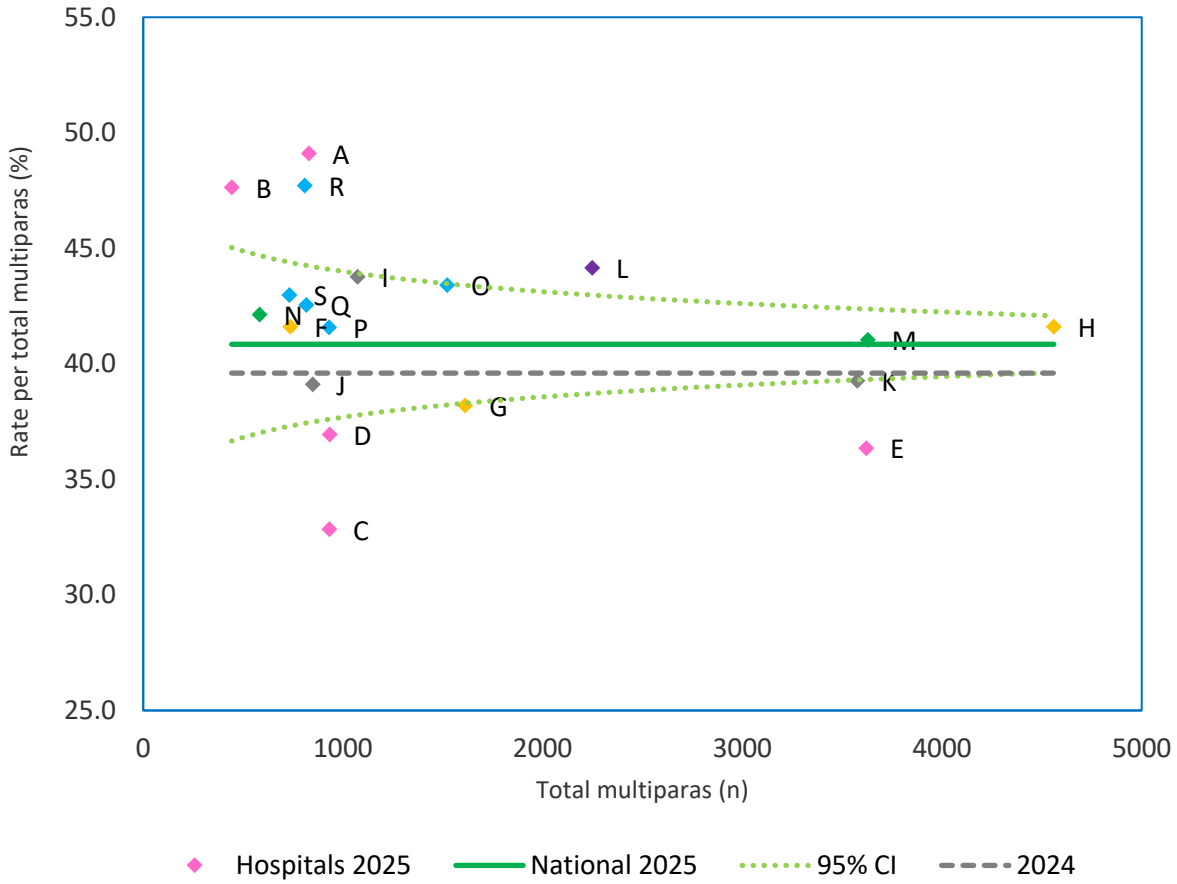
	2024	2025
Rate *(% nulliparas)*	42.0%	44.3%
95% CI	41.4%-42.7%	43.7%-45.0%
Range	36.0%-52.8%	31.7%-53.9%
CS among nulliparas (n)	9,338	10,082
Total nulliparas (n)	22,207	22,747

Caesarean sections among multiparas



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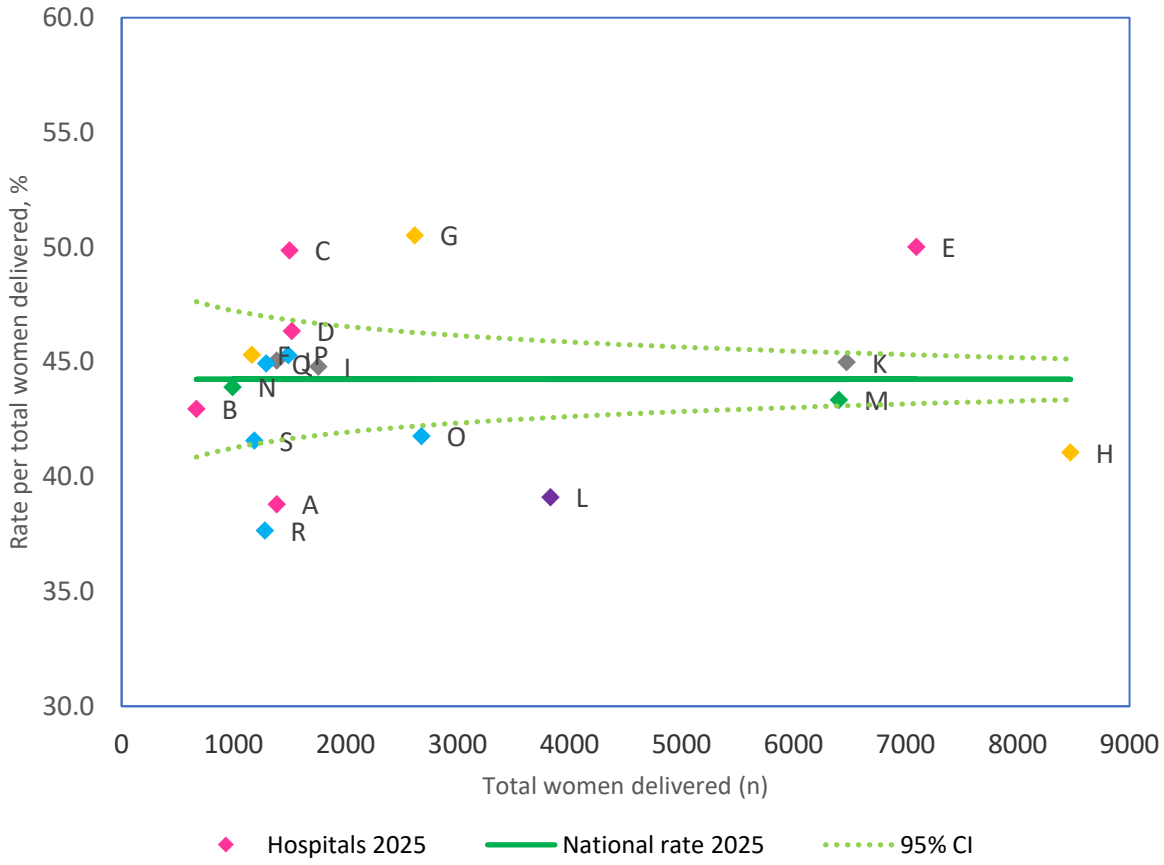
	2024	2025
Rate *(% multiparas)*	39.6%	40.9%
95% CI	39.0%-40.1%	40.3%-41.4%
Range	32.8%-45.9%	32.8%-49.1%
CS among multiparas (n)	11,912	12,436
Total multiparas (n)	30,121	30,445

Total Spontaneous vaginal deliveries (SVD)



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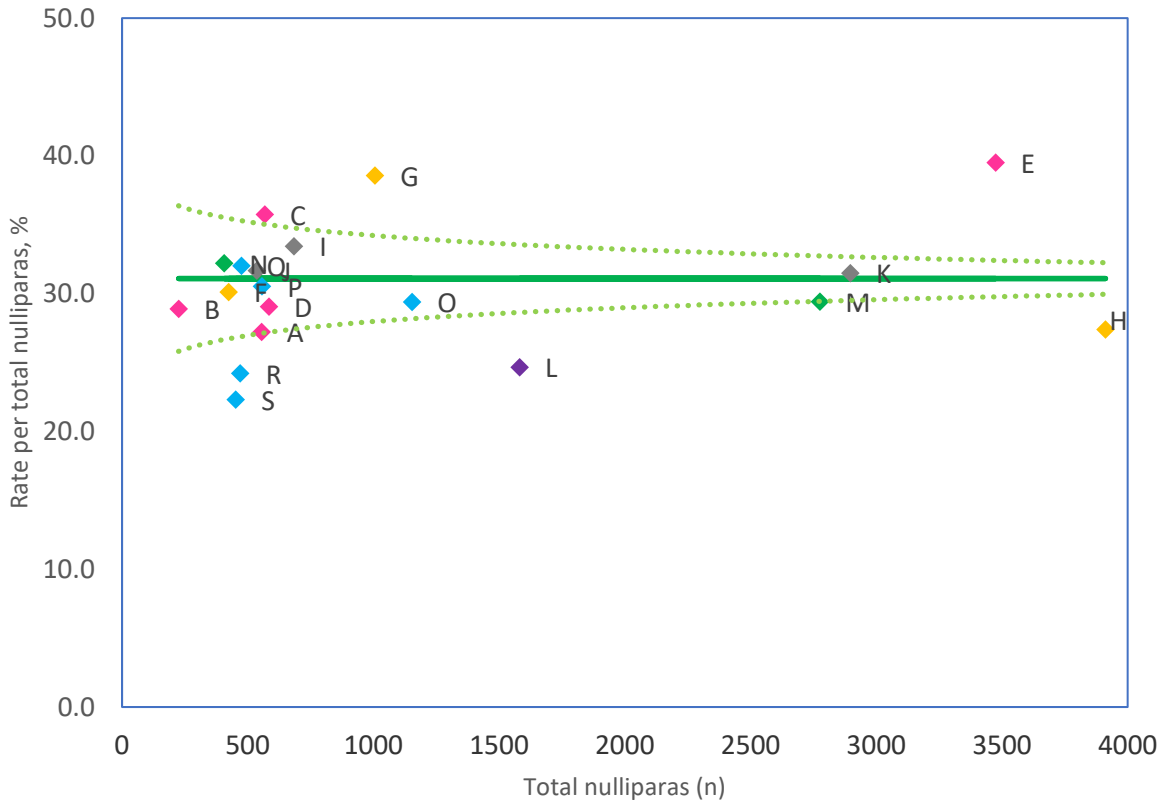
	2024	2025
Rate *(% total women delivered)*	--	44.2%
95% CI	--	43.8%-44.7%
Range	--	37.7%-50.5%
Total SVD (n)	--	23,534
Total women delivered (n)	52,328	53,191

Definition: Women with a spontaneous vaginal delivery (SVD)/delivery that happens without requiring doctors/midwives or tools, after labour, cervix dilated to at least 10cms.

SVD among nulliparas



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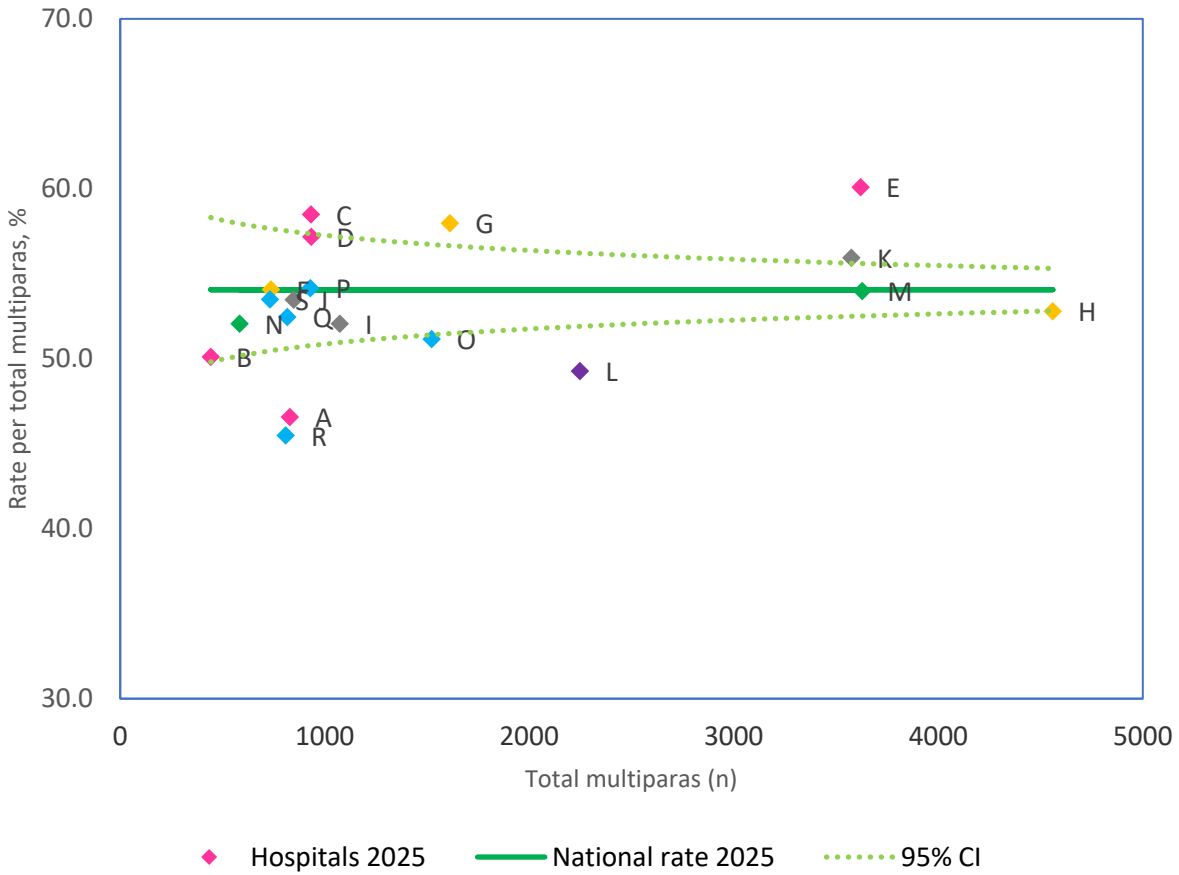
	2024	2025
Rate *(% nulliparas)*	--	31.1%
95% CI	--	30.5%-31.7%
Range	--	22.3%-39.5%
SVD among nulliparas (n)	--	7,074
Total nulliparas (n)	--	22,747

SVD among multiparas



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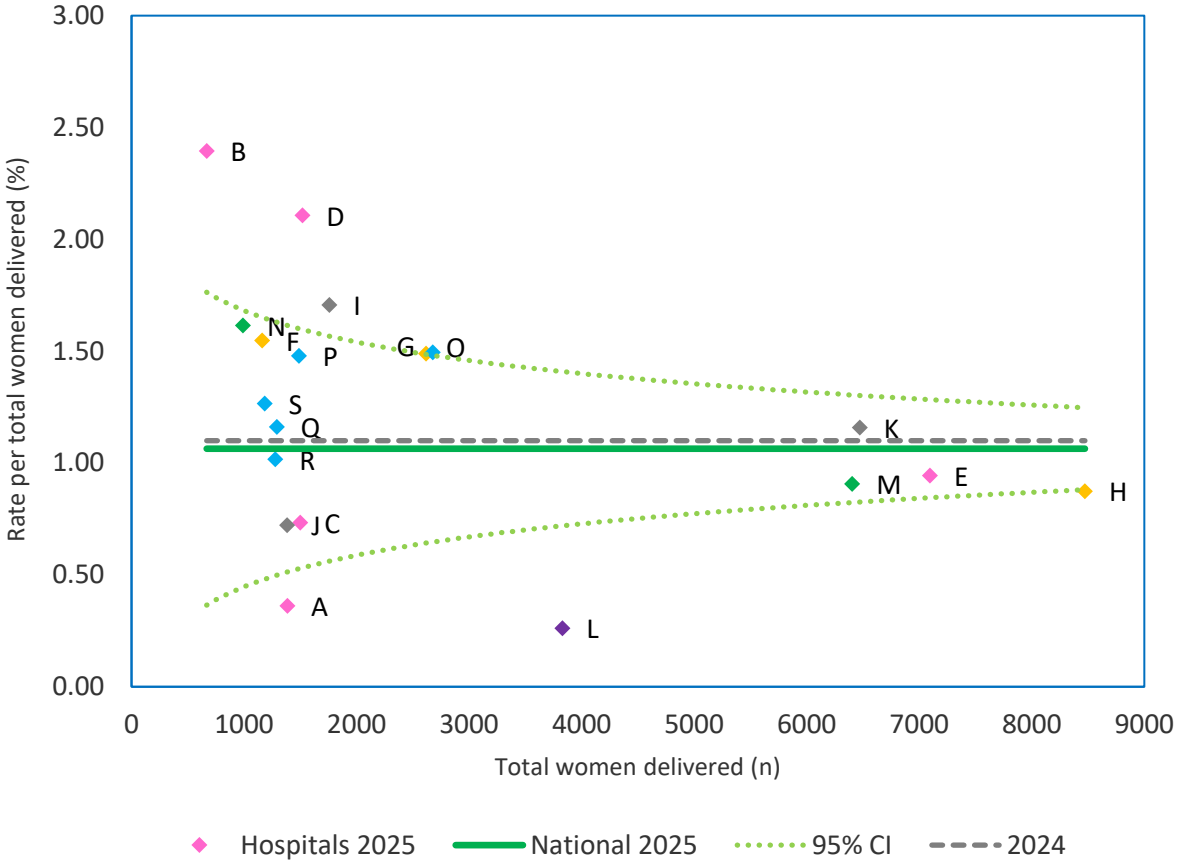
	2024	2025
Rate *(% multiparas)*	--	54.1%
95% CI	--	53.5%-54.6%
Range	--	45.5%-60.1%
SVD among multiparas (n)	--	16,460
Total multiparas (n)	--	30,445

Caesarean sections at full dilatation



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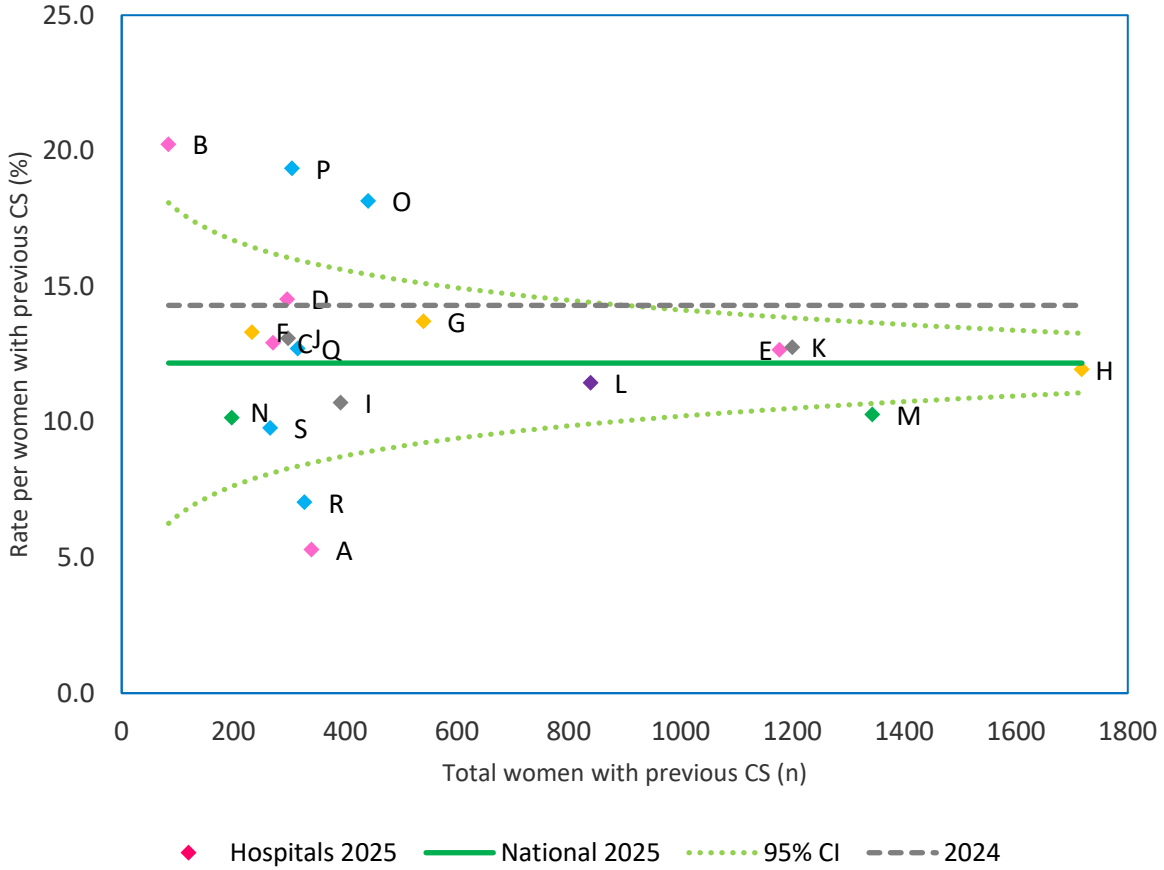
Hospitals 2025 — National 2025 — 95% CI — 2024

	2024*	2025
Rate *(% total women delivered)*	1.10%	1.06%
95% CI	1.00%-1.19%	0.98%-1.15%
Range	0.15%-2.33%	0.26%-2.40%
CS at full dilatation (n)	503	566
Total women delivered (n)	45,857*	53,191

Definition: Women with a Caesarean section at full cervical dilatation (with or without attempt at assisted vaginal delivery).

**Missing data at CUMH for 2024 and partial/incomplete data from several units.*

Vaginal births after Caesarean sections (VBAC)



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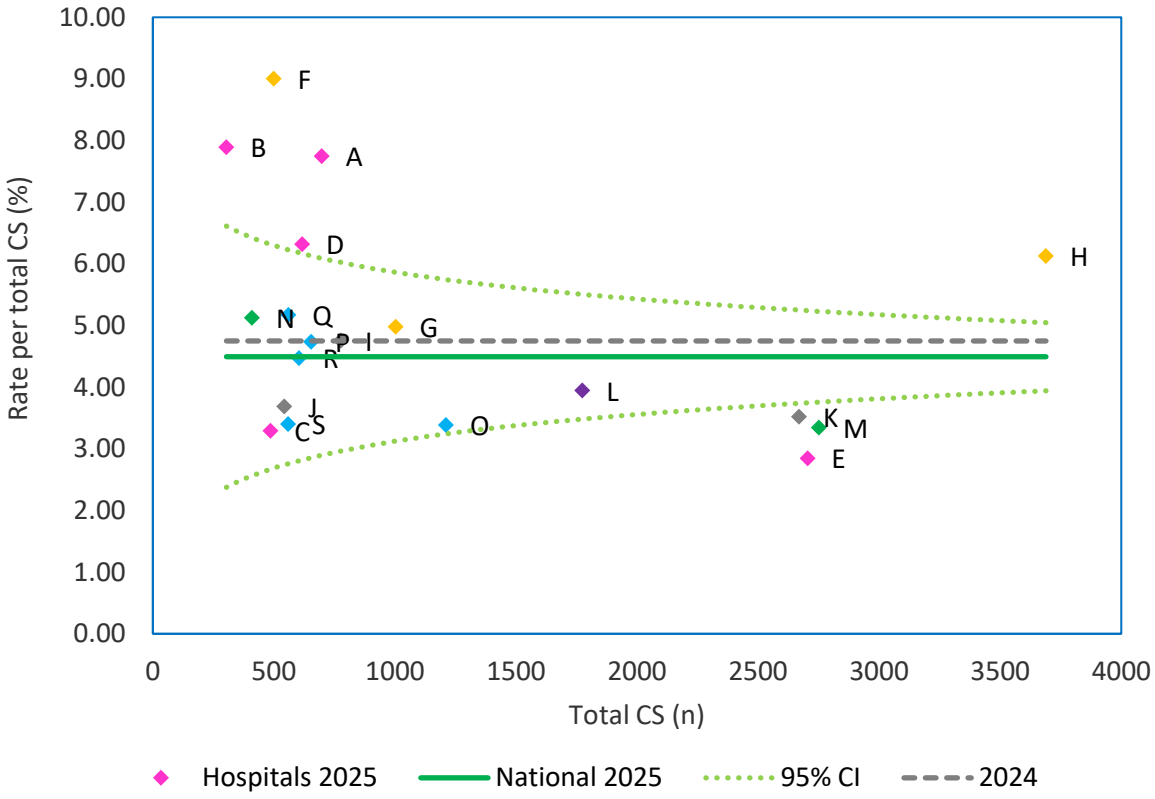
	2024	2025
Rate *(% women with previous CS)*	14.3%	12.2%
95% CI	13.7%-15.0%	11.6%-12.8%
Range	6.5%-28.1%	5.3%-20.2%
VBAC (n)	1,435	1,288
Total women with previous CS (n)	10,008	10,582

Definition: Successful vaginal delivery after one previous Caesarean section (not failed VBAC). Denominator: Number of women who had a previous CS (at any time prior to the current pregnancy).

General anaesthetic for Caesarean sections



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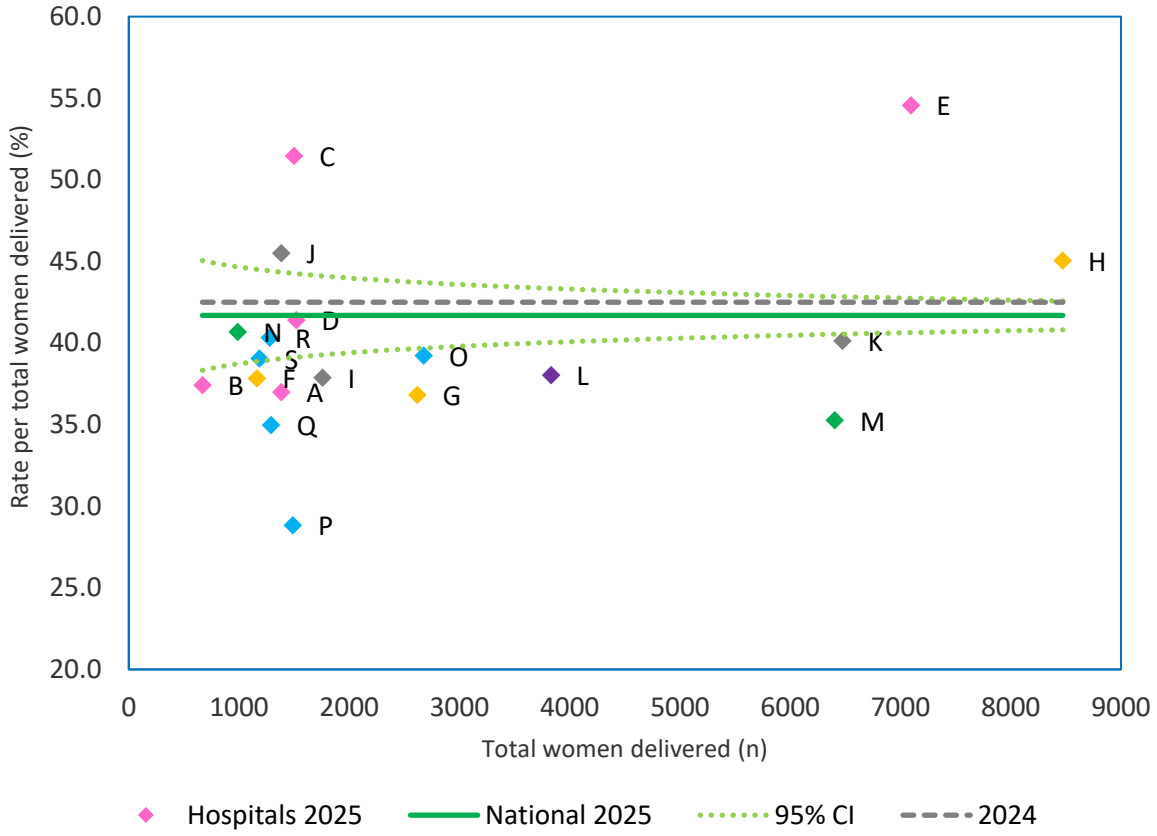
	2024	2025
Rates *(per total CS (%))*	4.8%	4.5%
95% CI	4.5%-5.0%	4.2%-4.8%
Range	2.2%-9.7%	2.9%-9.0%
GA for CS (n)	1,009	1,012
Total Caesarean sections (n)	21,250	22,518

Definition: Women who underwent CS and were administered a general anaesthetic (GA), incl primary GA and conversion to GA from regional anaesthetic (epidural or spinal).

Labour epidurals



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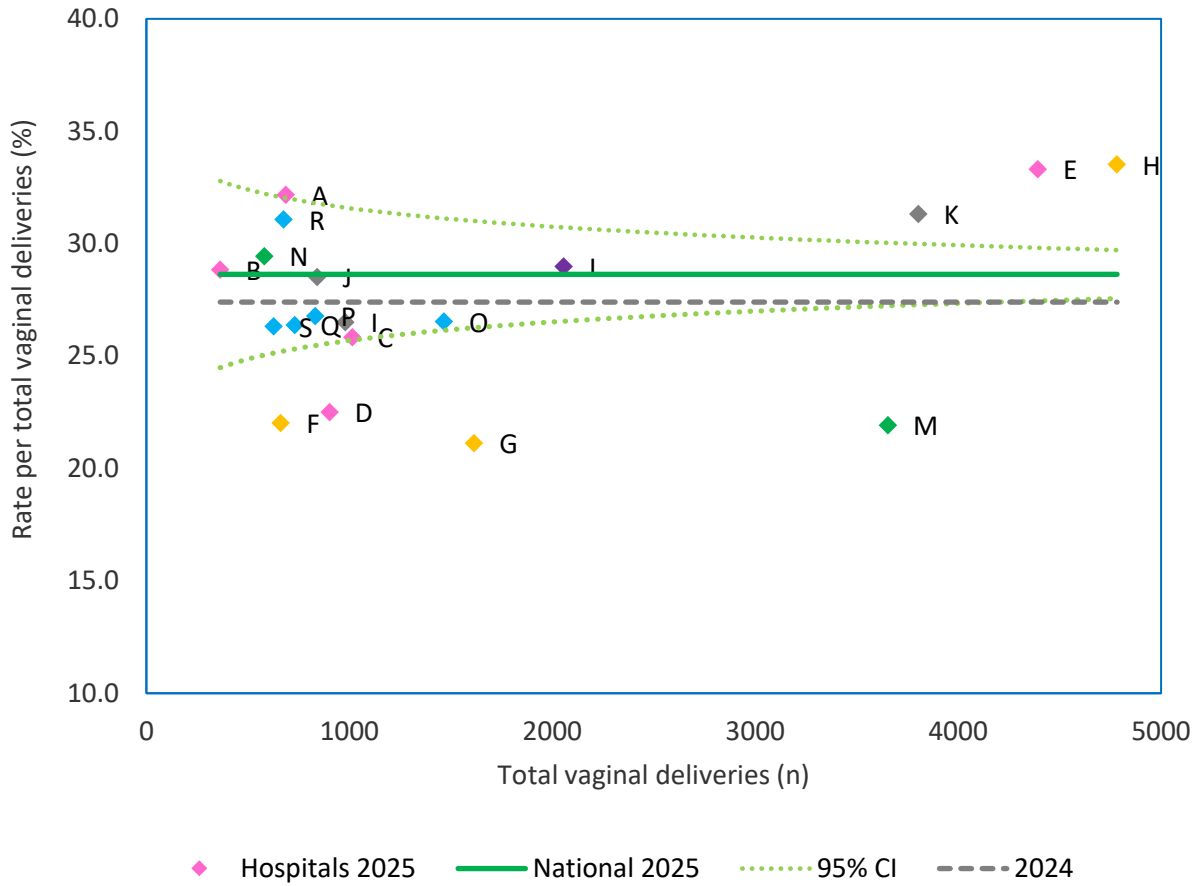
	2024	2025
Rates *(% per total women delivered)**	42.5%	41.7%
95% CI	42.1%-42.9%	41.3%-42.1%
Range	29.7%-52.9%	28.8%-54.6%
Labour epidurals (n)	22,244	22,176
Total women delivered (n)	52,328	53,191

*Definition: Women for whom labour epidurals were administered, incl Neuraxial block during labour and Neuraxial block during labour and delivery procedure. Does not refer to spinal anaesthesia. *Note: The base 'per total women delivered' is a proxy denominator for total women in labour.*

Episiotomies



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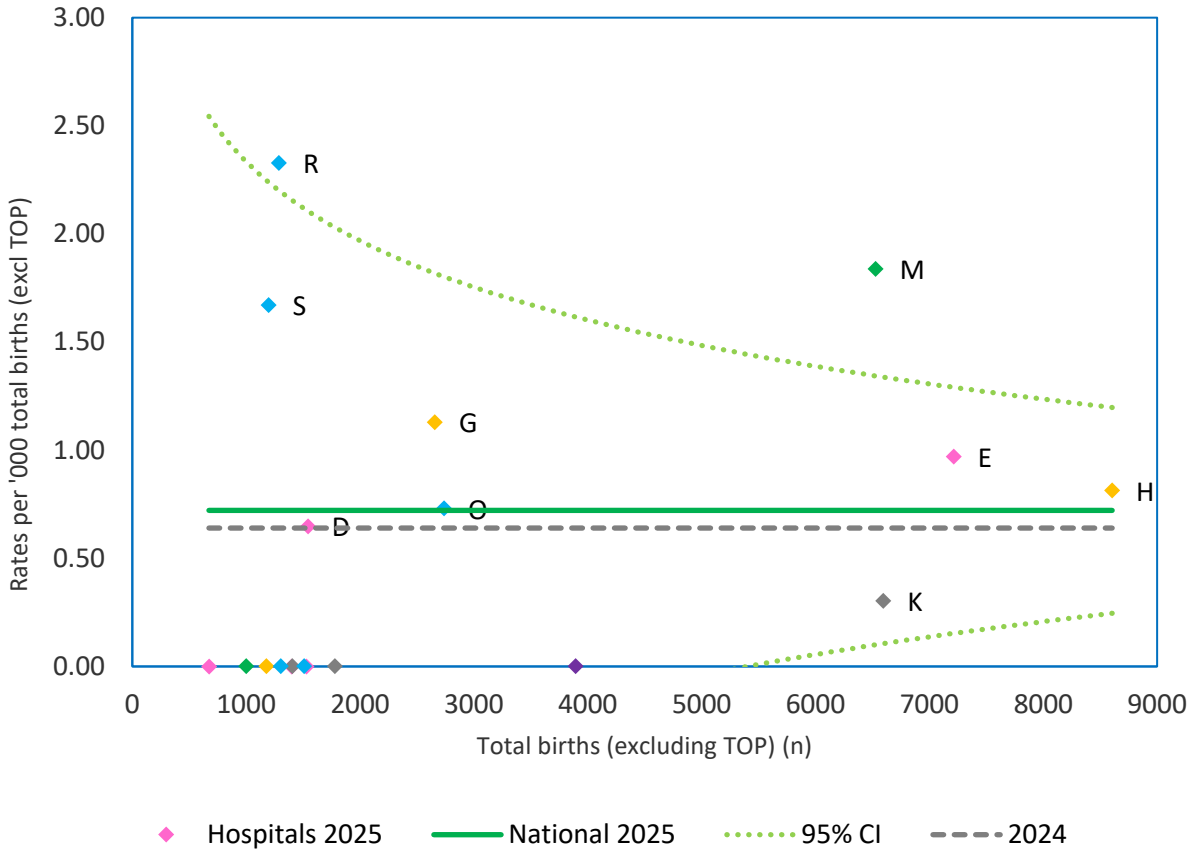
	2024	2025
Rates *(per total vaginal deliveries (%)*	27.4%	28.6%
95% CI	26.6%-27.9%	28.1%-29.1%
Range	19.6%-32.4%	21.1%-33.5%
Episiotomies (n)	8,515	8,783
Total vaginal deliveries (n)	31,082	30,673

Definition: Women who had a vaginal delivery undergoing episiotomy procedures.

IMIS 2024: Neonatal care

Obstetric, brachial plexus injury (BPI)



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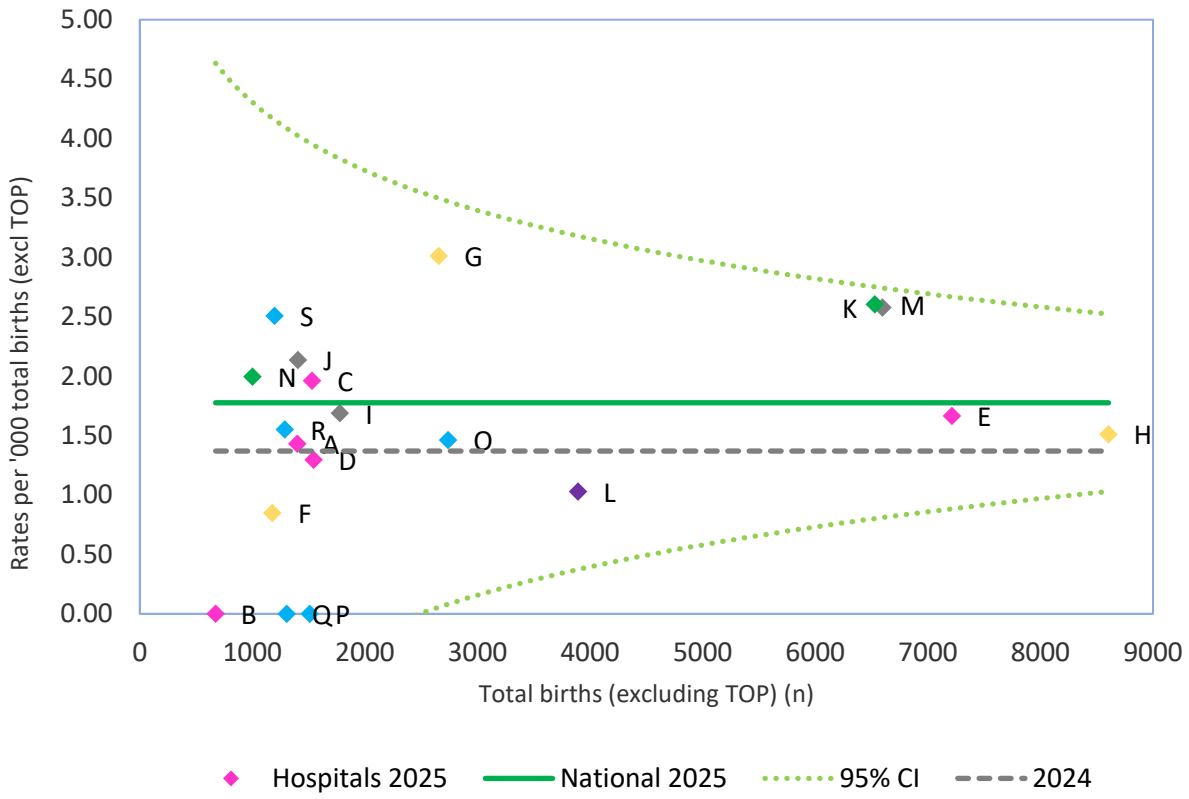
	2024	2025
Rate *(per '000 total births, excl TOP)*	0.64	0.72
95% CI	0.42-0.85	0.50-0.95
Range	0.00-2.28	0.00-2.33
Brachial plexus injury (n)	34	39
Total births /Total births (excl TOP)* (n)	53,185	54,046

Definition: Babies diagnosed with Brachial Plexus Injury at two weeks after birth, i.e., the injury should still be present two weeks after birth.

**Note: Rates for 2024 are based on denominator, Total births; Rates for 2025 based on Total birth excluding termination of pregnancy (TOP)*

Neonatal encephalopathy (NE)



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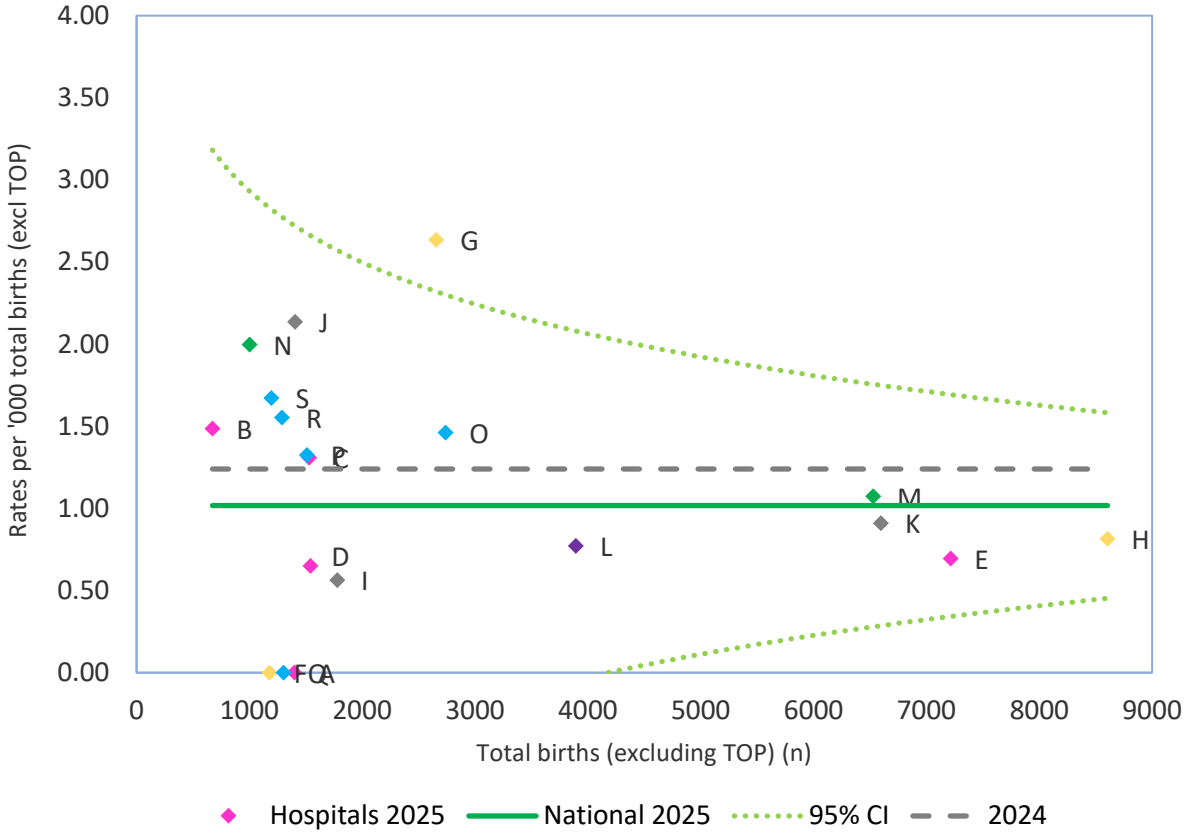
	2024	2025
Rate *(per '000 total births, excl TOP)*	1.37	1.78
95% CI	1.06-1.69	1.42-2.13
Range	0.00-4.59	0.00-3.01
Neonatal encephalopathy (n)	73	96
Total births / Total births excl TOP* (n)	53,185	54,046

Definition: Babies diagnosed with NE (moderate or severe). (See IMIS Manual 2024 for further details).

** Note: Rates for 2024 are based on denominator, Total births; Rates for 2025 based on Total birth excluding termination of pregnancy (TOP) (the comparable rate with 2024 (per Total births) is 1.78 per '000).*

Therapeutic hypothermia (TH)



Hospitals 2025 — National 2025 ····· 95% CI – – 2024

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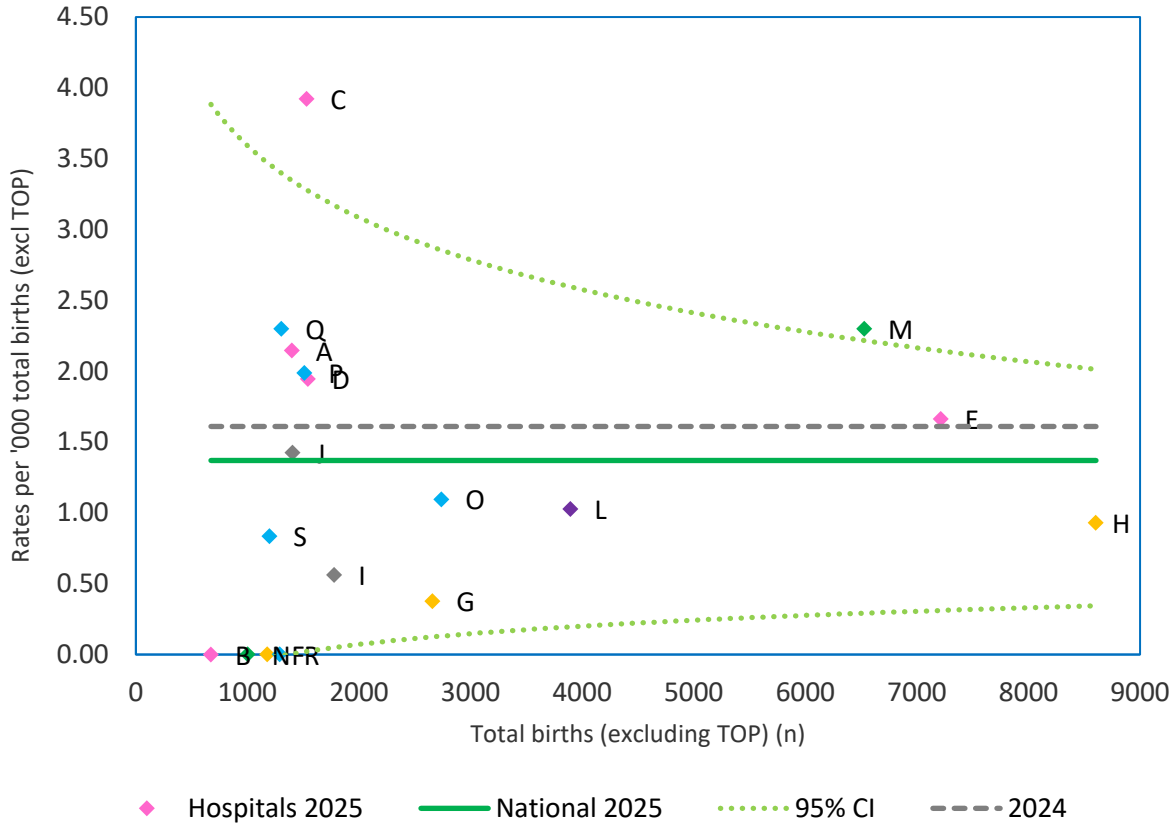
	2024	2025
Rate *(per '000 total births, excl TOP)*	1.24	1.02
95% CI	0.94-1.54	0.75-1.29
Range	0.00-3.82	0.00-2.63
Therapeutic hypothermia (n)	66	55*
Total births / Total births (excl TOP)* (n)	53,185	54,046

Definition: Active 'whole body' neonatal cooling (not passive), administered during the current birth episode as a treatment for NE. (See IMIS Manual 2025 for further details.)

Rates for 2024 are based on the denominator, Total births; Rates for 2025 based on Total birth excluding TOP (comparable rate with 2024 is 1.02 per '000).

**Two infants included were transferred with the intention to receive TH treatment, but did not complete the full cooling period.*

Neonatal sepsis (positive blood cultures)



Hospitals 2025 — National 2025 ····· 95% CI - - - 2024

Dublin & SE	A	St Luke's Hospital Kilkenny
	B	Tipperary University Hospital
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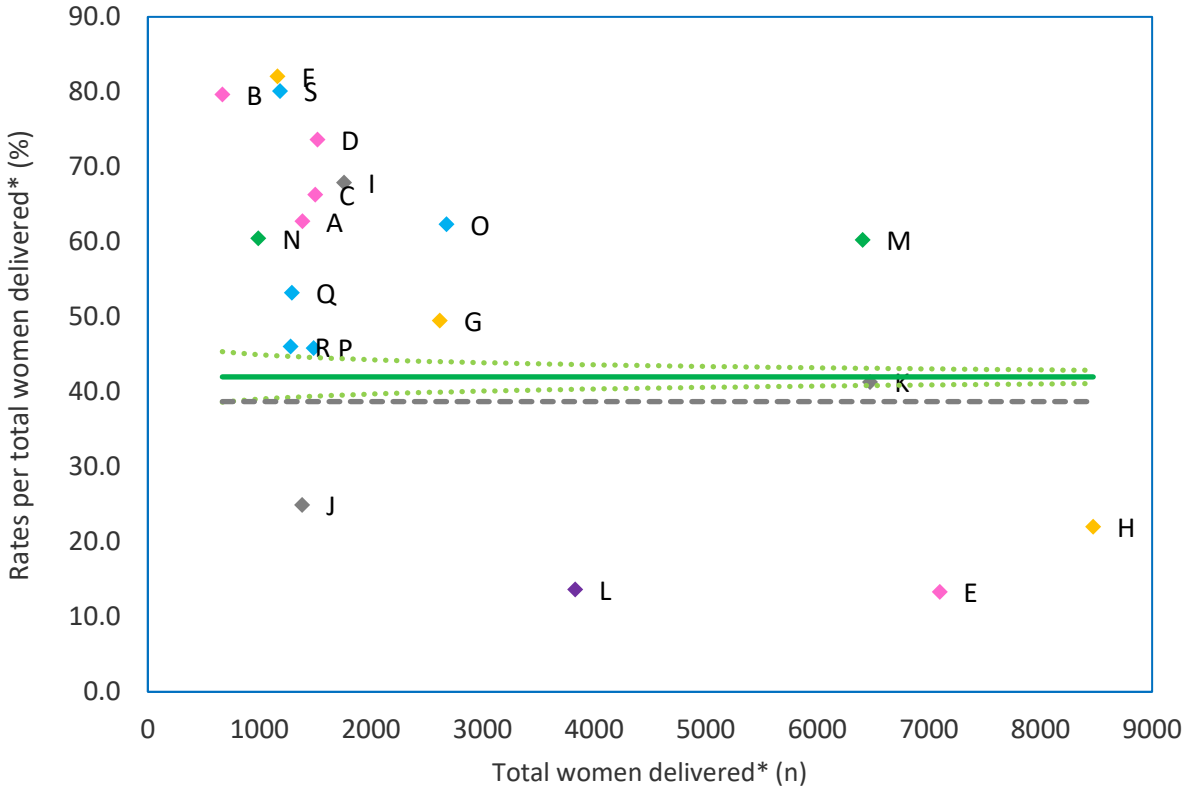
	2024*	2025*
Rate *(per '000 total births, excl TOP)*	1.61	1.37
95% CI	1.24-1.97	1.04-1.70
Range	0.00-2.99	0.00-3.92
Neonatal sepsis (n)	75	65
Total births / Total births excl TOP* (n)	46,679	47,493

*Definition: Infants ≤28 days old diagnosed with Sepsis positive blood culture of a known pathogen. Include all early-onset sepsis (occurring within the first 24 hours to first week of life) and late-onset sepsis (after 24 hours or after the first week of life, up to 28 days). Note: Rates for 2024 are based on denominator, Total births; Rates for 2025 based on Total birth excluding TOP (the comparable rate with 2024 (per Total births) is 1.37 per '000). *Missing data from Coombe Maternity Hospital in 2024 and 2025.*

IMIS 2024: Antenatal & Postnatal activities

EPAU first visits



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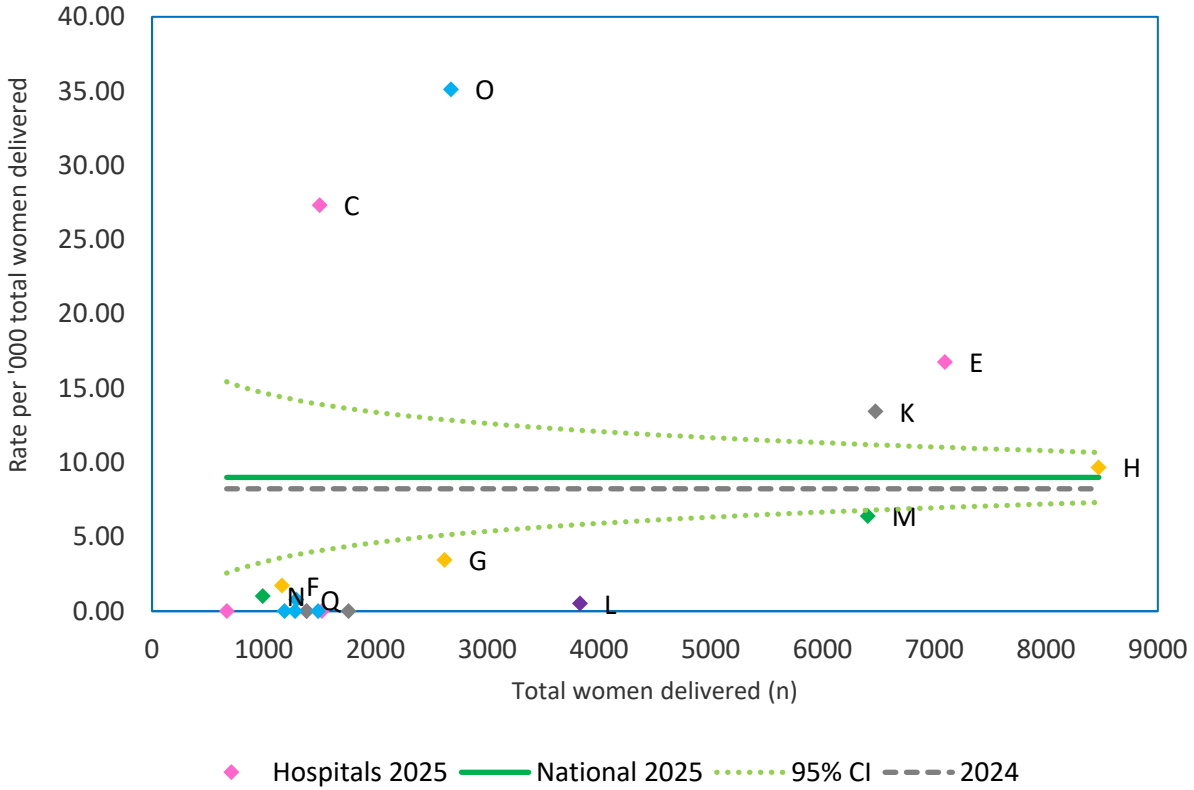
	2024	2025
Rate *(% of total women delivered)*	38.7%	42.0%
95% CI	38.3%-39.1%	41.6%-42.4%
Range	10.0%-85.4%	13.3%-82.0%
EPAU first visits (n)	20,234	22,336
Total women delivered* (n)	52,328	53,191

Note:
There is a high level of over-dispersion, or variation, on this metric, suggesting that some units may be using the EPAU for a multiplicity of uses, including as a booking mechanism.

Definition: Number of first visits to Early Pregnancy Assessment Unit (EPAU) during current month (do not count combined first and return visits).

**The denominator 'per total women delivered' is a proxy denominator denoting the overall level of capacity of the maternity hospital/unit*

In utero transfers admitted



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	2024	2025
Rate *(per '000 women delivered)*	8.24	9.01
95% CI	7.46-9.01	8.20-9.81
Range	0.00-24.79	0.00-35.11
In-utero transfers admitted (n)	431	479
Total women delivered (n)	52,328	53,191

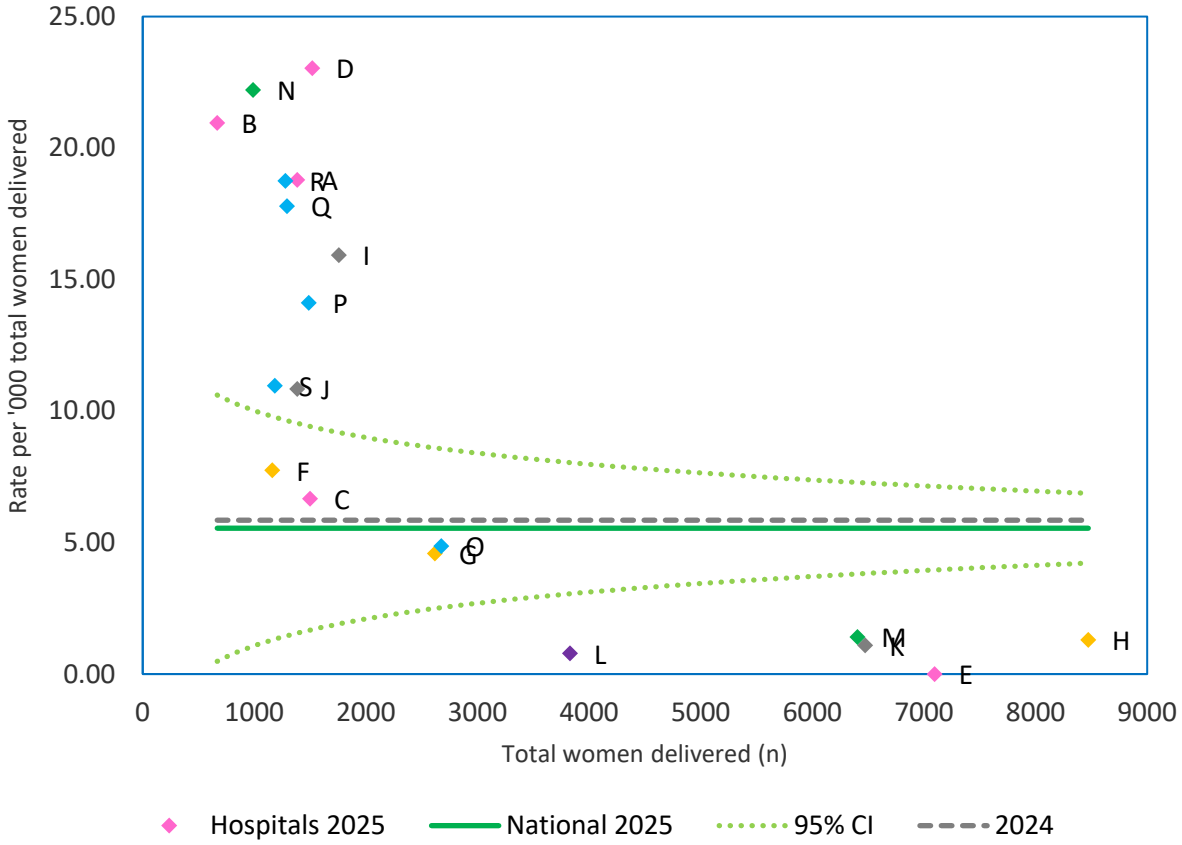
Notes:

There is a tradition of in utero transfers at UHW.

As part of integration of Maternity services at UHG and PUH and in light of referral criteria for Fetal and Maternal High-Risk Care in the WNW region, 94 women were transferred to UHG during pregnancy in 2025. Some transferred back to original booking unit or to Level 1 Unit.

Definition: Women with fetus in-utero admitted into the hospital after being transferred from another hospital in the fetal interest, during the current birth episode.

In utero transfers sent out



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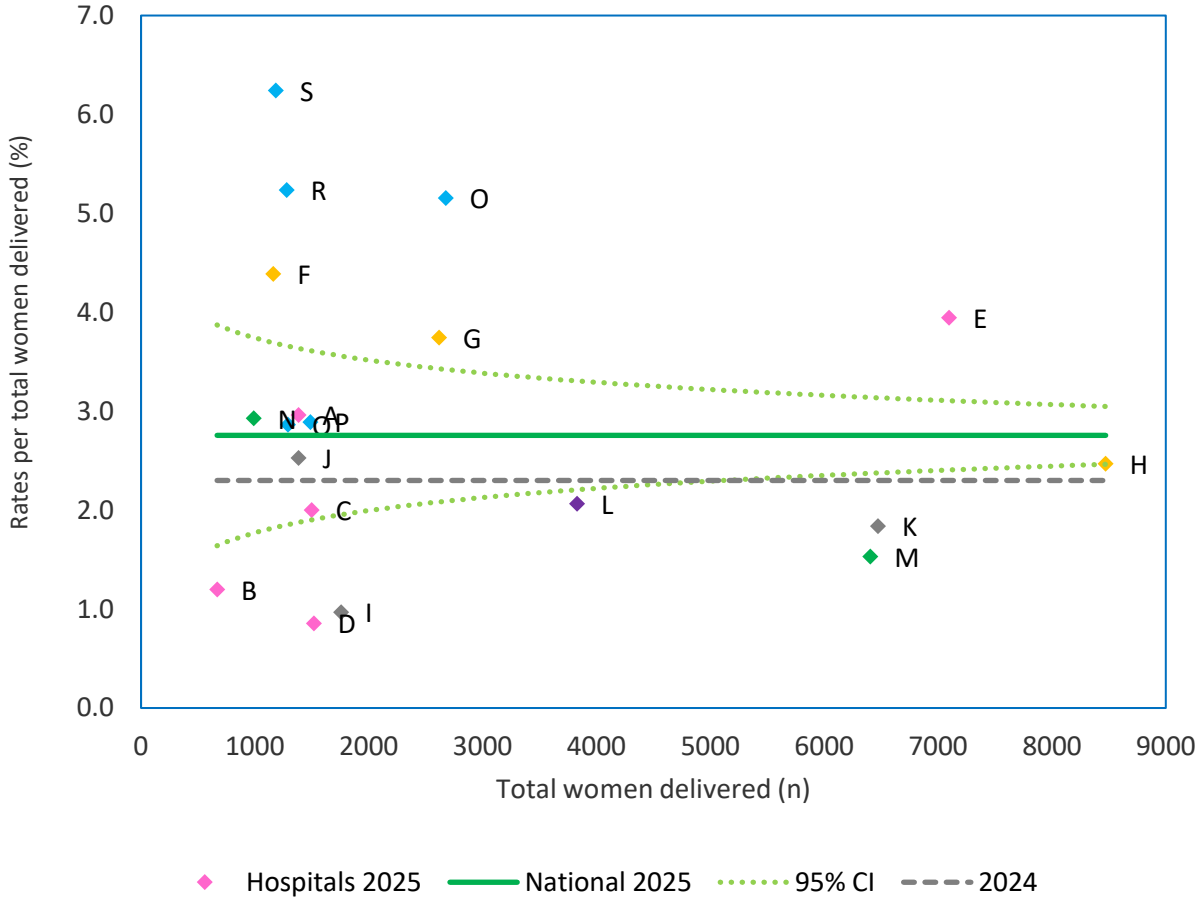
	2024	2025
Rate *(per '000 women delivered)*	5.85	5.55
95% CI	5.19-6.50	4.91-6.18
Range	0.00-27.33	0.00-23.04
In-utero transfers sent out (n)	306	295
Total women delivered (n)	52,328	53,191

Definition: Women with fetus in-utero transferred to another hospital in the fetal interest, during current birth episode (refers to transfers of inpatients only, not outpatients.)

Readmissions up to seven days after discharge



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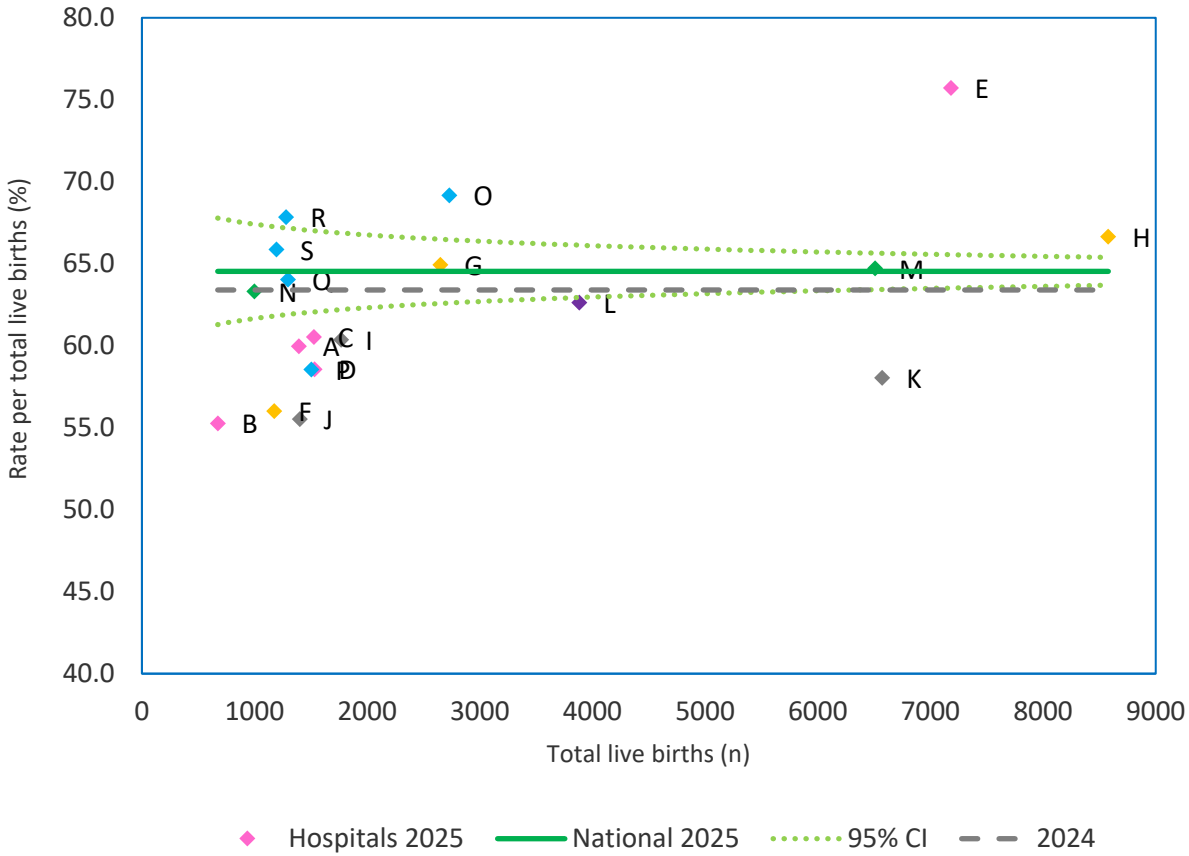
	2024	2025
Rate *(% total women delivered)*	2.30%	2.76%
95% CI	2.17%-2.43%	2.62%-2.90%
Range	0.48%-5.59%	0.86%-6.24%
Readmissions up to seven days (n)	1,202	1,466
Total women delivered (n)	52,328	53,191

Definition: Women readmitted to the same maternity hospital/unit up to seven completed days after discharge following delivery.

IMIS 2024: Breastfeeding

Any Breastfeeding *(derived)*



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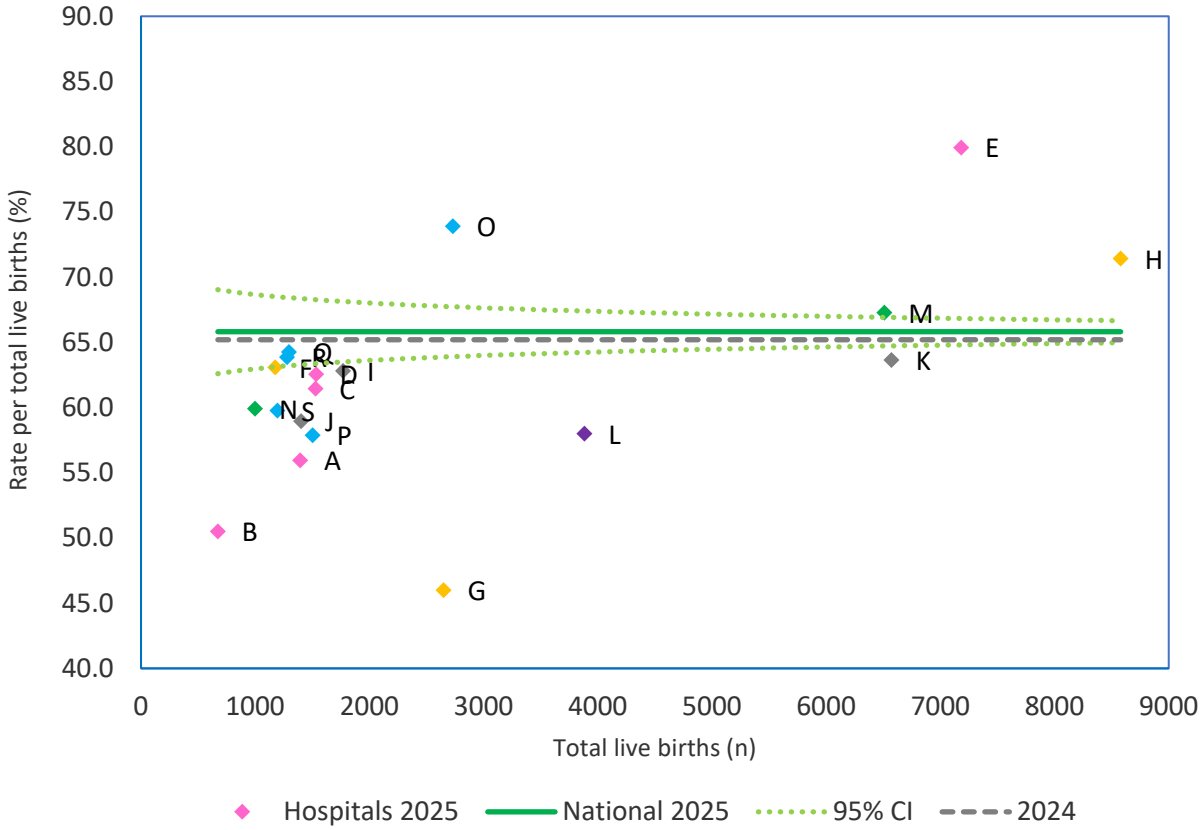
	2024*	2025
Rate *(% total live births)*	63.4%	64.5%
95% CI	63.0%-63.8%	64.1%-64.9%
Range	50.8%-75.7%	55.3%-75.7%
Any breastfeeding (n)	31,155	34,764
Total live births (n)	49,125	53,868

*Derived variable based on numbers of babies exclusively and non-exclusively breastfed prior to discharge from the hospital/unit. *Missing data from UMHL in 2024*

Breastfeeding initiation



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	2024	2025
Rate *(% total live births)*	65.2%	65.8%
95% CI	64.8%-65.6%	65.4%-66.2%
Range	44.9%-78.9%	46.0%-80.0%
Breastfeeding initiation (n)	34,548	35,454
Total live births (n)	53,000	53,868

Definition: Babies breastfed at first feed following birth, i.e., direct from the breast or expressed. Include babies transferred to NICU whose first feed after birth is EBM/Donor milk.

Include babies transferred to NICU who are given IV fluids/TPN initially and then given breastmilk as their first feed.

Appendices

Appendix 1. IMIS data collection form (2025)

			Previous year		Current year	
			Month	YTD	Month	YTD
A DEMOGRAPHICS	1.	Total women delivered *(baby ≥400g, 23+wks)* (n)				
	2.	Parity: Total nulliparous / Total multiparous women (n)				
	3.	Total births *(≥400g, 23+wks)* (n)				
	4.	Total live births (n)				
	5.	Total multiple pregnancies (n)				
	6.	Total maternal deaths (n)				
	7.	Total perinatal deaths (n)				
	8.	Adjusted perinatal deaths (n)				
B OBSTETRIC RISKS	9.	Maternal sepsis (n)				
	10.	Ectopic pregnancies, total / transfused (n)				
	11.	Eclampsia (n)				
	12.	Uterine ruptures: Total / VBAC,TOLAC (n)				
	13.	Peripartum hysterectomy (n)				
	14.	Pulmonary embolism (n)				
	15.	Perineal tears (3^{rd}/4^{th} degree), including by Parity (n)				
	16.	Primary PPH, Vaginal deliveries / CS (n)				
	17.	Obstetric blood transfusions (n)				
	18.	Miscarriage misdiagnosis (n)				
	19.	Retained swabs (n)				
	20.	Episiotomies (n)				
C DELIVERIES, ANAESTHESIA	21.	General anaesthetic for Caesarean sections (n)				
	22.	Labour epidurals (n)				
	23.	Spontaneous vaginal deliveries, including by Parity (n)				
	24.	Assisted vaginal deliveries (AVD): including by Parity (n)				
	25.	Inductions of labour (IOL): including by Parity (n)				
	26.	Caesarean sections (CS): including by Parity (n)				
	27.	CS at full dilatation (n)				
	28.	VBAC (Vaginal birth after CS) (n)				
	29.	Women with previous CS (n)				
D NEONATE	30.	Obstetric Brachial Plexus Injury (n)				
	31.	Neonatal Encephalopathy (n)				
	32.	Therapeutic Hypothermia (n)				
	33.	Neonatal sepsis: EONS / LONS (n)				
E ACTIVITIES	34.	EPAU first visits (n)				
	35.	Maternal critical care *(ICU/CCU, Level 2/Level 3)* (n)				
	36.	Readmissions up to seven days post-discharge (n)				
	37.	In-utero transfers admitted (n)				
	38.	In-utero transfers sent out (n)				
F BF	39.	Breastfeeding initiation (n)				
	40.	BF exclusively/non-exclusively (n)				

Appendix 2. IMIS Officers/Teams in the 19 maternity hospitals/units

Cavan General Hospital Karen Malocca, Lisa Brady, Georgina Crowe, Claire Kelly, Jessica Spendlow

Cork University Maternity Hospital Claire Everard, Katie Bourke, Claire O'Halloran, Mairéad O'Riordan

The Coombe Hospital Julie Sloan, Emma McNamee

Our Lady of Lourdes Hospital, Drogheda Maeve Gaynor, Emily McAteer, Áine Curtis, Mercy Tanimola Omoyemwense

Galway University Hospital Clare Greaney, Anne-Marie Grealish, Helen Murphy

University Hospital Kerry Mary Stack-Courtney, Mairéad Griffin, Sandra O'Connor

St Luke's Hospital, Kilkenny Ann Margaret Hogan, Kayla Thornton

Letterkenny University Hospital Billie Ní Riada, Marion Doogan, Mary Lynch, Alison Johnston, Evelyn Smith

University Maternity Hospital Limerick Stephen Culligan, Indraneel Kotoki, Caroline Dickinson

Mayo University Hospital Kathryn Henry, Jacinta Byrne, Louise O'Malley, Andrea McGrail

Regional Hospital, Mullingar Maureen Revilles, Emma Lally

National Maternity Hospital, Dublin Fionnuala Byrne, Cillian Power

Portiuncula University Hospital Sheila Melvin, Deirdre Naughton, Diane Fitzgerald, Ann Marie Culkin

Midland Regional Hospital, Portlaoise Ita Kinsella, Melanie Adams

Rotunda Hospital, Dublin Kathy Conway

Sligo University Hospital Geraldine O'Brien, Ita Morahan, Juliana Henry

Tipperary University Hospital Maggie Dowling, Anastasia McGuigan

University Hospital Waterford Janet Murphy, Gemma Fitzpatrick, Bríd Galvin

Wexford General Hospital Norma Doyle, Helen McLoughlin

Appendix 3. IMIS Implementation Guidelines

1. The IMIS is designed to capture and measure clinicial activities in the maternity unit. It is intended for within-hospital use: the data will be collected by hospital staff within the maternity hospital/unit and reviewed by senior hospital managers.
2. The IMIS should be based entirely on data sourced directly from maternity units.
3. Monthly completion of the IMIS is mandatory for the 19 maternity units.
4. The IMIS is approved by the National Implementation Group HSE/HIQA Maternity Services Investigations and is aligned with national recommendations in the Investigation Report of the HSE National Incident Management Team (2012); HIQA Investigation Report (2012); Report of Chief Medical Officer on Perinatal Deaths 2006-date (February 2014), Safety Incident Management Policy (June 2014), Review by Dr Peter Boylan (June 2015), the National Maternity Strategy 2016-2026, and the HSE Maternity Clinical Complaints Review (May 2016).
5. The IMIS Officers in all 19 maternity units were nominated to work part-time on implementing the IMIS, whilst continuing with their other existing roles. The IMIS Officer should have access to maternity hospital/unit data files and should be accustomed to dealing with data within the hospital/unit.

IMIS Monthly data collection and reporting

6. The reporting period is the calendar month (i.e., from first to last day of the month).
7. The IMIS Officers should send a monthly IMIS report to senior managers in their hospital/unit:
    - Chief Executive Officer or Master
    - Clinical Director(s), as appropriate
    - Director of Midwifery/Nursing
8. Senior managers should review the monthly IMIS. If they have concerns arising from the IMIS, these should be discussed with the clinical staff and, if appropriate, reported to the Hospital Board or equivalent. In the event of concerns with national implications arising, these should be reported to the head of HSE Acute Hospitals Division via NWIHP.
9. Following internal sign-off, the IMIS should be sent on a monthly basis to the NIWHP by the 20th day of the following month.

IMIS Annual reporting

10. Staff at the NWIHP will check and verify annual data in collaboration with staff at maternity hospitals/units.
11. All annual IMIS data should be completed by the end of March of the following year.
12. The NWIHP will prepare IMIS reports and disseminate to maternity hospitals/units and relevant organisations.
13. If senior managers of the hospitals have concerns arising from the annual IMIS data, these should be discussed and escalated as above.
14. Reviews of the IMIS format will be conducted by the NWIHP and any changes required should introduced at the beginning of the calendar year.

Appendix 4. National recommendations

There follows an outline of the relevant national recommendations and initiatives produced since June 2013, which align with and support the IMIS as a management instrument for quality improvement in maternity services.

1. **HSE NIMT Recommendations, Incidental factor 1 (June 2013)**

   'The review team recommends consideration of a National Quality Assurance Programme of Obstetrics and Gynaecology as an initial step to maintain confidence amongst patients/services users, staff, the public administrators and regulators and to put into place safety systems and interventions before a catastrophe happens. Monthly workloads, clinical outcomes, and adverse incidents should be monitored by using a dashboard to include green, amber and red signals to warn of the possibilities of impending problems.' (HSE, June 2013).

2. **HIQA National Recommendations (October 2013)**

   In October 2013, the HIQA produced national statutory recommendations, two of which refer directly to quality assurance in the maternity services.

   'The HSE and key stakeholders should agree and implement effective arrangements for consistent, comprehensive national data collection for maternity services in order to provide assurance about the quality and safety of maternity services. This should include the development of an agreed and defined dataset and standardised data definitions to support performance monitoring, evaluation and management of key patient outcome and experience indicators.' (National Recommendation N16)

   'The arrangements for collecting, reviewing and reporting maternal morbidity and mortality should be reviewed by the HSE to facilitate national and international benchmarking for improved learning and safety in the provision of maternity services. This should include a formal process for the implementation of recommendations of the Confidential Maternal Death Enquiries.' (National Recommendation N17)

HSE Midland Regional Hospital, Portlaoise, Report of Chief Medical Officer on Perinatal Deaths 2006-date (2014):

In February 2014, Dr Tony Holohan, Chief Medical Officer, reported to the Minister for Health Dr James Reilly TD, about perinatal deaths in Portlaoise. The report contained a list of recommendations, several of which are relevant to quality and safety (and measurement) in the maternity services and which led to the development (by the HSE Acute Hospitals Division, the National Clinical Programme in Obstetrics and Gynaecology, the HSE Quality Assurance and Verification Division, and the HSE Quality Improvement Division) in May 2015 of the Maternity Patient Safety Statement (MPSS). The MPSS is intended to be a monthly statement on the quality of care in maternity units. It is based on the design of the IMIS and uses 16 IMIS indicators.

Theme IV recommendations:

- The HSE should issue a directive to all providers to require them to notify the director of quality and patient safety and HIQA of all 'never events' (R.21)
- The HSE should ensure that every maternity service (and later every health service provider) should be required to complete a Patient Safety Statement which is published and updated monthly (R.22) (O.R.10)

Overall recommendations:

- Every maternity service (and later every health service provider) be required to complete a Patient Safety Statement which is published and updated monthly (O.R.10)
- The Patient Safety Statement should be a requirement of hospital licensing (R.23) (O.R.10)
- A National Patient Safety Surveillance system should be established by HIQA (O.R.11)

3. HSE NIMT, Safety Incident Management Policy (June 2014)

In June 2014, the HSE National Incident Management Team drafted the Safety Incident Management Policy, which was approved by Dr Philip Crowley, National Director Quality and Patient Safety, HSE. The purpose of the document is to set out the HSE policy for managing safety incidents across a range of areas, including surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events. Several of the Serious Reportable Events (SRE) are relevant to maternity services.

4. HIQA Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise (May 2015)

Recommendation 6c: 'The Health Service Executive (HSE), along with the chief executive officers of each hospital group, must ensure that the new hospital groups prioritise the development of strong clinical networks underpinned by regular evaluation and audit of the quality and safety of services provided.'

5. Boylan P. Report, 'A Review of 28 Maternity Case Notes' (June 2015)

Recommendation: 'Each hospital in the State should implement a formal system of audit of pregnancy outcome classified according to the Ten Groups Classification as recently endorsed by the WHO. This audit should take place on a monthly basis and involve all relevant clinicians. Each hospital needs to supply relevant administrative support.' […] 'Using data from individual maternity units, an annual audit of Irish maternity services should be implemented without delay.' […] 'Ongoing audit in this manner will allow a pattern of adverse outcomes to be identified in a timely fashion so that appropriate action can be taken.'

6. 'Creating a better future together', National Maternity Strategy 2016-2026 (2017)

Action: Measurement and analysis for quality improvement and safety will occur at national, network and service level, based on an agreed minimum dataset (Action 4.14.5).

7. HSE Maternity Clinical Complaints Review (May 2017)

The final report of the Maternity Clinical Complaints Review concluded a review process commissioned by the HSE in 2014. The report reviewed complaints received from patients and their families and outlined recommendations for all maternity services nationally.
Recommendation: 'External oversight should be provided in order to assure the public of the quality of maternal services. The National Women and Infants Health Programme (NWIHP) should develop a model to ensure external oversight is applied across each hospital group. The Irish Maternity Indicator System (IMIS) currently provides information for local scrutiny of clinical maternity activity. The NWIHP will expand the role of IMIS to provide for Group and National level oversight, as well as local.'

8. HSE National Maternity Strategy Implementation Plan (October 2017)

Developed by the National Women and Infants Health Programme (NWIHP) in 2017, the Implementation Plan stipulates that the IMIS will be the agreed measurement instrument for quality improvement and safety at national, network and service level and the IMIS will form part of the standing agenda for monthly meetings with the maternity networks.

Appendix 5. IMIS data and methods

Data

The IMIS 2025 data were provided by IMIS Officers, or nominated personnel at all maternity hospitals/units, following review and approval by hospital senior management. They were checked and verified by staff at the NWIHP.

Methods

The IMIS data were analysed using MS Excel. National rates were calculated for all maternity units and hospital-level rates were calculated for each unit individually. Confidence intervals at 95% levels were calculated and customised funnel charts designed for the IMIS indicators.

Funnel charts

Funnel charts are useful where observations for different hospitals are based on varying sample sizes. They are a form of scatter-plot, in which observed area rates are plotted against area populations. Control limits are then overlaid on the scatter plot. The control limits represent the expected variation in rates assuming that the only source of variation is stochastic (i.e., including a random variable). The control limits were computed in a fashion very similar to confidence limits and exhibit the distinctive funnel shape as a result of smaller expected variability in larger populations.

The funnel-shaped confidence limits indicate that, as sample sizes decrease, an observation must be further from the national rate to be considered significantly different. The purpose of the charts is to enable each maternity unit to observe their position relative to the national benchmark and the upper and lower control limits.

Caution is advised where small values are concerned.

Maternity hospitals/units lying beyond the confidence limits on the funnel plots may be considered in a 'warning' sector. However, since no statistical analysis has been conducted to take formal account of the multiple characteristics that are not shown in the funnel plot, in this report crossing a threshold does not indicate high or low 'quality'. We recommend senior managers at maternity units should investigate the reasons for variations at the hospital level before action is taken.

Several funnel plots in the IMIS National Reports show evidence of a phenomenon known as overdispersion (Spiegelhalter 2005).[1] This overdispersion is not an unusual phenomenon in health data and, in fact, can be useful in model specification (Birkmeyer 2001).[2] Overdispersion occurs when a greater level of variability is demonstrated than can be explained by chance and the existence of a small number of outlying maternity hospitals/units.

Potential explanations for overdispersion are differences in data quality, lack/limitations of risk adjustment, and clinical uncertainty. Given that no risk adjustment has been executed in the analysis presented in this report, it is likely that these are the underlying reasons for much of the systematic variation between units. Consequently, it would be premature to draw conclusions from the charts alone about whether differences in the patterns of maternity care provision reflect differences in quality.

To compensate for the absence of statistical risk adjustment, notes are provided after the funnel charts. These notes contain crucial details that inform or explain the results. They are based on clinical expertise and hospital management experiences. The notes contribute explanations of the annual

1 Spiegelhalter DJ. (2005). Handling over-dispersion of performance indicators. *Qual Saf Health care 14*: 347–51.

2 Birkmeyer JD. (2001). Primer on geographic variation in health care. *Effective Clinical Practice 4*(5): 232-33.

hospital rates where they lie above or below the national rates and, particularly, where they lie beyond the confidence limits**.**

Interpreting a funnel plot:

Diamond-shaped markers represent the 19 maternity hospitals/units.

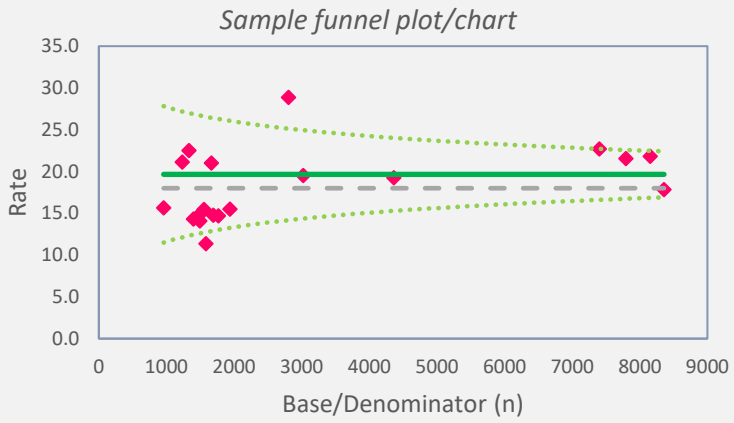
The horizontal axis represents the base number (in most charts, the base is the number of total births or total maternities). The diamond shapes further to the right are maternity units with more births/maternities.

The vertical axis measures the frequency of the outcome, usually expressed as a percentage rate or rate per thousand ('000) women delivered or births. The diamond shapes placed higher up on the chart represent maternity units with higher rates of an outcome.

The solid horizontal green line shows the national rate in the current year. The horizontal dotted line shows the national rate in the previous year (where relevant).

The dotted curved green lines constitute the statistical reference range or 95% confidence limits for the current year. The reference range defines what is regarded as the 'normal', or typical, range. Anything beyond the range is regarded as non-standard. The reference range allows us to say that if the true value of the parameter lies beyond the 95% confidence limits, then an event has occurred which had a probability of 5% (or less) of happening by chance alone.

With all funnel plots, interpretation is subject to limitations including small numbers, lack of formal risk adjustment, and variation in service configuration or referral patterns. Where the IMIS addresses rare events, such as maternal morbidities like eclampsia and uterine rupture for example, small case numbers can produce large apparent rate differences, which should be interpreted with caution.



Appendix 6. Maternity hospitals/units in Republic of Ireland (n=19)

Appendix 7. HSE Health Regions (2025)

Dublin & South East	National Maternity Hospital, Dublin
	St Luke's Hospital, Kilkenny
	Tipperary University Hospital
	University Hospital Waterford
	Wexford General Hospital
Dublin & North East	Rotunda Hospital, Dublin
	Cavan General Hospital
	Our Lady of Lourdes Hospital, Drogheda
Dublin & Midlands	Coombe Hospital, Dublin
	Midland Regional Hospital Portlaoise
	Regional Hospital Mullingar
Midwest	University Maternity Hospital Limerick
South & South West	Cork University Maternity Hospital
	University Hospital Kerry
West & North West	University Hospital Galway
	Letterkenny University Hospital
	Mayo University Hospital
	Portiuncula University Hospital
	Sligo University Hospital

Appendix 8. Relevant data sources/agencies

The following offices collect and provide health- and hospital-related data, including data on maternity and perinatal activities, in ROI:

BNF01 Birth Notification Form
Four-part form completed by staff at maternity hospitals/units for each live birth and stillbirth and returned to the HPO for distribution to CSO, GRO, and NPRS.

CSO Central Statistics Office
Ireland's national statistical office provides vital statistics, including births, stillbirths, and deaths.

GRO General Register Office
Central civil repository for records including births, stillbirths, and deaths in Ireland.

HIPE Hospital In-Patient Enquiry system
A health information system designed to collect demographic, clinical, and administrative data on hospital day cases and in-patients as well as deaths from acute hospitals nationally. The HIPE is the only source of morbidity statistics available nationally for acute hospital services. All acute public hospitals participate in HIPE, reporting on over 1.5 million records annually.

IMIS Irish Maternity Indicator System
The IMIS is a standardised data-based management tool for individual maternity hospitals/units and national analysis. Data are collected and reviewed monthly. National reports are published annually.

MSS Maternity Safety Statement
Initiated by the Department of Health, the MSS is published for all maternity hospitals/units on a monthly basis and is intended to provide assurance that maternity services are delivered in an environment that promotes open disclosure. Completion and publication of the MSS is included in the Key Performance Indicators in the HSE National Service Plan.

NPEC National Perinatal Epidemiology Centre, University College Cork
The NPEC collaborates with maternity services and publishes annual data on perinatal mortality and severe maternal morbidity using a range of research methodologies and drawing on the HIPE data.

NPRS National Perinatal Reporting System
Based on data derived from the BNF01, the NPRS provides national statistics on perinatal events, in particular data on pregnancy outcomes, perinatal mortality, and important aspects of perinatal care.

NWIHP National Women and Infants Health Programme
Established in 2017, the NWIHP leads the management, organisation, and delivery of maternity, gynaecology and neonatal services in line with the National Maternity Strategy. The NWIHP is overseeing development of maternity networks and has responsibility for allocating development funding for maternity services.

Appendix 9. Glossary and Abbreviations

ACHI	Australian Classification of Health Interventions
AVD	Assisted vaginal delivery (also Operative or Instrumental vaginal delivery)
BPI	Brachial plexus injury
CA	Congenital anomaly
CS	Caesarean section
ECDC	European Centre for Disease Prevention and Control
EPAU	Early Pregnancy Assessment Units
GA	General anaesthetic
HIE	Hypoxic ischaemic encephalopathy
HIPE	Hospital In-Patient Enquiry system
HIQA	Health Information and Quality Authority
HPO	Healthcare Pricing Office
HSE	Health Services Executive
ICD	International Classification of Diseases
IMIS	Irish Maternity Indicator System
IOL	Induction of labour
NCG	National Clinical Guideline
NE	Neonatal encephalopathy
NPEC	National Perinatal Epidemiology Centre
NPRS	National Perinatal Reporting System
NWIHP	National Women and Infants Health Programme
PPH	Postpartum haemorrhage
QA	Quality Assurance
TH	Therapeutic hypothermia (also whole body neonatal cooling)
WHO	World Health Organisation

Irish Maternity Indicator System (IMIS)

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