

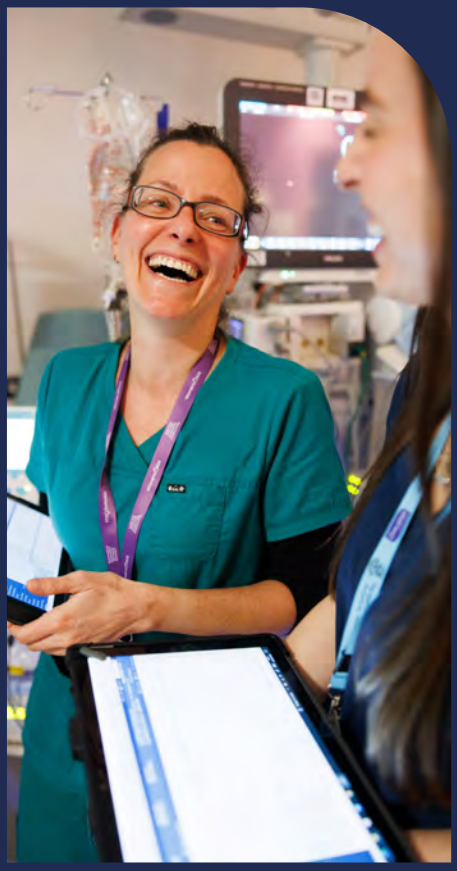






The National Maternity Hospital Annual Report 2025

An tOspidéal Náisiúnta Máithreachais
The National Maternity Hospital

Mission, Vision and Values of The National Maternity Hospital

Aisling and Patrick with their newborn daughter Cora.

Mission

We are the national centre of clinical excellence in maternal, neonatal and gynaecological health. Our mission as leaders in women's healthcare is to deliver the highest quality of safe, evidence based care. We are committed to providing choice, listening to and learning from our patients' experiences. Through excellence and innovation in research and education, we drive the advancement of women and babies' healthcare in Ireland. Our team is our greatest asset, and we are dedicated to investing in and supporting our people.

Vision

To continuously advance the health of women and babies through excellence in healthcare led by our dedicated teams.

Values

Quality
Compassion
Respect
Collaboration
Innovation
Sustainability

Births
7,096

Babies
7,218

Staff
1,029 WTE

Outpatient Attendances
128,000+

Busiest Day
34 births

Smallest Baby
550g

Laboratory Requests
214,791

Caesarean Section Rate
38.2%

Beds
187

Emercency Room Attendances
14,726

Medications Dispensed
28,770

Breastfeeding Rate
76%

Food Safety Professionals Association Audit
100%

Neonatal Unit Admissions
1,337

Avg Age of First Time Mother
32

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Baby Cora with her Mother Aisling MacIntyre.

Governance Reports

Deputy Chairman's Report

The year 2025 was another significant year at The National Maternity Hospital (NMH). Our staff continue to maintain the excellent care for all our patients and continue to provide services to meet the varying needs of our patient population.

This is provided in an environment which continues to be challenging due to difficulties with the aging infrastructure and lack of appropriate space in Holles Street. Patients and their families are the primary focus for our staff, and this focus is a quality that is actively encouraged by every group within NMH staff. There is a very strong, shared vision combined with great inventiveness amongst our people in the NMH and this vision is centred on enhancing patient care and patient experience and also promoting best clinical practice through training and research. This is all focused on providing improved high quality maternity, gynaecology and neonatal care for our patients and for future generations. The positive energy and team spirit that staff consistently demonstrate no matter what the situation consistently impresses me and this is demonstrated by the excellent people we attract to work in our Hospital. The NMH, both nationally and internationally, has an outstanding reputation for quality and excellence and this is due to all of our staff who continue to deliver at the highest level in spite of any limitations of the current site. In recent years we have experienced difficulty in recruiting staff in many areas, and this continues to be a challenge in the NMH similar to other hospitals in the Dublin region. It is essential that we recruit and retain staff of the highest calibre to enable us to continue to provide high quality clinical care into the future.

Pat McCann, Deputy Chairman with Prof Jennifer Walsh who was elected as Master during the year.

The number of deliveries increased by 7.5% during 2025 and totalled 7,096. Once again, an analysis of the data indicates that 47.6% of our births are to women aged 35 years or older and 10.7% of those are aged over 40 which can lead to additional complications.

We continue to expand and evolve services for women in many areas such as fertility, genetics, menopause, pain management, psycho sexual counselling, perinatal mental health, diabetes, fetal MRI, neonatal additional therapies, endometriosis to highlight just a few of the recent areas of expansion. The NMH is one of six national hubs for the public fertility services, and we anticipate these services evolving with expanded services being offered with the support of National Women and Infant's Health Programme and the Department of Health and Children. Our goal continues to be to provide quality care for our patients and to provide them with options for all the services that they need. We will continue to do this with the assistance of the National Women's and Infant Health Programme (NWIHP) and the Dublin South East Hospital Group (DSE). We continue to be heavily involved in pursuing the implementation of the National Maternity Strategy and the rollout of Sláintecare with the NMH being the major hub in the Dublin South East Region for the provision of women's and neonatal care.

During this year there were some important milestones in relation to the project to co-locate the NMH to the Elm Park Campus. The tender documents were issued to the market, and the tender returns were received back during 2025. Enabling works continued and were completed under

Framework 2 and further enabling works commenced under Framework 3. These enabling works are designed to assist with the main project as the site will be well prepared for the when the main contractors commence. The new governance arrangements for the next phase (the build phase) of the project were put in place with a new Programme Board appointed. The project now has effectively three pillars – Capital Build, ICT, and Operational Readiness and all of these will be supported by a Project Management Office (PMO). As the year ended the number of members of the Capital Build pillar were in place and as we move into 2026 we anticipate the other teams will be populated. We also anticipate the formal contract award in early 2026, and the contractor commencing onsite during the year.

Whilst the Elm Park project is progressing well, it will still be a number of years before the new Hospital is ready for occupation. The many infrastructural concerns highlighted in recent years on the Holles Street site remain unresolved. Apart from maintaining the aging infrastructure there is a requirement for additional space for the existing and developing services. Within such a confined site creating any additional space is problematic. The current site is clearly deficient in terms of space. This was a factor in announcing the co-location in 2013; and since 2013 the range of services, numbers of patients and staff have continued to expand. There remains a number of urgent projects that were clearly identified as necessary and urgent in 2022 which we hope will be progressed in the next few months to provide the facilities required for our staff to continue to deliver essential services to women and neonates to the end of the decade.

The continued implementation introduction of the public only consultant contract since March 2023 (POCC23) which has a cut-off date of 1 January 2026 for those who switched contracts, has implications for the NMH, our staff and our patients. In obstetrics, it is important to note that there are no hospitals in Ireland that offer private inpatient obstetrics. When all remaining obstetricians who hold a "B" contract retire, likely within a decade at most, then the option of private obstetrics, with continuity of care, will likely no longer be an option for patients. The benefits of POCC23 also allows for extended service delivery and particularly the expansion of the services across the day/week. This will be subject to all relevant resources being in place for the extended times as consultants do not function in isolation. Currently there are consultants on "B" contracts and also others on POCC23 (new entrants) and there will be a gradual transition over the coming years and the impacts of the change to only POCC23, both positive and negative, will need to be carefully managed.

The Research and Innovation Symposium Exhibition (RISE) is an amazing event that engages many staff and Departments each year.

RISE highlights the incredible work of the Hospital and the commitment and inventiveness of the undeniably gifted staff that make up the Hospital team. As in previous years I commend Prof Fionnuala McAuliffe and all her team for introducing this symposium and for all the work they undertake every year to ensure that it continues to thrive.

There was a HIQA visit in July, and this was as usual, very well managed by the Quality Department over the two days. The report was overall very positive and highlighted one or two areas for minor improvements and these are being worked on. I extend the thanks of the Executive to all staff who were involved or were spoken to by the HIQA inspectors during the inspection.

Once again, the NMH Catering Team managed to maintain their high standards and achievements and during the year received a number of awards including obtaining a score of 100% in the FSPA audit, for the fourth year in a row and ISO 22000 certification 2025.

The staff at the Hospital are at the centre of the delivery of all our services and we rely on them to continue to excel and maintain and develop the highest quality care for our patients. The issues with healthcare recruitment and scarcity of qualified candidates continued in many categories of staff including Midwifery and Nursing and associated healthcare professional grades. We continue to utilise international recruitment to provide certain staff, but this is expensive and there is often a long lead time waiting for the individuals to arrive.

As has been mentioned in previous years the issue of availability of affordable accommodation within a reasonably commutable distance of the Hospital continues to be a barrier to recruitment.

We often have newly qualified staff leaving our employment for work in other parts of Ireland or other countries. This is a continuing and worrying trend and, while no doubt there are many issues contributing to this difficulty, it is clear that accommodation costs and availability and transport are a factor. The HSE imposed 'Pay and Numbers Strategy' is also an ongoing issue with the numbers 'capped' at a time when we had a significant number of vacant posts and a number of approved development posts unfilled. The pay and numbers levels were set by the HSE in December 2023 which was a particularly low level for NMH due to the recruitment issues already highlighted. Some adjustments have been agreed for midwifery students but moving the cap upwards is an ongoing challenge. Many of these issues are not unique to us and have been highlighted by the NMH and many other Hospitals but there are unlikely to be any solutions in the short term, but the combined health services need to identify and implement viable long-term solutions. The Executive Management Team and Executive Committee are very mindful of the difficulties and the potential risks and the ongoing service needs of our patients in circumstances where staff replacements are necessitated.

The Hospital's Executive Committee and the sub committees have continued to engage in their significant work programs during the year constantly evaluating risks and strategy and ensuring that our structures and governance is appropriate to our needs as a hospital providing women centred care in the 21st century. We continue to engage directly with NWIHP, our Dublin and South East Hospital Group (DSE) and Integrated Healthcare Area manager, and we have an ongoing significant and evolving role in women's and infant's health in the DSE region.

During the year Ms Mary Brosnan, our Director of Midwifery and Nursing, took early retirement. Mary, over the course of her career, was a national and international leader in Midwifery and Nursing and advanced both the profession and womens healthcare. She will be greatly missed and we wish her well in her retirement. We are pleased to welcome Marys successor, Annmarie Sliney, back to The NMH and look forward to working with her in the coming years.

Every seven years we go through a process to appoint a new Master for the Hospital and 2025 was such a year. This is an extremely important event for the NMH. Professor Shane Higgins has been the Master of NMH for the past seven years. His term ended on December 31st, 2025, I would like to pay tribute to Professor Higgins and thank him for his outstanding contribution to the Hospital. He has been an outstanding leader and was instrumental in introducing many new services that will have a very positive impact on woman's health for years to come. I really enjoyed working with Shane over the past six years. It is so important that the Chief Executive (Master) and Board Chair have a good working relationship. Shane and I built a strong trust and worked extremely well together.

What amazed me was how quickly Shane moved from his Clinical role to a much more corporate role. I wish Shane and his family a healthy and rewarding future. As Professor Higgins moves on to pastures new, Professor Jennifer Walsh takes up the role as the new Master of NMH in January 2026.

It is only a few short months since Jenny's appointment, and I am delighted to tell you that she has hit the ground running. We are blessed to have such excellent people like Shane and Jenny to lead the wonderful institution that is The National Maternity Hospital. Long may it last.

I am honoured to have a role in this wonderful Hospital. Every time I am in the NMH it gives me immense satisfaction and optimism. Our Board are fully informed and engaged on all of the matters that require their input. I am grateful to have so many individuals with such a depth of intellect and experience who fully commit to the tasks of the Executive and the many sub committees. The NMH Executive Committee are fully aware of our responsibilities as Board members and the need for diligence for continued good corporate governance. We are assisted in this by an experienced executive team led by Professor Shane Higgins and now Professor Jenny Walsh. I am very grateful to you all for your ongoing involvement in the NMH. We have plenty to do in 2026 and no doubt face some challenges but also opportunities.

***Pat McCann,* Deputy Chairman**

Masters's Report

It is a great privilege to introduce the combined Corporate and Clinical Reports for the year 2025. This will be the final report I write as Master of The National Maternity Hospital, as my seven-year tenure in the role comes to an end.

It has been the honour of my professional life to serve as Master of this remarkable institution, and I have been continually inspired by the commitment, compassion and resilience of the staff who embody the Holles Street ethos. The National Maternity Hospital is a place of extraordinary history, clinical excellence and enduring humanity, and it has been a privilege to contribute to its leadership during a period of significant challenge and progress.

Prof Shane Higgins who completed his term as Master at the end of the year.

As always, I would like to take this opportunity to thank some of the many people who have supported me throughout this year and throughout my time as Master.

My sincere thanks to Mr Pat McCann, Deputy Chair of the Executive Committee, whose calm judgement, strategic insight and steadfast commitment to the Hospital have been invaluable. Pat has consistently demonstrated a deep understanding of the mission of the NMH, and his guidance has helped to ensure we remained focused on both immediate priorities and long-term ambition. I also wish to acknowledge his ongoing engagement with the Executive Management Team and the wider organisation, which has helped drive progress through periods of complexity and uncertainty.

My thanks also to Mr Tom Murphy, Honorary Treasurer, Mr William Johnston, Honorary Secretary, and all members of the Board for giving so freely of their time, expertise, and support. The strength of the NMH as an independent Voluntary Hospital is built on the governance and commitment of those who continue to safeguard its values and ensure its future.

I owe an enormous debt of gratitude to the Executive Management Team: Ms Mary Brosnan, Director of Midwifery and Nursing, Mr Ronan Gavin, Secretary General Manager, Dr Roger McMorrow, Clinical Director, and Mr Alistair Holland, Financial Controller. Their professionalism, loyalty and leadership have been central not only to the success of 2025, but to the continued resilience of the Hospital during the many challenges of recent years. Their support to me personally throughout my tenure has been immense. Mary Brosnan retired during the year and we will miss her immensely. Mary has been a tireless advocate for women's health, midwifery leadership, and service development at national level. Roger has provided consistent clinical leadership and guidance at a time of evolving complexity in maternity and neonatal care. I wish to congratulate Ms Annmarie Sliney who was appointed to the role as Director of Midwifery & Nursing and I wish her all the best.

To all my consultant colleagues, thank you for your ongoing support. To the midwives and nurses who deliver the majority of care to mothers and babies every day, your skill and dedication are the foundation upon which this

Hospital stands. To the wider multidisciplinary staff and every member of our organisation, thank you for your loyalty, professionalism and pride in your work. This Hospital continues to be defined by its people.

The National Maternity Hospital has been in operation at Holles Street since 1894 and continues to hold a unique place in Irish healthcare. Across my tenure, I have repeatedly reflected on the strength of the NMH's voluntary ethos, its proud history under the Royal Charter of 1903, and its role as a national leader in maternity, gynaecology and neonatal care. The NMH has always combined compassion with innovation, and clinical excellence with education and research.

The last number of years have been marked by both extraordinary challenges and meaningful achievements. The COVID-19 pandemic defined the early part of my term, and the efforts made by staff in 2020 and 2021 will remain one of the most remarkable demonstrations of teamwork and professionalism I have witnessed in healthcare.

The creation of new systems of care, rapid response structures such as the COVID-19 Task Force, drive-through testing, and the ability to maintain safe maternity care through an unprecedented global crisis reflected the best of the NMH.

As the Hospital emerged from the pandemic, 2022 and 2023 saw a return to more normal clinical activity, but also highlighted structural pressures across the Irish healthcare system. Staff recruitment and retention, particularly among midwives and nurses due to the rising cost of living in Dublin, remains a serious challenge. The Hospital has continued to work creatively to support staff, including the provision of short-term accommodation options, but this remains an issue requiring national policy solutions.

A major theme across my reports has been the urgent need to progress the relocation of the NMH to the Elm Park campus at St Vincent's University Hospital. The case for relocation has never been stronger. Our current buildings, many approaching or exceeding a century in age, continue to present significant infrastructural constraints. Despite this, staff have continued to deliver outstanding care.

In parallel with the relocation project, the Hospital has continued to expand and modernise services. Across recent years we have seen the growth of ambulatory gynaecology, with high-volume outpatient hysteroscopy procedures and the achievement of national key performance indicators. We have continued to provide specialist services for patients suffering mesh complications and have developed a complex menopause service.

We have established and expanded vital services such as the Iris clinic for hyperemesis and the TLC clinic for recurrent miscarriage, both of which have received national recognition. The Hospital's commitment to innovation and research has continued to strengthen through initiatives such as the Research and Innovation Symposium (RISE) and the awarding of the Declan Meagher Medal for Research and the Professor Colm O'Herlihy Medal for Innovation.

The Hospital has also continued to strengthen its national specialist services. The establishment of a public infertility service has been a major step forward, and the more recent development of publicly funded IVF cycles represents a significant advance for equitable reproductive care. The NMH remains committed to ensuring that couples experiencing subfertility can access high-quality services regardless of financial circumstance.

We have also continued to develop specialist fetal and maternal medicine services. The perinatal genetics service, now a defining feature of the NMH's clinical offering, remains the only full dedicated service of its kind in a maternity hospital in Ireland. This service provides support to complex pregnancies, recurrent pregnancy loss, and subfertility cases, and supports fetal medicine units nationally.

Our Placenta Accreta Spectrum Service has also expanded, now funded to run as a national multidisciplinary team. This represents an important example of how the NMH continues to lead the development of national models of care for high-risk pregnancies.

We have continued to invest in the current campus where possible. Over the years, key projects such as the Labour and Birthing Unit extension and theatre developments have improved clinical capacity. The introduction of a hydrotherapy pool and the expansion of water birth services reflect our ongoing commitment to safe, patient-centred

maternity care. Planning permission has been secured for a new patient transport lift, improving safety for patient transfers, and the ambulatory gynaecology suite project is progressing with completion expected in 2025. We continue to seek funding for a new Perinatal Pathology and Bereavement Suite and redevelopment of the Clinical Decontamination Unit.

Throughout the years, the Hospital has also remained deeply connected to its community roots and charitable tradition. The Linen Guild continues to play an essential role in supporting vulnerable women and families, and the NMH Foundation continues to offer investment in innovation, research, and patient support.

As I conclude my term as Master, I wish to reflect on the privilege of leading an institution that has shaped maternity care in Ireland for over a century. I have seen the NMH adapt through pandemic crisis, develop new national specialist services, and continue to deliver excellence in clinical outcomes despite significant infrastructural and workforce challenges. I have also witnessed a culture of compassion and collegiality that is rare and precious in modern healthcare.

I wish to conclude by expressing my deepest gratitude to every staff member of The National Maternity Hospital, clinical and non-clinical, for the work you do every day. You have carried this Hospital through some of its most demanding years while continuing to deliver safe care to women and babies, often under immense pressure. Your professionalism and humanity represent the very best of Irish healthcare.

I have no doubt that my successor, Professor Jennifer Walsh, who takes over as Master in 2026, will bring tremendous leadership, fresh energy, and great vision to the role.

It has been my great privilege to serve as Master of The National Maternity Hospital. I leave the role with confidence in the strength of the organisation, and with optimism for its future as it continues its journey toward a new hospital at Elm Park and a new chapter in its proud history.

Prof Shane Higgins
Master

Prof Shane Higgins.

Honorary Treasurer's Report

The financial results for the hospital for 2025 reflected an overall deficit of €0.9m.

Total Income for the year at €116m was up €5.5m (5%). Income for the hospital comes from two primary sources. Funding from the HSE amounted to €104.8m for the year which was 90% of overall income. HSE income is up €4.7m (5%) on prior year reflecting both cost inflation as well as an increasing volume of services and specialties that the hospital delivers. This includes expanding activity in the genetics function and a fertility service among other things. Overall the breadth and complexity of services provided by NMH continues to increase year on year. The balance of funding primarily comes from services provided to private and semi-private patients. This amounted to €12.8m for 2025 which was a very healthy increase of 8% on the prior year. Considerable effort is being made in maintaining and enhancing this very important source of income. The introduction of Sláintecare POCC23 will lead to an inevitable drop off in this source of income over the coming years.

Total costs incurred were €117m an increase of €5.6m (5%) over 2024. Of this, €95m related to Pay which saw an increase of €6m (7%) over the prior year. The main reason for this increase was government mandated pay awards, as well as continuing migration towards Sláintecare POCC23. Consistent with previous years the cost base of the hospital remains largely fixed with staff costs accounting for 81% (prior year 80%) of hospital spend.

The major elements of non-pay costs relate to medicine, pathology costs, medical supplies, catering, energy and maintenance costs. Non-Pay expenditure at €22m was a decrease of €0.5 (2%) over last year. Year on year savings were made in some areas however these were countered by increases in clinical costs and maintenance. Recruitment costs for foreign nurses and midwives remains high and reflects a general shortage. Staff retention remains a challenge for the hospital in particular due to the cost of accommodation and we continue to look at all possible avenues to try and support staff with this issue.

Whilst the hospital awaits the move to The NMH @ Elm Park, it continues to provide excellent care in an aging building. The move is still some years away. The current building does need continual maintenance but also investment in the intervening period. Discussions are ongoing with HSE in relation to funding of additional essential upgrade works. Approval for new capital projects or upgrades is long and protracted. In general, we have received a good level of funding for smaller capital projects such as IT upgrades, bleep system and roof repairs, however funding for larger products such as the necessary lift upgrade and pathology laboratory has been very slow, resulting in a suboptimal working environment.

The funding model from the HSE has again improved somewhat but the timeframe remains a challenge. There can be considerable delays in approval for any new funding – capital or revenue and the revenue allocation for a given year is never fully confirmed until a couple of months post the year end. This is inefficient from a financial planning, cash management and audit perspective. The upfront allocation and timely provision of funds would result in a much more effective outcome both in terms of administration and value for money for all concerned.

Other areas of focus by the Finance Committee during 2025 included NMH @ Elm Park, governance, procurement, impact of Sláintecare, policies and procedures, management of debtors, compliance, activity based budgeting, new services and SORP accounting.

I would like to extend my appreciation to all the The NMH finance team and my fellow members of the Finance Committee. The NMH finance team have successfully exercised strong financial control whilst concentrating on essential spend to ensure we can continue to deliver excellent care to the patients.

Tom Murphy
Honorary Treasurer

Executive Committee Report

Executive Committee (The Board)

At the first Board meeting following the 2025 AGM, Mr Pat McCann was re-elected unanimously as Deputy Chair – effectively the Chair of the Hospital.

Cllr Emma Blain, one of the DCC representatives on the Board, was elected as Lord Mayor on 18th December 2024, and served in that role until June 2025, she then returned to the Board as one of the DCC representatives.

During the year four Board members retired: Naoise Ó Muirí, TD; Dr Roger McMorrow, Ms Michele Connolly and Mr Frank Downey.

Deputy Naoise Ó Muirí, was originally welcomed to the NMH Board as Lord Mayor in July 2012. Following his one year term as Lord Mayor and his active interest in the NMH, the then, Cllr Ó Muirí, was elected as a Governor and to the Board in September 2013. Naoise also served on several of the Board's sub-committees: He served on the Quality, Risk and Patient Safety (QRPS Committee) from its inception in March 2015, serving initially as chair; the Audit Committee from 2023 and the Executive Ethics Committee from June 2021; he retired from the Board and these subcommittees in Jan 2025. Naoise was elected to Dáil Éireann in November 2024. Naoise remains a Governor.

Dr Roger McMorrow, was elected as an NMH Governor in June 2018 and onto the Board in June 2019. He was subsequently elected to the QRPS Committee in September 2019 and the Co-Location Committee in December 2019, both of which benefited greatly from his expertise in his position as Clinical Director. He served as Clinical Director for the Hospital from January 2018 until May 2025, when he also stepped down from the Board and its sub-committees. Dr McMorrow remains a Governor.

Ms Michele Connolly, was originally elected as a Governor and onto the Board in March of 2016, she was elected onto the Finance Committee at that time, and was appointed Honorary Treasurer in May 2016. She was elected to the Audit Committee when it was formed later in 2016. In January of 2019 she was election onto the Co-Location Committee and the Nominations Committee. She served on these committees until stepping down from the role of Honorary Treasurer in May of 2024. Michele was also elected onto the Medical Fund Committee in October 2021 and subsequently became Chair, where she remained until she retired from the Board in May of 2025. Michele remains a Governor.

Mr Frank Downey, was originally elected as a Governor and onto the Board in October 1998. Since joining the Board Frank has served on the Finance Committee from 2000 - 2008: Serving as Honorary Treasurer from 2002 – 2007, he served on the Risk Committee, now the QRPS, when it was formed in 2016, until 2021, the Exec. Ethics Committee from 2012, and the Audit Committee when it formed in the 2017, and he was elected onto the Medical Fund Committee in 2019. Despite having stepped down from the Board, Frank remains a Governor and will continue on the sub-committees until the AGM 2026.

We are hugely indebted to each of the foregoing Board members for their unstinting commitment, expertise and service to the Hospital.

It was with great sadness that we learned of the death, in August 2025, of Dr John F Murphy, Consultant Obstetrician and Gynaecologist. Dr Murphy was a Consultant Obstetrician & Gynaecologist in The National Maternity Hospital from 1980 - 2008. He contributed enormously to the development of the Hospital and provided education and support to his colleagues long after his retirement. Dr Murphy was elected as a Governor in 1991 and served as valued member of the Board from 1991-2008. Dr Murphy was also the President of the Royal College of Physicians from 2006- 2007.

The following were appointed to the Board during 2025:

Dr Nikki Higgins, Consultant Anaesthesiologist, was appointed to replace Dr Roger McMorrow on the Board as Director of Anaesthetics, Mr Charles Watchorn, Mr Keith McCormack and Ms Caroline Devlin.

Board Work

To enhance the understanding of, and thus contributions by Board members, there have been several presentations to the Board during the year:

Month	Name	Title	Presentation
January	Dr Catherine Hinds	Consultant Psychiatrist	Perinatal Mental Health at NMH
March	Liz Byrne	Catering Manager	Catering Services
June	Carl Alfvag	Compliance and Operations Manager, Chair of the NMH Environmental Committee	Environmental, Social and Governance
August	Ms Helen Thompson	CNM3	Women's Outpatient Services
September	Patricia Ryan	Director of the Public Relations Company DHR	overview of the services they provide for the NMH
October	Prof Fionnuala McAuliffe	NMH Director of Academic Affairs, UCD Professor, Obstetrics & Gynaecology and Director of UCD Perinatal Research Centre	The NMH Strategy 2024 – 2028, Goal 3: To foster excellence in research, education and innovation with our staff and academic partner
November	Rory Timlin and Kelan Daly	KPMG (hosted at KPMG)	AI Transformation in Health
December	Ms Erica Mullins	Assistant Director of Midwifery & Nursing (Night Duty)	The Complexity of Running the Hospital Out of Hours

At each monthly meeting of the Board, reports from members of the Executive Management Team (the EMT) are discussed and, where considered appropriate, further direction is given by the Board to the EMT. Clinical aspects of these reports are covered elsewhere in the Annual Report.

The year marked the final year of the Mastership of Prof Shane Higgins. Accordingly, the Board appointed a panel of twelve persons, which included Prof Dame Lesley Regan of Imperial College, London to consider and interview the candidates for the next Mastership. Prior to the interviews, the candidates made a presentation to the Governors and answered questions posed by the Governors. Following the review and interviews by the Panel, Prof Jennifer Walsh was the recommended candidate. Shortly thereafter Prof Walsh was elected by the Governors as the next Master.

The NMH Trust Fund (Trust Fund) and NMH Science and Research College (SRC) have been in existence for almost 50 years, and both of these funds were subject to the NMH Board. The Trust Fund and SRC have both remained effectively dormant for almost two decades with the last "operational" interactions going back to late 1990s/ early 2000s. The function of the Trust Fund was to fund pensions for any staff not in the State supported health sector schemes in the early 1970s. There are no further liabilities, so the Trust Fund is no longer required. The SRC purpose was to utilise interest generated on seed capital to fund research projects. Education and Research is now substantially funded through the Medical Fund so there is no rationale to maintaining a separate fund.

After lengthy consideration and discussions having sought legal advice and analysis the Board agreed to terminate both the Trust Fund and the SRC and transfer any remaining assets and liabilities to the Medical Fund for the primary purpose of clinical research and education.

Corporate Governance

The Board met on eleven occasions in 2025 and attendances were as follows:

Members of Executive Committee (The Board)	Meetings Attended	Meetings Appointed to Attend
Mr Pat McCann, Deputy Chair	10	11
Mr William Johnston, Honorary Secretary	9	11
Mr Tom Murphy, Honorary Treasurer	9	11
Prof Shane Higgins, Master	11	11
The Lord Mayor, Cllr. Emma Blain, *(to Jun)*	1	6
The Lord Mayor, Cllr. Ray McAdam *(from Jun)*	0	5
Ms Jill Beck	7	11
Cllr Emma Blain as Nominee of DCC *(from Jun)*	2	5
Ms Sarah Claxton	8	11
Ms Denise Cole	10	11
Ms Michele Connolly *(to May)*	3	4
Mr Andrew Crotty	9	11
Mr Aidan Devlin	10	11
Mr Frank Downey *(to May)*	2	4
Cllr Cian Farrell	3	11
Dr Nikki Higgins *(from May)*	7	7
Fr Alan Hilliard	9	11
Prof Declan Keane	9	11
Ms Carmel Logan	10	11
Prof Fionnuala McAuliffe	6	11
Ms Jane McCluskey	8	11
Dr Roger McMorrow *(to May)*	3	4
Cllr Naoise Ó Muírí *(to Jan)*	1	1
Ms Patricia O'Shea	5	11
Ms Alison Quinn	10	11
Dr Michael Robson	8	11
Dr Deirdre Sweetman	10	11
Prof Jennifer Walsh	11	11
Mr Charles Watchhorn *(from May)*	6	7
In Attendance		
Mr Ronan Gavin, Secretary/General Manager	7	11
Mr Carl Alfvag, Compliance and Operations Mgr, deputising for Secretary./ Manager	1	1
Ms Mary Brosnan, DOM&N *(to Jun)*	5	6
Mr Alistair Holland, Financial Controller	10	11
Mr Francis Rogers, Management Accountant, deputising for the Financial Controller	1	1
Ms Annmarie Sliney *(from Jul)*	5	5
Ms Geraldine Duffy, ADoMN deputising for DoMN	1	1

His Grace the Catholic Archbishop of Dublin does not attend the meetings.

At the AGM, following the recommendation of the Nominations Committee, Dr Nikki Higgins, in her role as Director of Anaesthetics was elected as a Governor of the Hospital.

Following the recommendation from the Nominations Committee's meeting in November 2025, Mr Keith McCormack was elected as a Governor in December 2025.

Sub Committees of the Board

Finance Committee

The Financial report is summarised on pages 216 and 217 with further detailed commentary on the Finances provided in the Honorary Treasure's Report on page 10.

The committee met on eleven occasions during 2025 and attendances were as follows:

Members of Finance Committee	Meetings Attended	Meetings Appointed to Attend
Mr Pat McCann, Deputy Chair	11	11
Mr William Johnston, Honorary Secretary	8	11
Mr Tom Murphy, Honorary Treasurer	11	11
Prof Shane Higgins, Master	11	11
Ms Denise Cole	8	11
Mr Aidan Devlin	11	11
Ms Carmel Logan	11	11
In Attendance		
Prof Jennifer Walsh, Director of Fetal Medicine, (Master elect) *(from Aug)*	5	5
Mr Ronan Gavin, Secretary/General Manager	7	11
Ms Mary Brosnan, DOM&N *(to Jun)*	5	6
Mr Alistair Holland, Financial Controller	10	11
Ms Annmarie Sliney, DOM&N *(from Jul)*	5	5
Mr Carl Alfvag, Compliance and Operations Manager	1	1
Mr Francis Rogers, Management Accountant	1	1
Ms Geraldine Duffy, ADOM&N	1	1
External Attendees		
Mr John McConville, KPMG Lead	2	2

Audit Committee

The Audit Committee continued its work throughout the year and a separate report on the work of the committee is provided on page 26.

The committee met five times during 2025 and attendances were as follows:

Members of Audit Committee	Meetings Attended	Meetings Appointed to Attend
Mr Aidan Devlin, Chair	4	5
Mr Tom Murphy, Honorary Treasurer	2	5
Mr Frank Downey	4	5
Mr Charles Watchorn	4	5
In Attendance		
Mr Ronan Gavin, Secretary/General Manager	2	5
Mr Alistair Holland, Financial Controller	4	5
Mr Eoghan Hayden, Clinical Engineering Lead	4	5
External Attendees		
Mr Alan Davidson (Crowe)	1	1
Aisling Fitzgerald (PWC)	1	1
Ms Carron Heffernan, Risk Consultant (Crowe)	2	2
Ms Catherine Rogers (Crowe)	2	2
Mr Cameron Kasavan (PWC)	1	1
Ms Julie Monaghan (Crowe)	1	1
Matthew Ryan (Crowe)	1	1

Prof Jennifer Walsh Consultant Obstetrician & Gynaecologist, Director of Fetal Medicine and Master elect with Prof Declan Keane, Consultant Obstetrician & Gynaecologist and former Master.

QRPS Committee

The QRPS (Quality, Risk & Patient Safety) Committee continued its work throughout the year and a separate report on the work of the Committee is provided on page 27.

The committee met on five occasions in 2025 and attendances were as follows:

Members of QRPS Committee	Meetings Attended	Meetings Appointed to Attend
Ms Sarah Claxton, Chair	5	5
Mr Aidan Devlin *(to May)*	1	2
Prof Declan Keane	5	5
Ms Carmel Logan	5	5
Prof Fionnuala McAuliffe	2	5
Ms Jane McCluskey	3	5
Mr Bernard McLoughlin	2	5
Dr Roger McMorrow *(to May)*	1	2
Ms Patricia O'Shea	3	5
In Attendance		
Dr Orla Sheil, Director of QRPS *(from Jul)*	5	5
Mr Ronan Gavin, Secretary/General Manager	0	5
Mr Carl Alfvag, Compliance & Operations Manager	4	5
Mr Martin Creagh, Operational Risk Manager	5	5

Co-Location Committee

This committee did not meet in 2025 as the project tenders were being evaluated by the design team and there were no developments requiring the committee's input.

Margaret Fanagan, CMM2 Antenatal Education (retired) and member of the House Committee (left) and Cora McComish, Principal Midwifery Tutor (retired).

Nominations Committee

The Nominations Committee provides the Board with recommendations in relation to the appointment of Governors and the appointment of members of the Board and other committees provided for under the Charter and bye-laws and regulations in line with succession planning and criteria.

The committee met on two occasions during 2025 and attendances were as follows:

Members of the Nominations Committee	Meetings Attended	Meetings Appointed to Attend
Mr Pat McCann, Deputy Chairman, Chair	2	2
Mr William Johnston, Honorary Secretary	1	2
Mr Tom Murphy, Honorary Treasurer	2	2
Prof Shane Higgins, Master	2	2
Ms Sarah Claxton	0	2
Ms Denise Cole	2	2
Mr Aidan Devlin	2	2
Prof Declan Keane	2	2
Mr Andrew Crotty *(from May)*	1	1
Ms Cecilia Barker *(from May)*	0	1
Dr John Murphy *(to May)*	0	1
In Attendance		
Mr Ronan Gavin, Secretary/General Manager	2	2

Medical Fund Committee

This committee, which receives funds from the Fitzwilliam Semi-private Clinic, provides funding principally for education and research relating to the medical services provided by the Hospital. A separate report on the work of the committee is provided on page 29.

The committee met on five occasions during 2025 and attendances were as follows:

Members of the Medical Fund Committee	Meetings Attended	Meetings Appointed to Attend
Ms Michele Connolly, Chair *(to May)*	3	3
Mr Andrew Crotty, Chair *(from Jun)*	5	5
Prof Shane Higgins, Master	4	5
Dr Stephen Carroll	4	5
Mr Frank Downey	3	5
Prof Declan Keane	5	5
In Attendance		
Mr Ronan Gavin, Secretary/General Manager	4	5
Mr Alistair Holland, Financial Controller	5	5
Mr Francis Rogers, Management Accountant	5	5
Ms Ann Barry, Acting Manager, Fitzwilliam Clinic (SPC)	1	1
Prof Jennifer Walsh, Director of Fetal Medicine	1	1
External Attendees		
Ms Aisling Fitzgerald PWC *(part of)*	1	1
Mr Cameron Kasavan, PWC *(part of)*	1	1

Executive Ethics Committee

The Executive Ethics Committee met once during the year to review the terms of reference, the Committee's effectiveness/self-assessment and review the succession/ skill mix.

House Committee

The committee, which is one of the longest serving the Hospital, assists in ensuring that the Hospital's infection control strategies are effective. The work of the committee involves carrying out on-site inspections of various areas in the Hospital. A separate report on the work of the committee is provided on page 30.

The committee met on five occasions during 2025 and attendances were as follows:

Members of the House Committee	Meetings Attended	Meetings Appointed to Attend
Ms Catherine Altman, Chair *(to Jun)*	5	5
Ms Cecilia Barker, Chair *(from Jun)*	5	5
Ms Sara Appleby,	3	5
Ms Louise Bennett	4	5
Ms Bernadette Campion	2	5
Ms Sheena Carton	4	5
Ms Fiona Davy	4	5
Ms Elaine Doyle	3	5
Ms Margaret Fanagan	5	5
Ms Kate Higgins	3	5
Ms Keara McAndrew	2	5
Ms Margaret McCourt	2	5
Ms Anne Murphy	4	5
Ms Teresa Murphy	1	5
Ms Suzanne O'Brien	2	5
Ms Aoife O'Shea	3	5
In Attendance		
Prof Shane Higgins, Master	2	5
Ms Mary Brosnan, DOM&N *(to Jun)*	3	3
Ms Annmarie Sliney, DoMN *(from Jul)*	2	2
Mr Mark Anderson, Hygiene Services Manager	5	5
Ms Sharon Hynes, Patient Services Administrator	5	5
Mr Ciprian Gulea - Assistant Hygiene Services Manager	2	2

People and Organisation Committee

The People and Organisation Committee provides oversight of the Human Resources (HR) function and HR policies within the NMH. A separate report on the work of the committee is provided on page 25.

The committee met on seven occasions during 2025 and attendances were as follows:

Members of the People & Organisation Committee	Meetings Attended	Meetings Appointed to Attend
Ms Denise Cole, Chair	7	7
Ms Mairéad Callanan	4	7
Ms Sarah Claxton	7	7
Mr George Maybury	6	7
Ms Patricia Nolan	7	7
Ms Alison Quinn (from May)	4	5
In Attendance		
Mr Ronan Gavin, Secretary/General Manager	2	7
Ms Mary Brosnan, DOM&N (to Jun)	4	4
Ms Annmarie Sliney, DOM&N (from Jul)	2	3
Ms Yvonne Connolly, Dir. of Learning & Development	5	7
Ms Caoimhe de Brun, HR Manager	7	7
Prof Jennifer Walsh, Director of Fetal Medicine	1	1
Ms Erika O'Shaughnessy, Deputy HR Manager	4	4
Ms Alison Quinn, invited attendee	1	1
External Attendees		
Ciara Keane - Accenture	1	1
Catrina Silva - Accenture	1	1

Annmarie Sliney, Director of Midwifery & Nursing who took up the post in July and Prof Jennifer Walsh, Consultant Obstetrician & Gynaecologist, and Director of Fetal Medicine who was elected Master in 2025.

Maternity Hospitals Joint Standing Committee

The committee of the three Dublin Maternity Hospitals continues to meet to discuss issues of common interest and concern. During 2025 the committee, under the Chairmanship of Dr Don Thornhill met five times. Some of the issues discussed were the Service Level Agreements between the HSE and the Hospitals, Consultants Public only Contracts (POC), the HSE's Integrated Staff Records and Payroll, and Financial and Procurement Services system and the issues around implementation and the impact of the above on the Hospitals concerned.

Regular meetings with NWIHP now form part of the committee's programme.

Charter Day

The annual Charter Day celebrations in 2025 had to be postponed due to the severe weather warning issued for the 23rd January 2025. They were held instead on 27th and 28th February 2025. The Charter Day reception was hosted by the Master, Prof Shane Higgins and his wife, Mrs Kate Higgins to whom we are most grateful.

Prof Shane Higgins delivered his final address as Master, to the Governors, guests, staff, prize-winners and their families. He reflected on his seven years in the role of Master noting the challenges as well as the highlights and thanked his fellow consultants, the Executive Management Team and other staff and the Board for their support. He made particular reference to Mary Brosnan, Director of Midwifery and Nursing in anticipation of her upcoming retirement.

The 68th Annual Charter Day Lecture was also postponed and held in the Lecture Theatre on Friday, 28th February 2025. The Lecture entitled 'The National Maternity Hospital and a changing Ireland' was delivered by Prof Mary E Daly, Professor Emerita of Modern Irish History University College Dublin. A Symposium entitled 'The National Maternity Hospital's Role in The History of the Irish State', was held as part of the Charter Day celebrations. The symposium was chaired by the Master, Prof Shane Higgins and the following lectures were delivered.

'Merrion Square and Holles Street: origins and early development'

Mr Collum O'Riordan, CEO of the Irish Architectural Archive

'Hospitality on Holles Street: Joyce, Care and Maternity'

Prof Luke Gibbons, Former Professor of Irish Studies at Maynooth University, Ireland and University of Notre Dame, USA.

'Caring for the History of the Profession. The National Maternity Hospital and RCPI'

Ms Harriet Wheelock, Director of the Heritage Centre in the RCPI

'"I think after a year of this life I ought to be able to tackle anything": Marie Martin, the Great War, and the Medical Missionaries of Mary'

Dr Fionnuala Walsh, Associate Professor in Modern Irish History, UCD

Hospital Awards & Certificates

Awards for 2025 examinations are as follows

Medical Students	
John F. Cunningham Medal	Dr Louise Murphy
RCSI/NMH Medal	Ms Eve Lehane
Kieran O'Driscoll Prize	Ms Sara Brady
A. Edward Smith Medal	not awarded for 2025
Student Midwives	
Hospital Gold Medal	Ms April Hayden Ms Áine Denise Castaneda
Elizabeth O'Farrell Medal	Ms Lucia Jiménez de Parga Moller Ms Joy Adekanmbi Baka
Neonatal Medal (established by Dr Nial O'Brien)	Ms Niamh Kilroy

We congratulate each of them for their hard work and excellence and wish them every success in their future careers.

William Johnson, Honorary Secretary, presenting Dr Louise Murphy with the John F. Cunningham Medal, awarded for achieving the highest first-class honours in the Obstetrics and Gynaecology exam and overall honours in the final examination.

Additional awards obtained during the year:

Colm O'Herlihy Medal: Dr Gillian Corbett, Academic Clinical Fellow - Obstetrics.
This medal is awarded for Research and Innovation. Gillian's research undertook a study on *'Oral Bifidobacterium breve supplementation alters Faecal Metabolome in Pregnancy with Reduced Risk of Gestational Diabetes: results from a randomised controlled trial'*

Declan Meagher Medal: Ms Niamh Murray, and Prof Venita Broderick.
This medal was awarded for the following project *'Development of a video animated Patient Information Resource for Ambulatory Gynaecology'*

The Catering Team, who are renowned in the Hospital for the excellent service they provide, were recognised this year at the Catering Gold Medal Awards in June when they won the Gold Medal for 'Best Healthcare Caterer 2025'. This represents an outstanding performance by all members of the Catering Team and is a great cause for a joyful celebration.

The Food Safety Assurance Accreditation inspection in October, once again returned a score of 100% and the inspector commented in his report that *'every member of staff was engaging and extremely proactive in answering questions about their role.... Each had knowledge and confidence to support their answers. The NMH should be a benchmark in best practice for other Hospital Catering Departments. ...'*

Research and Innovation Symposium Exhibition – (RISE)
The RISE event took place in May when staff members from across the Hospital made oral and poster presentations on both research and innovation projects, across a wide range of subjects including improving patient information, timing for dressing removal post caesarean section, stress and depression risk in early pregnancy, infant feeding, a review on the impact of e-cigarettes in a maternity setting and gestational diabetes.

Appointments, Promotions, Retirements and Deaths

Senior appointments included:
Ms Annmarie Sliney, Director of Midwifery and Nursing
Dr Omar Elabbasy, Consultant Anaesthesiologist

Internal promotions included:
Caoimhe De Brun, HR Manager
Erika Martin O'Shaughnessy, Deputy HR Manager
Aoife Menton, Principal Clinical Psychologist
Gillian Canty, Assistant Director of Midwifery and Nursing
Heather Hughes, Antenatal Outpatient & Ultrasound Services
Jean Kavanagh, Community Midwifery Services and infant feeding
Harriet Kinsman, Clinical Midwife Specialist Lactation Support

Long serving staff
We would like to congratulate the following members of staff who, in 2025, marked 40 years working in the NMH: Ann Barry, Brian Byrne. Bridget Carew, Lein Dang Tring, Pamela Mac Keogh. We acknowledge the dedication and service to the Hospital.

Carol O'Brien and Peter Fry both of whom retired after many years of service in the Patient Services Department.

Staff retirements

The following staff members retired during the year after many years of service.

Name	Department	Years of service
Nora Curran	Household	45yrs
Miriam Griffin	CNM 2	37yrs
Niamh Cunningham (nee Guidera)	Grade IV, Radiology	33yrs
Ann Calnan	ADOM	33yrs
Mary Brosnan	DOM	33yrs
Angela Edmonds	Catering Assistant	32yrs
Edel Kimmage	Domestic	26yrs
Colette Finnegan	Snr Enhanced Midwife	26yrs
Clare Gray	Grade VI	25yrs
Helen Batson	CMS	24yrs
Pat Tobin	Porter	24yrs
Joseph Talento	Snr Enhanced Midwife	24yrs
Ludmilla O'Toole	Grade IV	23yrs
Angela Deegan	Enhanced Midwife	22yrs
Maria Beverly Abellanosa,	Snr Enhanced Midwife	21yrs
Yvonne Connolly	Grade VIII	17yrs

Staff retirements

The following staff members retired during the year after many years of service.

We would particularly like to thank Mary Brosnan who was Director of Midwifery and Nursing for 19 years, not only for her pleasant and dedicated service to the Hospital, but also for the great publicity she brought to the Hospital with her awards which were rightly recognised nationally. Mary will be missed and we wish her a very comfortable and satisfying retirement.

Ms Clare Gray started with the NMH in 1995 and became Secretary to the Secretary/Manager in May 2000. Clare was an extremely efficient operator and served always in a most pleasant manner. We wish Clare a very happy and enjoyable retirement.

Deaths

During the year the following retired staff died and we send our sincere condolences to their families:
Dr John F. Murphy, Consultant Obstetrician and Gynaecologist.
Ms Moira Crawford, Administration.
Ms Margaret Moore, Ward Sister.
Ms Jane Woods, Catering, who was over 100 years old when she passed away.

Conclusion

The Board are grateful to the Executive Management Team for their tireless work during the year of continuing challenges, including the Directors of Midwifery and Nursing, Ms Mary Brosnan, until June and Ms Annmarie Sliney, from July, the Secretary/General Manager, Mr Ronan Gavin, the Clinical Director, Dr Roger McMorrow (to May) and Mr Alistair Holland, Financial Controller and their teams, and indeed all persons who have devoted their time during the year in the Hospital, deserve our special appreciation for their unstinting and selfless dedicated work in their care of woman and babies.

Finally, the Master, Prof Shane Higgins, served his seventh and final year as Master. Shane engaged with the Board in a very open and measured way and served his Mastership with great dedication for which we are very grateful. We look forward to the unveiling of his portrait in due course.

Mr William Johnston
Honorary Secretary

Secretary/General Manager's Report

During 2025, The National Maternity Hospital continued to expand its range of care and introduce new women's health initiatives. We endeavour to develop new programmes wherever a patient benefit or need is identified, while working within the context of our existing site with its known infrastructural limitations.

Many of the additional developments over the past decade have been initiated with the support of The National Women and Infants Health Programme (NWIHP) and recently Dublin South East Hospital Group (DSE) and many require additional resources, primarily staffing. The NMH Executive Committee (The Board) has, in recent years, recognised and funded new services due to the clear patient benefits and the absence of any central funding. Often this leads to central recognition of the need for these services and the funding following in later years. Maternity numbers showed a slight increase from recent years, and the patient cohort continue to provide added complexity and the reasons are multifactorial. All of our new and recently developing services continue to grow. Many existing Departments such as dietetics, perinatal mental health and social work have continued to expand by providing additional supports to our patients, seeing increasingly complex referrals and providing increased access through extended work patterns. In 2025, there was continued expansion and investment in public fertility and the respiratory syncytial virus (RSV) immunisation program introduced in 2024 continued into the 2025 RSV season. A number of postnatal hubs in the Community were initiated in the latter part of the year.

The new Hospital, to be constructed at Elm Park, continued to be a priority of the Executive Management Team (EMT) and the Executive Committee. Enabling works on the site made significant progress during 2025. During late 2025 there were interviews and appointments for a number of the posts to work on the project, primarily related to the capital /construction workstream. The major focus of the Project Board was the evaluation reports from the main contract tenders. Tenders for main contractors were received back in late 2024 and the sub specialist contract tenders in early 2025. The tender evaluation report and recommendation and revised Business Case were approved by the HSE and issued to the Department of Health for final approval by Government and hopefully award of contract during 2026.

The buildings purchased in Elm Park by the HSE are making some progress with the NMH Program Team utilising some of the offices in the Vista building. The Seamark building has seen some activity with the fit-out for St Vincent's University Hospital Dermatology Department (part of the project enabling works) having progressed significantly. However the fit-out of the other shell space in Seamark for use by NMH and others has not progressed and we continue to have space and capacity issues that need to be resolved long in advance of the availability of our new Hospital.

Prof Declan Keane, Consultant Obstetrician & Gynaecologist, Clinical Director and former Master with Aidan Devlin Audit Committee Chair and Ronan Gavin, Secretary/General Manager.

Once again, continuing to deliver services to patients in the confines of the aging infrastructure on the Holles Street site continues to present challenges. During 2025 work continued on the ambulatory gynae unit, refurbishment of on-call rooms commenced as did the design for the provision of an additional modern patient lift. Other works onsite included repairs and upgrades to lifts, flooring and roofing. As noted previously the building is problematic including ageing lifts, heating and water systems, windows and downpipes. In addition there is the lack of adequate bathroom facilities for both patients and visitors. Planning permission for a new patient transport lift was granted early in the year and this project has a design team working under the HSE. The ambulatory gynae project (approved during 2023) commenced early in the year and unfortunately still has not been completed and handed over by year-end. The Central Decontamination Unit (CDU) and perinatal pathology/bereavement remain as major issues that need immediate resolution on the current site and have been highlighted as concerns for over five years.

The demand for additional space, both clinical and back office, continues to grow due to the expansion of existing services and the introduction of new services. We are at a critical juncture whereby if some further space does not become available our ability to continue to develop services will be greatly compromised. This need is immediate and urgent and space is needed in advance of our planned co-location to Elm Park. It was anticipated that the HSE acquisition of buildings on the Elm Park campus in 2024 would provide us with some options but unfortunately, this has not yet evolved and is unlikely to be materialise during 2026.

Once again, in order to improve to overall access and choice for patients a number of our services have now extended service periods including longer days and Saturdays. In addition, there has been extension of some services into the community with the opening of a number of post-natal hubs. Some departments operate extended hours/six days a week to provide additional supports onsite and to also allow them to access service areas that are fully utilised during weekdays. Virtual consultations continues to be an option offered by many Hospital departments where appropriate.

Information and Communication Technology (ICT) systems are now a fundamental tool in modern healthcare. We rely heavily on a number of clinical systems and the ability to interact and transfer data seamlessly across the site and also externally.

These systems and the associated networks and hardware are constantly evolving and this can prove challenging from both a resourcing and an infrastructural perspective. In 2025 the phone systems upgrade was completed with our core backbone now a full digital system. Work continued on upgrading our network infrastructure to provide enhanced resilience, security and longevity. In relation to Network and Information Systems (NIS) and cybersecurity an additional monitoring tool (Darktrac) was introduced and the Office 365 upgrade project was also initiated. Other major software upgrades which were initiated included the upgrade of the Winpath laboratory system, and fetal medicine system Viewpoint. We hope to complete a number of these projects during 2026 and continue to invest in our hardware and systems to continue to enhance overall security.

The NMH Executive continually monitor our governance processes, underpinned by our Charter, including review of committee memberships and skillsets and annual feedback from all committee members.

The Hospital's crucial resource is our staff and 2025 was another challenging year for the NMH, like many others, with regard to recruitment and retention combined with the continuing HSE 'Pay and Numbers' strategy. Recruitment continued to be difficult in many groups of staff and especially in midwifery and nursing and the health and social are professional (HSCP) grades. Once again the issues involved are multi factorial but there is no doubt that the lack of affordable accommodation in the Dublin region and transport difficulties are factors. The Hospital continues to source some accommodation that is available for new entrants on a short-term basis, but this is not a long-term solution. The continuing 'Pay and Numbers' strategy effectively sets a target employment limit at the level of

actual employees at the end of December 2023. This is an issue for the NMH as December 2023 was a particularly low employment figure due to all the aforementioned recruitment issues, resulting in many posts vacant at this point. During the year, our patient experience surveys continue to score in the high 90s for satisfactory rating. This is an endorsement of our staff and their enormous commitment and is amazing when we consider the infrastructural and space limitations.

During the year, many Departments again maintained accreditation and also won awards. The Pathology and Laboratory Department continued its accreditation to ISO 15189 standard and the Catering Department to ISO 22000:2018 standard. Once again I need to mention the Catering Department who once more won multiple awards including another Gold Award Certification from the Irish Heart Foundation for healthy catering practices; being nominated as finalists in the Irish Hotels and Catering Gold Medals Awards and obtaining a 100% score in the FSPA Audit (Food Safety Professional Association). Like many other Departments, they achieve these recognitions for a service that is provided in sub optimal infrastructural conditions.

Finally, I would like to thank all of the members of the Executive Committee and the various sub Committees for their ongoing support and advice during the year. I would also like to thank the other members of the EMT, Prof Shane Higgins, Master, Ms Mary Brosnan, and Director of Midwifery & Nursing, Dr Roger McMorrow, Clinical Director and Mr Alistair Holland, Financial Controller for their support and assistance. Special thanks to both Clare Gray and Pam Robinson who ensure that the work of my office and of the various Board Committees and sub committees is always under control. I would like to wish Clare Gray all the best wishes for her retirement and thank her again for the many years of service to the NMH. As always, the most important factor in providing quality patient care is our extraordinary staff and I thank them all for their tireless work on behalf of our patients throughout the year.

Ronan Gavin,
Secretary/General Manager

Clare Gray, who retired from the Secretary/Manager's Office during the year.

Director of Midwifery and Nursing

Annmarie Sliney, who was appointed Director of Midwifery & Nursing during the year.

It is my great pleasure to write my first annual report as Director of Midwifery and Nursing at The National Maternity Hospital.

Having previously worked at the NMH for 17 years, I was extremely honoured to return as the Director of Midwifery and Nursing in July 2025. I must thank my colleagues in the Executive Management Team, Prof Shane Higgins, Mr Ronan Gavin and Mr Alistair Holland for their support as I orientated to this role. As this was Prof Higgins' final year as Master of the Hospital, I would like to take this opportunity to thank him for his leadership and advocacy during his 7 year tenure. I also wish to thank the Midwifery and Nursing teams of every grade within the Hospital for their warm 'welcome home', along with my personal assistant Siobhan Flanagan and Ms Lisa Murray, Nursing and Midwifery HR, whom, along with the Assistant Directors of Midwifery and Nursing are the backbone of my office.

My predecessor Ms Mary Brosnan retired in July after 34 years of service to The National Maternity Hospital. During her time at the NMH, Mary worked in the fetal assessment unit before taking an Assistant Director of Midwifery and Nursing role, and ultimately the Director of Midwifery and Nursing role in 2006. Mary's leadership and commitment to women centred care is evident in the Hospital's response to many challenges during her career including the introduction of the Maternal Newborn Clinical Management System (MN-CMS,) the repeal of the 8th amendment, which led to the introduction of termination of pregnancy services, the Covid-19 pandemic and the HSE cyber-attack. In conjunction with colleagues in University College Dublin, Mary established the Joint Research Network (JRN) in 2007. The JRN is the only direct research collaboration between a maternity hospital and university in Ireland. It continues to promote and support midwifery and nursing research with the following studies undertaken this year:

- An evaluation of the Birth Reflection Service.
- Midwifery Care in the Fetal Medicine Clinic.
- The Matwell Study (Health and Wellbeing of the Health Workforce Across Maternity Settings)
- Labour Hopscotch Phase 2 Project.
- The EMER (Early Motherhood Expectations versus Reality) Study. Findings from the EMER study have been incorporated into the UCD Graduate Diploma in Public Health Nursing curriculum.

Staff Recruitment

Midwifery and nursing staff recruitment remains a key priority for the Hospital, we are operating in an economy where qualified Midwives and Nurses working in a fulltime capacity are finding it increasingly difficult to secure long term accommodation for themselves and their families, either to rent or to buy. During 2025, nine midwives and nurses celebrated their retirement and I wish to take this opportunity to thank each of them for their valued service to the NMH. 46 midwives and nurses resigned their position, some to travel while others took the decision to move outside of Dublin to work in regional units, reflecting the cost of living in the capital city. Our turnover rate was 12%, with 53 new midwives and nurses joining our team, this included 13 overseas candidates, 19 midwifery graduates and 17 midwifery interns along with 24 midwifery students.

Service Developments

Breastfeeding initiation rates this year were 75.8% with 49.6% women exclusively breastfeeding on discharge from the Hospital. Community midwife Alice Hoffmeister with the DOMINO team, and the communication team worked together to launch a set of breastfeeding affirmation cards, supported by The National Maternity Hospital Foundation, which are given to women intending to breastfeed when they attend their antenatal classes. The team hope to evaluate the impact of these cards in 2026, subject to ethical approval.

Our current building holds a special place in the hearts of many previous and current patients and all of our staff. However as we roll out new services, it is becoming increasingly difficult to find the required clinical and associated clerical space. During the year we commenced work on the fit out of a dedicated Ambulatory Gynaecology Unit; when complete this much needed space will enhance the patient experience for those attending for diagnosis and treatment.

In November we received approval from the Health Service Executive to increase our neonatal intensive care cots by 4. In order to facilitate this uplift in cot numbers there will be some minor works carried out in the NICU. Recruiting for the required staff has commenced, however as there is a shortage of suitably qualified NICU nurses in Ireland, this process will take some time as candidates will have to be recruited from abroad.

It is evident when walking around the Hospital, that staff are working to ensure all women who entrust us for their pregnancy or gynaecology treatment, receive kind, compassionate and evidence based care. This is reflected in our patient feedback with patients complimenting our staff across all departments. It is a pleasure to lead our dedicated midwifery and nursing team here at the NMH; I look forward to many exciting developments for the Hospital, our patients and staff in 2026.

Annmarie Sliney,
Director of Midwifery & Nursing

Mary Brosnan, Director of Midwifery & Nursing (2006 - Jun 2025), Annmarie Sliney, Director of Midwifery & Nursing (Jul 2025 - present) and Maeve Dwyer, Director of Midwifery & Nursing (1991 - 2004).

The People and Organisation Committee

The People and Organisation Committee was formed in 2022 with a mandate to: *"advise The National Maternity Hospital Executive on all matters relating to People and Organisation, to maintain and grow the reputation of The National Maternity Hospital as one of Europe's leading providers of maternity and women's healthcare services with a focus on the proposed move to Elm Park campus."* This is done through the provision of strategic oversight to the Human Resources (HR) Department and Executive Management Team, on matters to support the people ambitions of the NMH Strategy, and provide assurance to the NMH Executive Committee that the HR and People and Organisation related activities, are in place and deliver the required outcomes and benefits.

The focus of the Committee for 2025 was to look at recruitment challenges particularly against the wider Pay and Numbers limits implemented nationally, people risks, HR Process assurance and governance pathways in conjunction with the implementation of the revised hospital strategic plan for the period 2024- 2028, which is currently being developed into a People Strategy for the Goal 2 strategy stream. In addition, the Committee supported the HR Department in identifying and developing staff retention initiatives, as well as providing guidance on industrial relation matters, and through the review and testing of controls as relates to its people risks at both a corporate and departmental level.

***Ms Denise Cole,* Chair**

Labour and Birthing Unit Staff and Students.

Audit Committee

The Audit Committee's roles and responsibilities include:

- Oversight of the audit of The National Maternity Hospital (NMH) annual financial statements including the terms of engagement of the external auditor, the nature and scope of the annual audit programme and to assess on an annual basis, the independence, objectivity and effectiveness of the external auditor.
- Review of the NMH Annual Report and Financial Statements and to consider whether they are fair, balanced and understandable, and provide the information necessary for an understanding of the NMH framework. Specific responsibilities in this regard include recommending to the Board approval of the annual financial statements.
- Oversight of compliance with legal and regulatory requirements including Charities Act 2015, Charities Governance Code and HSE Service Level Agreement.
- Provide assurance to the Board as to the effectiveness of the Hospital's systems of internal control, including financial, operational and compliance controls and non-clinical risk management.

The Audit Committee convened five times during the year, which included meeting with the Hospital's external auditors, PWC, to agree their terms of engagement for the audit of the Hospital's annual financial statements and, following completion of the audit, to receive and consider PWC's post audit report and recommendations.

The Audit Committee also had ongoing interactions throughout the year with the Hospital's internal auditors, Crowe, to agree their work plan for the year and review reports issued. Internal Audit reports received from Crowe and considered by the Audit Committee during 2025 covered Inventory Management, Payroll Premium (overtime/weekend) Payments, GDPR Compliance and Risk Management. All reports received confirmed the Hospital's systems of internal control to be satisfactory.

In addition, Crowe reviewed the Hospital's ongoing implementation of recommendations of a 2024 review of ICT security systems noting the implementation of recommendations that fall within the control of the Hospital have been implemented and implementation of recommendations that require support of external parties are being progressed.

The Audit Committee also tracks and monitors the implementation of recommendations of earlier internal audit reports.

The Audit Committee, in conjunction with Finance Committee, continues to oversee preparations for the adoption of the Charities SORP (Statement of Recommended Practice) for the Hospital's accounts, which will become mandatory following approval of the Charities Amendments Bill, which is currently before the Houses of the Oireachtas.

***Aidan Devlin*, Chair**

The Gahan Family.

Quality Risk & Patient Safety Committee

The Quality Risk and Patient Safety Committee (QRPS) operates under Terms of Reference approved by the Board. These are reviewed annually and changes made as needed.

The main aims of the QRPS Committee are to:

- Understand the risks to which the patients and the staff are exposed and to provide assurance that process is in place to ensure they are managed adequately;
- Drive quality, risk and patient safety strategy, management and improvement within the NMH and
- Provide a level of assurance to the Board that there is adequate and suitable governance of quality, risk and patient safety in place.

The QRPS Committee met five times during the year. At these meetings reports from various departments were reviewed, covering matters such as data protection, incident management and risk management in general.

The Committee continues its work in all aspects of potential risk: Departmental Risk Registers Reports are reviewed as are reports in relation to General Data Protection Regulation (GDPR) and Health and Safety. The IT Department continues to ensure that the Hospital follows the HSE guidelines in relation to Cyber Security, an area where that the hospital has always been at the forefront. There was continued engagement with the National Cyber Security Centre in relation to Network & Information Systems. Consideration of the best means, and possible software to manage data extraction from various systems for the best possible risk related reports was initiated.

The digitisation of administrative processes for off-site and electronic patient records has progressed steadily throughout the year. Several awareness campaigns were also conducted to minimise data breaches.

The HSE Enterprise Risk Management Policy and Procedures 2023 has been embraced and the QRPS department and committee strive to comply. Further work is planned for the coming year with assistance from members of the committee. The review of the Operational Risk registers was completed, resulting in a significant reduction in current active risks recorded.

The Hospital remains fully compliant with the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 processes and the Department acknowledges the support from the executive management team and Hospital board in achieving this.

During the year the hospital had an unannounced two day inspection by the Health Information and Quality Authority (HIQA). Their report was favourable and noted that the service provided is of high standard. Eleven standards were examined, with full compliance in seven, substantial compliance in three and partial compliance in one (a minor staffing issue that has since been resolved). The QRPS department was audited by Crowe Auditors and achieved a rating of Satisfactory Assurance, indicating an adequate and effective system of governance, risk management and control.

The National Maternity Experience Survey was conducted and reported. This is the first survey since 2020, of the eight standards surveyed then, the Hospital received higher ratings in five and no lower ratings.

Overall the Hospital rating of good/ very good care was 86% which is higher than the national average of 83%.

In particular, women acknowledged being treated with dignity and respect, being involved in decision making, receiving excellent care during labour and birth, being provided with emotional support and being able to discuss their concerns, all of which are a tribute to the hospital's dedicated staff.

The restriction of the Pay and Numbers Strategy continues. It remains an item of concern among an already stretched and stressed workforce. The provision of safe staffing is on ongoing challenge when caring for increasingly complex patients.

***Sarah Claxton,* Chair**

Co-location Committee

The Co-location committee did not meet during 2025 as there were no developments that required their consideration or decision. During this time HSE and the design team issued (April 2025) the tenders for the main build to the market and the tender bids were received in the final quarter. These tenders will be evaluated by the design team and a report issued to the Programme Board in early 2026. Substantial enabling works continued around the site during 2025 including a fit-out on ground floor of Seamark building for the St Vincent's University Hospital dermatology decant.

Bríd Shannon, CMM2 with some Labour and Birthing Unit Staff.

At NMH we are delighted to be leading a study on retinal photography to determine its potential use as a diagnostic tool for preeclampsia. This is the first study of its kind worldwide and will continue into 2027 as it is expanded from the diabetic population to all primiparous patients at NMH. Pictured: Professor Rhona Mahony, Dr Ita Shanahan, Dr Max Waterstone.

The Medical Fund

The Medical Fund committee met 6 times during 2025 and continued its remit of oversight of the Medical Fund including the Fitzwilliam semi-private clinic (SPC). The finances were monitored with regular reports on income and expenditures against the agreed budget and also cash-flow forecasts. The primary goal of the fund is to provide for clinical education and research and a total of seven fellowships were supported by the fund during the year. The funds overall objectives were achieved with the support for education and research, a stable financial position and the SPC functioning well.

The Executive Committee (The Board) of the NMH agreed to terminate the Trust Fund and the Scientific Research College and the finances and objectives of these will be absorbed into the Medical Fund at year end. The ongoing project to review the Fund's long-term strategy continued throughout 2025 and it is anticipated that a proposed strategy will be considered in early 2026. This strategy will consider impact of issues such as POCC23 and the co-location.

***Andrew Crotty,* Chair**

House Committee

The House Committee is one of the longest serving sub-committees of the Board and meets five times each year. The Committee conducts unannounced independent quality assurance inspections of the Hospital's facilities and equipment and communicates these findings to the Executive Management Team and the Board. The House Committee reviews the facilities through a structured format that is founded on the infection control requirements of the Health Protection and Surveillance Centre, and plays a significant role in monitoring many of the elements that contribute to the efficacy of the Hospital's infection control strategies.

In 2025, the Committee assessed 10 clinical areas of the Hospital. Collectively these assessments achieved an overall average score of 91%, exceeding the hospital's targets.

In January, Ms. Jane Collins retired and the Committee wishes to thank her for her contributions to the Committee's success during her many years of service.

***Cecilia Barker,* Chair**

Bobby and Harry Hyland.

An tOspidéal Náisiúnta Máithreachais
The National Maternity Hospital

Masters of The National Maternity Hospital

2019 – 2025	Shane Higgins
2012 – 2018	Rhona Mahony
2005 – 2011	Michael Robson
1998 – 2004	Declan Keane
1991 – 1997	Peter Boylan
1984 – 1990	John M. Stronge
1977 - 1983	Dermot W. MacDonald
1970 – 1976	Declan J.Meagher
1963 – 1969	Kieran O'Driscoll
1956 – 1962	Charles F.V. Coyle
1949 – 1955	Arthur P. Barry
1942 – 1948	Alex W. Spain
1932 – 1941	John F. Cunningham
1924 – 1931	Patrick T. McArdle
1923	Sir Andrew J. Horne
1923	Patrick T. McArdle
1909 – 1922	Sir Andrew J. Horne
1909 – 1922	Reginald J. White
1894 – 1908	Patrick J. Barry
1894 – 1908	Sir Andrew Horne
1885 – 1893	William Roe

Charter Day Lectures

2025	Prof Mary E Daly	*"The National Maternity Hospital and a changing Ireland"*
2024	Prof Thomas Bernd Hildebrandt	*"Working at unusual places with challenging patients"*
2023	Professor Michael A. Patton	*"The Importance of Genetics"*
2022	Professor Andrew Shennen	*"The 3 P's of Preterm Birth, Predict, Prevent & Prepare*
2021	Dr Sanne Gordijn, PhD.	*"The Placenta – A Love Story"*
2020	Dr Roch Cantwell	*"There is no Health without Perinatal Mental Health"*
2019	Professor Alan D. Cameron	*"Each Baby Counts - a Five Year Quality Improvement Programme"*
2018	Professor Lesley Regan	*"Current challenges for the President, Royal College of Obstetrics & Gynaecology, UK"*
2017	Dr David Hugh Richmond	*"When will we ever learn?"*
2016	Dr Jeanne A. Conry	*"The Ostrich And The Obstetrician Gynaecologist: How The Environment Can ImpactReproductive Health"*
2015	Dr John O. L. DeLancey	*"Birth, Pelvic Floor Injury and Prolapse: Who Cares?"*
2014	Professor Mark Kilby	*"Fetal Medicine & Therapy: A Fantastic Step Forward But Are We Delivering A Good Service?"*
2013	Professor Michael Raymond Foley	*"Discovering Fulfilment as a Medical Professional – Ancient Wisdom for Modern Medicine"*
2012	Professor Michael de Swiet	*"Saving Mothers' Lives: Lessons to be learned from the Confidential Enquiry into Maternal Mortality"*
2011	Professor Dian Donnai	*"Genetic Medicine – Possibilities and Promises"*
2010	Professor James Eisenach	*"Pain Pregnancy & Depression."*
2009	Dr Kenneth J. Leveno	*"Caesarean Memories"*
2008	Dr Terry Inder	*"The Pathway to Improving Neurodevelopment in at-risk Infants – Nurturing Fetal and Neonatal Neurons"*
2007	Prof Wolfgang Holzgreve	*"Fetal Cells and DNA in maternal circulation- clinical importance for non-invasive prenatal diagnosis and maternal diseases"*

2006	Dr José Belizán	*"Calcium Intake During Pregnancy- Maternal and Fetal Outcome"*
2005	Dr Robert C. Pattinson	*"Getting the Right Thing Done"*
2004	Prof Thomas F. Baskett	*"The Evolution of Operative Vaginal Delivery"*
2003	Prof Heman V. Van Geijn	*"Is Cardiotocography to Blame?"*
2002	Joseph J. Volpe	*"Brain Injury in the premature infant – is it preventable?"*
2001	Professor Frank A. Manning	*"Echoes from the Past: the Alpha-Omega Theory."*
2000	Raymond J. Reilly	*"Surgical Gynaecology, the Past, the Present and the Future."*
1999	Paul Hilton	*"Vesicovaginal Fistula – Of Historical Interest?"*
1998	Sir Naren Patel	*"Chronogenetics – Role of Obstetricians."*
1997	Dr Fredric D. Frigoletto Jr.	*"Is Obstetric Practice Evidence based?"*
1996	Carol J. Baker	*"Group B Streptococcal Disease: Pilgrims' Progress."*
1995	Prof Fiona Stanley	*"Cerebral Palsy – Contribution from the Antipodes."*
1994	R. W. Beard	*"Medicine in the New Europe – The Impact on Obstetrics and Gynaecology"*
1993	Knox Ritchie	*"Sad – but can anything be done? ..."*
1992	John Monaghan	*"A Century of Subspecialization in Gynaecological Oncology – are we progressing?"*
1991	Charles Whitfield	*"The Rh Story"*
1990	Roy M. Pitkin	*"Anatomy and Physiology of a Peer Review Journal"*
1989	Claude Sureau	*"Decision making in reproductive medicine."*
1988	Geoffrey Chamberlain	*"One up on Dactylonomy"*
1987	Hugh Philpott	*"Obstetrics of Poverty."*
1986	Charles R. Scriver	*"Medelian Disease – What can it do to us? Can it be treated?"*
1985	Alexander C. Turnbull	*"Learning Obstetrics in Scotland, Wales, England and Ireland."*
1984	Sir Rustam Feroze	*"What alternative to what Medicine?"*
1983	William Dignam	*"Post Graduate Education in Obstetrics and Gynaecology in the U.S.A.: At the Crossroads."*
1982	Richard Mattingly	*"New Horizons in Cervical Cancer Detection."*
1981	Robert H. Usher	*"The Very Low Birth-weight Infant – Immediate and Long Term Prospects."*
1980	Shirley Driscoll	*"Placentas I Have Known."*
1979	John S. Tomkinson	*"Ultimate Tragedy."*
1978	Otto Kaser	*"Post-operative Complications."*
1977	Denis Cavanagh	*"Eclamtogenic Toxaemia – The Science and the Art."*
1976	John H. Pinkerton	*"The Tell Tale Heart."*
1975	Marcel Renaer	*"Transplacental Haemorrhage as a Cause of Perinatal Mortality and Morbidity."*
1974	James Scott	*"Counting the Cost"*
1973	Mogens Ingerslev	*"Modern Democracy in the National Health Service"*
1972	Ian Donald	*"Naught for Your Comfort"*
1971	Raymond Illsley	*"Social Limitations on Obstetric Management."*
1970	Christopher J. Dewhurst	*"The Place of Modern Technical Advances in Obstetrics."*
1969	Dunanc Reid	*"The Right and Responsibility."*
1968	G. J. Kloosterman	*"The Practice of Obstetrics in the Netherlands."*
1967	Sir John Peel	*"Pre-Diabetes in Obstetrics and Gynaecology."*
1966	Hugh McLaren	*"The Conservative Treatment of Cervical Pre-Cancer."*
1965	John McClure Browne	*"Placental Insufficiency."*
1964	Sir Hector MacLennan	*"Version."*
1963	Harold Malkin	*"The Art of Obstetrics."*
1962	Charles Scott Russell	*"The Fetus and its Placenta."*
1961	Sir Norman Jeffcoate	*"Prolonged Labour."*
1960	John Stallworthy	*"The Debt We Owe."*
1959	George Gibbard	*"Changes in the Manifestations of Puerperal Sepsis."*
1958	Sir Arthur Gemmell	*"Some thoughts on the Adrenal in pregnancy."*

Executive Committee (The Board)

Pat McCann Deputy Chairman

Pat has over fifty years' experience in the Hotel business. He started in 1969 in Ryan Hotel Group plc before joining Jurys Hotel Group plc in 1989. He retired from Jurys Doyle in 2006 and founded Dalata Hotel Group in 2007. Pat served as President of IBEC from September 2019 to September 2020. Pat was Chairman of Whitfield Hospital in Waterford from 2011 to 2018. He is currently a Non-Executive Director of Glenveagh and a number of private companies.

William Johnston Honorary Secretary

William Johnston is an economics graduate of Trinity College Dublin, a solicitor and the external examiner in banking law for the Law Society; he is a member of the Governing Body and chair of the Finance and Property Committee of Technological University Dublin.

Prof Shane Higgins Master

Shane Higgins, is a Consultant Obstetrician/ Gynaecologist and the current Master of The National Maternity Hospital. He is an Associate Professor at UCD, Department of Obstetrics & Gynaecology and has a special interest in Maternal-Fetal Medicine. Shane has a broad range of clinical and management experience gained within Ireland, Scotland and Melbourne, Australia.

Jill Beck

Jill Beck graduated from Trinity College with a Mechanical Engineering and Mathematics Degree. She has been working as a Commercial Manager in the Construction Industry for the past 20+ years. She has been involved in such projects as semi-conductor plants, pharmaceutical manufacturing facilities, Data Centres, Hotels, College and many more.

Cllr Emma Blain

Emma is a councillor on Dublin City Council, having previously served on Dún Laoghaire Rathdown County Council from 2016-2024. She is also an Irish delegate to the European Committee of the Regions, representing the interests of Dublin City at the European Union. An experienced media and communications professional, she is also the editor of The Church of Ireland Gazette. She was elected Lord Mayor of Dublin in Dec 2024 and served in that role until June 2025.

Michele Connolly (to Jun)

Michele Connolly is a Chartered Accountant with over 25 years commercial experience. She is currently a partner in KPMG Ireland and Head of Corporate Finance. She specialises in supporting State, Semi State, not for profit and commercial companies in development of new infrastructure, fund raising and general financial matters.

Andrew Crotty

Andrew Crotty is a Chartered Accountant with over 40 years' experience initially in a partnership practice and subsequently in the commercial sphere as finance director of TileStyle. Whilst now retired he continues to be involved as a long-standing financial consultant to a number of companies and individuals.

Sarah Claxton

Sarah is an Engineer with over 24 years' experience in the energy industry. Having worked in technical engineering and line management roles, she completed an MSc in Work and Organisation Behaviour and has worked in the area of Strategic HR & Organisation Development for the past 10 years. She currently leads People and Organisation Capability at ESB Networks as that business transforms to enable wide-scale electrification of society in support of the National Climate Action Plan.

Denise Cole

Denise Cole has 25 years of experience working in Human Resources and combines a wealth of strategic and operational HR and organisation development experience in both the private and public sectors. Her career includes KPMG in London and Dublin, the Beacon Hospital as Head of HR and St James Hospital as Head of HR Strategy. Denise is currently Head of HR for the Courts Service where she leads a People & Organisation Transformation programme.

Aidan Devlin

Aidan Devlin is a Chartered Accountant and a UCC Commerce graduate. He is a member of the Institute of Directors in Ireland and the Mediators Institute of Ireland. Aidan has over 35 years' experience in Corporate Banking and Project Finance both in Ireland and the Middle East. He is also a board member of an Affordable Housing Body and was a founding board member of the NMH Foundation.

Frank Downey (to May)
Frank Downey has over 30 years' experience as an Actuarial and Employee Benefits Consultant. Frank is an economics graduate of Trinity College, Dublin, a Director of Invesco Limited and an actuary and advisor for corporate clients. Frank also acts as a trustee for a number of large pension schemes.

Cllr Cian Farrell
Cian Farrell is a Dublin City Councillor for the South East Inner City ward. Cian studied International Commerce in UCD, and currently works for a technology company.

Fr Alan Hilliard
Fr Alan Hilliard serves as administrator of Westland Row, City Quay and University Churches in Dublin's South Inner City. He spent many years as Coordinator of the Pastoral Care and Chaplaincy Service guiding it through the transition from DIT to TU Dublin while ensuring a high quality of service to all students and staff. He has had varied roles in his time with the Archdiocese of Dublin including Director of the Irish Episcopal Commission for Emigrants and Prisoner's Overseas. He is an author of many books published by Messenger Publications and is a familiar voice on RTE's A Word in Edgeways.

Dr Nikki Higgins (from May)
Nikki Higgins is a Consultant Anaesthetist who graduated from UCD with a Bachelor of Science degree in 2002, and later from the school of medicine in 2009. Having completed fellowships in Obstetric Anaesthesia, Bariatric Anaesthesia, and Intensive Care Medicine in the UK. She took up her first consultant role at St George's Hospital in London, where she remained for 4 years. She is currently Director of Anaesthesia at The National Maternity Hospital and also works as a Consultant Anaesthesiologist at St Vincent's Hospital Group. Her special interests include bariatric and obstetric anaesthesia, and improving patient experience, quality improvement and maternal critical care.

Prof Declan Keane
Declan Keane has been a Consultant Obstetrician since 1995 and is a former Master of the Hospital. He has worked in the UK and the USA and was recently appointed as a Professor to the RCSI. He has considerable administrative experience and was a former member of the National Women's Council and was the obstetrician advising the Citizen's Assembly on the 8th Amendment. Prof Keane commenced as Clinical Director in November.

Carmel Logan
Carmel Logan is a Chartered Accountant and Tax Adviser. She is a partner at KPMG with over 20 years' experience providing tax services to Irish and international companies across a range of sectors including real estate, infrastructure, technology and life sciences. She is also a member of a number of industry bodies across the sectors she works in.

Prof Fionnuala McAuliffe
Fionnuala McAuliff e is Chair and Professor of Obstetrics & Gynaecology, UCD, Director UCD Perinatal Research Centre, Head, Women's and Children's Health, UCD, Consultant Obstetrician & Gynaecologist at The National Maternity Hospital. Her subspecialty area is maternal and fetal medicine and she is Programme Director of the RCOG maternal and fetal medicine subspecialisation fellowship at NMH. She has received significant grant funding both nationally and internationally. Fionnuala has developed guidelines for pregnancy both in Ireland, UK and internationally.

Jane McCluskey
Jane McCluskey is a lawyer with a large multinational technology company and has over ten years' experience practising corporate, commercial and intellectual property law. She is also a registered trade mark agent.

Dr Roger McMorrow (to May)
Roger McMorrow is a graduate of The Queens University of Belfast and he has been a Consultant Anaesthetist at the National Maternity Hospital and St Vincent's University Hospital since 2009. He has served as Clinical Director of the NMH from January 2018 to May 2025. He has a specialist interest in high risk obstetrics, clinical risk and high altitude mountaineering. In 2007 he was part of an expedition that reached the summit of Mt Everest and in 2024 he rowed the Atlantic as part of a crew of five.

Tom Murphy Honorary Treasurer
Tom Murphy is a Chartered Accountant with over 30 years of financial and commercial experience while based in the UK, the US and Ireland. He served as CFO of Fyffes Plc. for 14 years. Now retired, he is a non-executive director of several companies.

Cllr. Naoise Ó'Muirí (to Jan)

Naoise Ó Muirí has served as a Dublin City Councillor since June 2004 and is a former Lord Mayor of Dublin. Naoise studied Engineering at the National University of Ireland, Galway and runs a technology company. He was elected to Daíl Éireann in November 2024.

Alison Quinn

Alison graduated from UCD with a BComm degree and then completed a Masters in International Business from Smurfit Business School before qualifying as a solicitor. Alison is an experienced commercial lawyer and litigator with more than 12 years experience advising multinational companies, Irish corporations and semi-state bodies on a range of commercial, consumer, data protection (GDPR) and technology matters. Her work has included secondment to a large tech organisation and representing clients before the Irish Commercial Court, the Irish High Court, and the European Court of Justice.

Dr Michael Robson

Michael Robson is a Consultant Obstetrician & Gynaecologist and former Master of the NMH. Dr Robson is the National Clinical Director of the Maternal and New-born Clinical Management System (Maternity, neonatal and gynaecology electronic patient record for Ireland). He also developed the methodology behind the perinatal and caesarean classification system used world wide known as the Ten group (Robson) Classification System.

Patricia O'Shea

Patricia O'Shea is a law graduate of University College Cork and is Group Head of Legal Affairs & Secretariat for a semi-state company. She was formerly General Counsel of a US multinational company serving as Company Secretary and a Director of a group company.

Dr Deirdre Sweetman

Dr Deirdre Sweetman graduated from UCD School of Medicine and began her training in Paediatrics and Neonatology in Ireland. She completed a PhD in neonatal brain injury in the NMH and moved to Melbourne where she undertook a neonatology fellowship in the Royal Women's Hospital and Royal Children's Hospital. Deirdre returned to Ireland and took up a Consultant Neonatologist post in Holles Street in 2015. Deirdre is the Director of Neonatology at the NMH and continues to have a strong interest in neonatal neurocritical care.

Prof Jennifer Walsh

A graduate of UCD, Jennifer Walsh is a Consultant Obstetrician & Gynaecologist and Maternal and Fetal Medicine Subspecialist at the National Maternity Hospital. She was appointed to NMH in 2016 following completion of postgraduate subspecialty training at Columbia University NYC. She is the Director of Fetal Medicine at the NMH. Jennifer sits on both the Project Team and Programme Board (formerly Project Board) for the move to SVUH campus at Elm Park and chairs the Digital Health Steering Group for the future hospital.

Charles Watchorn (from May)

Charles Watchorn is a Chartered Accountant and a Dublin University mathematics graduate. He is a member of the Institute of Directors in Ireland. Charles has over 30 years' experience working in US software multinationals with responsibilities across Europe, India and Asia. He is also a board member of Tusla and Chairs the board of Saint John of God Community Services.

Executive & Sub Committees

Executive Committee

Most Rev. Dr Dermot Farrell, Archbishop of Dublin, *Chairman*
Lord Mayor, Emma Blain *(to Jun)*
Cllr Emma Blain *(from Jun)*
Lord Mayor, Ray McAdam *(from Jun)*
Mr Pat McCann, *Deputy Chairman*
Mr William Johnston, *Honorary Secretary*
Mr Tom Murphy, *Honorary Treasurer*
Prof Shane Higgins, *Master*
Fr Alan Hilliard
Cllr Cian Farrell
Ms Patricia O'Shea
Ms Jill Beck
Ms Sarah Claxton
Ms Denise Cole
Michele Connolly *(to May)*
Mr Andrew Crotty
Mr Aidan Devlin
Mr Frank Downey
Dr Nikki Higgins *(from May)*
Prof Declan Keane
Ms Carmel Logan
Prof Fionnuala McAuliffe
Ms Jane McCluskey
Dr Roger McMorrow *(to May)*
Cllr Naoise Ó Muirí *(to Jan)*
Ms Alison Quinn
Dr Michael Robson
Dr Deirdre Sweetman
Prof Jennifer Walsh
Mr Charles Watchorn *(from May)*

In Attendance

Mr Ronan Gavin, *Secretary/General Manager*
Ms Mary Brosnan, *Director of Midwifery & Nursing (to Jun)*
Ms Annmarie Sliney, *Director of Midwifery & Nursing (from Jul)*
Mr Alistair Holland, *Financial Controller*

Finance Committee

Mr Pat McCann, *Deputy Chairman*
Mr William Johnston, *Honorary Secretary*
Mr Tom Murphy, *Honorary Treasurer, Chair*
Prof Shane Higgins, *Master*
Ms Denise Cole
Ms Carmel Logan
Mr Aidan Devlin

In Attendance

Mr Ronan Gavin, *Secretary/General Manager*
Ms Mary Brosnan, *Director of Midwifery & Nursing (to Jun)*
Ms Annmarie Sliney, *Director of Midwifery & Nursing (from Jul)*
Mr Alistair Holland, *Financial Controller*

Audit Committee

Mr Aidan Devlin, Chair
Mr Tom Murphy, *Honorary Treasurer*
Mr Frank Downey
Mr Charles Watchorn

In Attendance

Mr Ronan Gavin, *Secretary/ General Manager*
Mr Alistair Holland, *Financial Controller*
Mr Eoghan Hayden, *Chief Clinical Engineer*

QRPS Committee

Ms Sarah Claxton, Chair
Mr Aidan Devlin *(to May)*
Prof Declan Keane
Ms Carmel Logan
Prof Fionnuala McAuliffe
Ms Jane McCluskey
Mr Bernard McLoughlin
Dr Roger McMorrow *(to May)*
Cllr Patricia O'Shea

In Attendance

Mr Ronan Gavin, *Secretary/ General Manager*
Dr Orla Sheil, *Director of Quality Risk & Patient Safety*
Mr Carl Alfvag, *Compliance & Operations Manager*
Mr Martin Creagh, *Operational Risk Manager*

Co-Location

Mr Pat McCann, *Deputy Chairman*
Mr Tom Murphy, *Honorary Treasurer*
Prof Shane Higgins, *Master*
Ms Jill Beck
Ms Sarah Claxton
Dr Orla Sheil
Mr Roger McMorrow *(to May)*

In Attendance
Mr Ronan Gavin, *Secretary/ General Manager*
Ms Sarah McCourt, *Project Coordinator*

Nominations Committee
Mr Pat McCann, Deputy Chair *(Chair)*
Mr William Johnston, *Honorary Secretary*
Mr Tom Murphy; *Honorary Treasurer*
Prof Shane Higgins, Master
Prof Declan Keane
Dr John Murphy *(to May)*
Ms Denise Cole
Ms Sarah Claxton
Mr Aidan Devlin
Mr Andrew Crotty *(from May)*
Ms Cecilia Barker *(from May)*

In Attendance
Mr Ronan Gavin, Secretary/General Manager

Medical Fund Committee
Ms Michele Connolly, Chair *(to May)*
Mr Andrew Crotty, Chair *(from May)*
Prof Shane Higgins, *Master*
Dr Stephen Carroll
Mr Frank Downey
Prof Declan Keane

In Attendance
Mr Ronan Gavin, *Secretary/General Manager*
Mr Alistair Holland, *Financial Controller*
Mr Francis Rogers, *Management Accountant*

Executive Ethics Committee
Dr John Murphy, *Consultant Neonatologist, Chair*
Prof Shane Higgins, *Master*
Ms Catherine Altman
Dr Ingrid Browne
Ms Denise Cole
Ms Caroline Devlin
Mr Frank Downey
Dr Paul Downey
Ms Jane McCluskey

In Attendance
Mr Ronan Gavin, *Secretary/ General Manager*

House Committee
Ms Catherine Altman *(Chair to Jun)*
Ms Cecilia Barker *(Chair from Jun)*
Ms Sara Appleby
Ms Louise Bennett
Ms Bernadette Campion
Ms Sheena Carton
Ms Fiona Davy
Ms Elaine Doyle
Ms Margaret Fanagan
Ms Kate Higgins
Ms Keara McAndrew
Ms Margaret McCourt
Ms Anne Murphy
Ms Teresa Murphy
Ms Suzanne O'Brien
Ms Aoife O'Shea

In Attendance
Prof Shane Higgins, *Master*
Ms Mary Brosnan, *Director of Midwifery & Nursing (to Jun)*
Ms Annmarie Sliney, *Director of Midwifery & Nursing (from Jul)*
Mr Mark Anderson, *Hygiene Services Manager*

People & Organisation Committee
Ms Denise Cole, *Chair*
Ms Sarah Claxton
Mr George Maybury
Ms Patricia Nolan
Ms Mairéad Callanan
Ms Alison Quinn *(from May)*

In Attendance
Mr Ronan Gavin, *Secretary/General Manager*
Ms Mary Brosnan, *Director of Midwifery & Nursing (to Jun)*
Ms Annmarie Sliney, *Director of Midwifery & Nursing (from Jul)*
Ms Caoimhe de Brun, *HR Manager*
Ms Erika O'Shaughnessy, *Deputy HR Manager (from Jul)*
Ms Yvonne Connolly, *Director of Learning and Development*

Board of Governors

Governors Ex-Officio

Most Rev Dr Dermot Farrell, Archbishop of Dublin, Chairman
Cllr Emma Blain, Lord Mayor (to Jun)
Cllr Ray McAdam, Lord Mayor (from Jun)
Prof Shane Higgins, Master
Very Rev Alan Hilliard, Administrator, Parish of St. Andrew, Westland Row

Nominated by the Minister for Health

Ms Patricia O'Shea
Vacant

Nominated by Dublin City Council

Councillor Cian Farrell
Councillor Emma Blain (from Jun)

Governors Elected

Dr Niall O'Brien
Mr J. Brian Davy
Mrs Judith Meagher
Dr Jack T. Gallagher
Mr Gabriel Hogan
Mrs Anne Davy
Mrs Margaret Anderson
Mrs Kathleen O'Grady
Dr Frances Meagher
Mr Kevin Mays
Dr Declan O'Keeffe
Prof Colm O'Herlihy
Mr William Johnston
Dr Peter Boylan
Mrs Joanne Keane
Mrs Anne Murphy
Mr Frank Downey
Mr Anthony Garry
Ms Alexandra Spain
Mrs Margo McParland
Mrs Catherine Altman
Dr John Murphy (Neonates)
Mr Niall Doyle
Ms Lydia Ensor
Ms Sara Appleby
Ms Sheena Carton
Ms Elaine Doyle
Ms Maeve Dwyer
Ms Caroline Hayes (Simons)
Prof Declan Keane
Dr Peter Lenehan
Dr Peter McParland
Dr Orla Sheil
Dr Kevin McKeating
Mrs Mary Donohoe
Ms Catherine Ghose
Mr Barry Dixon
Mrs Margaret McCourt
Ms Suzanne O'Brien
Ms Paula Reid
Ms Teresa Murphy
Ms Eugenee Mulhern
Ms Fiona Davy
Dr Michael Robson
Dr Deirdre MacDonald
Ms Isabel Foley
Prof Fionnuala McAuliffe
Ms Jane McCluskey
Deputy (TD) Naoise Ó Muirí
Ms Elizabeth Nolan
Dr Ingrid Browne
Ms Niamh Callaghan
Ms Helen Caulfield
Ms Marie Daly Hutton
Mr Aidan Devlin
Ms Rachel Hussey
Ms Lisa Taggart
Mr Stephen Vernon
Mr Nicholas Kearns
Ms Michele Connolly
Ms Aoife O'Connor
Dr Roger McMorrow
Dr Paul Downey
Mrs Kate Higgins
Dr Rhona Mahony
Ms Caroline Devlin
Ms Aoife O'Shea
Ms Denise Cole
Mr Pat McCann
Ms Louise Bennett
Dr Stephen Carroll
Ms Sarah Claxton
Mr George Maybury
Mr Bernard McLoughlin
Ms Patricia Nolan
Ms Carmel Logan
Prof Jennifer Walsh
Mr Tom Murphy
Ms Cecilia Barker
Ms Bernadette Campion
Ms Sara Spencer
Mr Andrew Crotty
Mr Charles Watchorn
Ms Keara McAndrew
Ms Margaret Fanagan
Dr Deirdre Sweetman
Ms Jill Beck
Ms Mairéad Callanan
Ms Alison Quinn
Dr Nikki Higgins
Mr Keith McCormack

Professional Advisors

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Eleanor Durkin and Theresa Barry, Clinical Midwifery Managers in our Parent Education Department.

Neonatology

The Department of Neonatology aims to deliver excellence in neonatal care through innovation, co-operation, education, research with attention to evidence based practice, empathy and a family-centred approach. The NMH Neonatal Intensive Care Unit (NICU) provides tertiary medical services for newborns up to 6 weeks of age and admits patients from all over Ireland.

The neonatal unit has 35 beds (9 NICU, 13 HDU, and 13 SCBU) and provides a high level of care to medically complex neonates. It is recognised for its expertise in the management of prematurity, neonatal encephalopathy, seizures, perinatal stroke, sepsis, twin-to-twin transfusion syndrome, rhesus isoimmunisation and congenital anomalies.

We supervise the care of all liveborn babies (n=7,218) who are born in the Hospital even if they do not require admission to the Neonatal Intensive Care Unit (NICU). Our staff attend all instrumental deliveries, emergency caesarean sections and the delivery of any baby where there are recognised risk factors: in 2025, the instrumental delivery rate was at 11.9% and emergency C/S rate 20.1%. Every baby born in NMH undergoes a comprehensive physical examination by one of the neonatal team before discharge home. On average, we examine approximately 20 babies a day. Apart from providing reassurance to parents, this examination allows us to pick up conditions including heart murmurs, unstable hips and congenital anomalies that may not have been suspected antenatally so that advice can be given, and appropriate follow-up arranged. With mothers and babies spending less and less time in hospital, it is often a challenge to arrange such tests and referrals in such a short-time frame, particularly over weekends. We provide a 24/7 nurse-doctor team every third week to the National Neonatal Transport Programme (NNTP), a vital service that transports critically ill newborn babies from anywhere in the country. Our staff is available to meet any family in advance of a delivery where problems are anticipated. This service has grown significantly over the past few years for a variety of reasons including more widespread access to routine antenatal scanning, advances in neonatal care and recent legislation allowing for termination of pregnancy in cases of fatal fetal anomalies. Our care of a baby does not end when the baby is discharged from the hospital as many of our babies return to clinic for follow-up or are referred for assessment by their GP or Public Health Nurse.

Last year, in 2025, we admitted 1,337 babies to the NICU. On average, 1 in every 6 babies delivered in the Hospital is admitted to us even if only for a brief period of time. Many first-time parents are surprised to hear how high that figure is and are often not prepared for the fact that they may be separated from their baby for several hours. For the past number of years, we have made every effort to keep our admission rates for term infants (those infants born ≥37 weeks' gestation) as low as possible. We do this by auditing the reasons why babies are admitted and by looking at alternative ways to provide care that minimise the chances of mothers and babies being separated. In 2020, we introduced changes to how hypoglycaemia (low blood glucose) was managed in the newborn period. By doing so, our staff, supported by our nursing and midwifery colleagues on the postnatal wards, reduced the admissions for hypoglycaemia from 306 babies in 2019 to 52 babies in 2025. We will continue to make incremental changes year on year guided by feedback received from families who have used our services. A core value in our department is the concept of family-centred care, not just for those babies who spend long periods of time in our NICU, but also for those babies who may only be with us for a few days. As the clinicians caring for babies, we believe our role is to support families to provide as much of the direct care that their babies need as possible. Family Integrated Care (FICare) is a model of care developed initially in North America which aims to involve families in an integral way in the care of their babies while in NICU. FICare integrates families as partners in the NICU care team and provides a structure that supports the implementation of family-centred care. In 2023, we first introduced FICare initiatives to our NICU. We began by instituting a number of changes in the NICU to align more closely with a FICare model. For example, we have rolled out regular FICare group meetings for parents

Dr Georgia Dugaci Neonatal SpR and Dr Amna Elgaali, Neonatal SHO.

(mother's group, father's group and joint group sessions) to encourage mutual parental emotional and psychological support and to give parents a forum to feedback to us on where we could improve our NICU service. In 2025, we expanded our NICU parental support group in the form of a "NICU Parents' Café" on the hospital campus. This a weekly sit-down session for NICU parents facilitated by NICU staff. This initiative has been predominantly led by NMH neonatal nursing and Health and Social Care Professionals and I would like to thank all those involved in making these meetings a success. We are also working on FiCare cot cards for parents and nurses to fill in with the aim of increasing parental involvement in the day-to-day activities of their NICU baby. Also, during the ward rounds, parents are now encouraged to be at their baby's cotside to contribute to the ward round discussion and parents at a neighbouring cotside are offered noise cancelling headphones to promote confidentiality between patients. Ideally, mothers (and partners) should be accommodated in beds beside their sick babies. Obviously, the infrastructural constraints of our hospital in its current location are the main reason why this cannot be achieved. This hospital was not built with modern neonatal intensive care in mind. This is another reason why this Department, along with the rest of the hospital, is fully supportive of our co-location to the St Vincent's University Hospital campus. In a newly built modern hospital, one that is specifically designed with mothers and babies in mind, mothers and partners will be able to room-in with their babies day and night. Our NICU is one of four designated tertiary care NICUs in this country that provides specialised care to the most premature of infants, many of whom are referred to us while still in-utero (i.e. when the mother is still pregnant) from locations all around the country.

Last year, in 2025, we looked after 113 Very Low Birth Weight Infants (babies born ≤29 weeks and/or ≤1500g). These infants are extremely vulnerable and often spend several weeks in hospital frequently not being discharged home before their due date. There have been major advances in neonatal intensive care medicine over the past 50 years and survival across all gestational ages is increasing. We now have reported survivors of infants born at 23 weeks' gestation. In our hospital, where healthy babies are born at a rate of about one every hour, it can be hard to fathom that just a few feet away, in our NICU on the first floor, a tiny baby weighing less than 1lb may be attached to a life-support machine, receiving high level intensive care. The probability of a baby surviving at 23 weeks is still quite low but some of these tiny babies can, and do, survive. Unfortunately, many will face ongoing challenges, particularly as they get older, in terms of their long-term neurodevelopmental outcome. As greater numbers of these tiny fragile babies survive, research has shown us that optimising babies' early neurosensory experiences, and social environment, impacts on their

long-term neurodevelopmental outcome. By providing individualised, neuroprotective care to each baby, by gentle containment, minimising stress and pain, safeguarding sleep and optimising nutrition, it has been shown that babies have better long-term physical, cognitive and emotional outcomes. Such developmental care principles underpin all of our care practices in the NICU. Our multidisciplinary team (MDT) which includes Psychology (Marie Slevin), Physiotherapy (Jo Egan and team), Dietetics (Roberta McCarthy and her team), Speech and Language Therapy (Zelda Greene), Neonatal Occupational Therapy (Aoife Tonge) and Medical Social Work (Sarah Lovely, Kim Bartley and team) complement the advanced medical and nursing care we provide, advising parents and staff alike on positioning, feeding and social interactions. We continue to benchmark our neonatal outcomes with the Vermont Oxford Network (VON) and the National Perinatal Epidemiology Centre (NPEC).

Our NICU is one of 4 centres in the country that provides therapeutic hypothermia to infants with Hypoxic Ischaemic Encephalopathy (HIE). In 2025, a total of 9 infants (5 inborn and 4 outborn) were reported with HIE of which 9 (5 inborn and 4 outborn) received therapeutic hypothermia. A further 3 infants (0 inborn and 3 outborn) were diagnosed with Neonatal Encephalopathy but did not meet the criteria for HIE. All 3 of these underwent therapeutic hypothermia. Details on these cases are included in this report (see Neonatal Encephalopathy section).

In late 2023, we launched the Early Detection and Intervention for Cerebral Palsy in Ireland (EDI-CPI). This project aims to reduce the age at diagnosis of cerebral palsy (CP) to < 12 months of age. It is supported by the Cerebral Palsy Foundation in the United States and has been rolled out nationally across all 4 tertiary maternity hospitals. The project involves identifying newborn babies who are at higher risk of developing CP prior to NICU discharge and following these babies in a structured way with regular neurological examinations in the outpatient setting (baby clinic and neonatal physiotherapy outpatients). Where neurodevelopmental concerns arise, there is a formal pathway for referral to a more specialised neurodevelopmental clinic in the NMH and MRI brain/genetic investigations as appropriate. In 2025, we continued to improve on recruitment and retention to the study. The CP early detection team in the NMH have undergone significant training and have invested huge time and energy into this project. I would like to take this opportunity to thank everyone involved.

Another significant development in our neonatal service over 2025 has been the expansion of our neonatal MRI service in the NMH. We are now able to offer neonatal inpatients an MRI scan within 2-3 days. For NMH infant outpatients, we have high success rates with 'Feed and Wrap' MRI scans up to the age of 16 weeks corrected gestational age. This is no small feat and in the main part, this success rate is due to the skill and dedication of our neonatal MRI nurses with the support of the NMH radiology team. We have further expanded this service to include babies from the Rotunda Hospital who require MRI scans and we are in discussions with the Coombe Hospital also.

2025 saw the continuation of the seasonal respiratory syncytial virus (RSV) immunisation programme (Nirsevimab) for all newborn infants born in the NMH from 1st September 2025, following a very successful introductory HSE pathfinder programme in autumn 2024. This immunisation is > 80% effective and protects babies for the first 150 days of life and is particularly effective in reducing the incidence of severe RSV infection. We had very high uptake rates in the NMH (>80%), congratulations to all the midwifery, nursing, medical and education and training staff who helped to make this programme such a success.

Our outpatient clinic continued to be very busy, with numbers attending increasing year on year. In all, 3,083 babies were seen in clinic of which 1,895 were first-time visits and 1,188 were follow-up visits.

Apart from overseeing the patients who attend, the outpatient nursing and administrative staff triage numerous queries, provide a huge amount of advice over the telephone to families, GPs and community services and follow up on a myriad of investigations and referrals. While a large part of this work often goes unnoticed, the clinic could not provide such a good service to our families without their dedication. Over the last number of years, we

Henry Murphy and his Mother Alice in the NICU.

have also developed a specialised multi-disciplinary clinic for follow-up of the ex-NICU high risk babies (ACORN clinic, see below).

The NMH neonatal Clinical Psychologist, Marie Slevin, continues her important work in seeing all our NICU graduates at 2 years corrected age for a detailed neurodevelopmental assessment. Such data are invaluable by providing us with important feedback as to how our babies do in the long-term. Additionally, these assessments can provide families with very useful information that can be used to lobby for additional resources for their infant, if required.

Staying with the neonatal follow-up theme, we held our World Prematurity Day Coffee afternoon for ex-NMH NICU graduates on Sunday 16th November 2025. We invited 85 families in advance and 109 people (36 families) attended on the day. This event was a resounding success with a huge attendance. The neonatal team pulled out all the stops for our ex-NICU families; there was a photo-booth, a soft play area, a 'mini-hospital play area', finger painting, arts and crafts area and lots of purple cupcakes. It provided a lovely opportunity for families to return to the NMH with their infants and toddlers for a happy, social occasion where they got to meet up with other families and with the nurses and doctors who cared for their babies while they were in the NICU.

Research plays a central and important role in the Neonatal Unit. In 2025, four Neonatology Specialist Registrars performed clinical research in the Department for higher degrees at UCD. Dr Elizabeth Murphy and Dr Laura Ryan studied airway management of newborns, supervised by Dr. Anna Curley and Dr. Eoin Ó Curraín; and Dr Robert Joyce studied the use of videolaryngoscopy when administering surfactant to preterm newborns in the delivery room, supervised by Prof Colm O'Donnell. Dr Daniel O'Reilly focused on neonatal platelet activation, targeting infection detection in preterm infants and was supervised by Dr Anna Curley and Dr Naomi McCallion (Consultant Neonatologist at the Rotunda Hospital). The Department also participated in several multi-centre trials. Our NCHDs and nursing staff are encouraged to participate in local projects and audits, and to present their work at local and international meetings. We are enormously grateful to our families for their willingness to participate in research at such a difficult time in their lives. We are also hugely grateful to our colleagues – nursing, administrative, clinical engineering, allied health and medical – for their support us as we try to answer important questions about how to better care for babies.

One achievement the Department would like to highlight this year is the continued promotion of breastfeeding for our most vulnerable babies. We actively encourage women to express breast milk for their premature babies and use those tiny precious drops of colostrum as babies' first feeds. With the support and encouragement, not just of the staff in the NICU but also of the staff on the postnatal wards, the numbers of babies receiving their own mother's milk is increasing and we are seeing for the first time, mothers who have successfully transitioned their baby from tube feeding to exclusive breastfeeding, before discharge home.

Our staff should take great pride in the role they play in empowering women to successfully breastfed their babies even when delivered prematurely.

In addition, 2023 saw the appointment of an additional lactation nurse dedicated to NICU, Ms Ramita Dangol. Ramita has hugely enhanced the lactation support service offered to NICU mothers and has introduced a number of quality improvement initiatives which have resulted in both cost and environmental savings. The wider hospital lactation team also help our NICU mothers hugely and we sincerely thank them for this support.

While most babies make the transition to extra-uterine life without a problem, we know that about 5 in every 100 babies born at term require medical assistance to help them begin breathing. As time is of the essence, much effort is focused on training staff, and not just those working in the Department of Neonatology, in the art of neonatal resuscitation. Increasingly, it is being recognised that simulation is a powerful tool to teach practical skills, build proficiency and speed and encourage good teamwork. Dr Eoin O'Currain, Dr Carmel Moore and Ms Shirley Moore ANP now run weekly neonatal resuscitation simulations in various locations around the hospital. These sessions have been very well received by staff and have resulted in improved core competencies across all levels and grade of staff.

Sadly, not all babies born in the NMH survive and ensuring that the journey travelled by these families is as free from distress as possible is extremely important. In 2025, we further expanded our neonatal palliative care service in conjunction with the paediatric palliative care team in Children's Health Ireland. Dr John Allen, consultant in paediatric palliative care medicine attends the NMH weekly and offers valuable insights and advice to the weekly perinatal meeting and the neonatal-fetal medicine MDT. Dr Allen provides excellent support to both the neonatal and fetal medicine teams and enhances the links with community palliative care services.

We continue our use of "AngelEye" in the NICU; a secure camera system that allows mothers and their partners to keep a watchful eye on their babies even when not in the hospital. This facility for families receives much positive feedback. The option to access all teaching sessions and hospital meetings using a virtual platform is now standard, allowing the staff much greater flexibility and leading to increased attendance rates. Our Allied Health Professionals and Clinical Discharge Coordinators took virtual platforms a step further and now host a number of parental educational webinars and facilitated Q&A sessions on-line and these have been very well received by families.

May I conclude by taking this opportunity to thank the entire neonatal team which includes consultant colleagues, our non-consultant hospital doctors, many of whom are with us for more than one year, our neonatal nursing staff under the excellent leadership of our CMM3, Ms Sara Rock, our allied health professionals, our multi-task assistants, our administrative staff and our dedicated household staff. We must also mention the many other ancillary services who support our work including the laboratory, pharmacy, radiology, infection control, ICT, portering and bioengineering. Over 2025, a number of senior NICU staff retired/left the neonatal department, we thank them for their years of service. We are very grateful to our visiting consultants from Children's Health Ireland Crumlin and Temple Street for the service they provide in reviewing our babies and for their support and expert advice.

I would like to thank all of those who contributed to the writing of this report. The time and effort invested is enormous and is much appreciated. Lastly, we acknowledge all the parents and babies who passed through our NICU in 2025, and in particular, the 16 babies who sadly died in our care. They remain in our thoughts.

Dr Deirdre Sweetman
Consultant Neonatologist

Neonatal Activity

Number of Admissions to the Neonatal Intensive Care Unit (NICU)

Year	2021	2022	2023	2024	2025
Number of Admissions	1243	1132	1198	1240	1337

Sources of Admission to the NICU

Year	2021	2022	2023	2024	2025
First admission for inborn infants	1059 (85%)	957 (85%)	1005 (84%)	1043 (84%)	1157 (87%)
- Delivery Ward	783	715	764	784	878
- Theatre	*Inc. above*	*Inc. above*	*Inc. above*	*Inc. above*	*Inc. above*
- Postnatal Ward	276	242	241	259	279
First admission for Outborn infants	60 (5%)	57 (5%)	28 (2%)	60 (5%)	53 (4%)
First admission from home	59 (5%)	48 (4%)	66 (6%)	64 (5%)	59 (4%)
Readmission from postnatal ward	15 (1%)	29 (3%)	43 (4%)	38 (3%)	30 (2%)
Readmission from other hospital	14 (1%)	11 (1%)	14 (1%)	16 (1%)	14 (1%)
Readmission from home	36 (3%)	30 (3%)	42 (4%)	19 (2%)	24 (2%)
Total	**1243**	**1132**	**1198**	**1240**	**1337**

Clinical Reasons for First Admission of Inborn and Outborn Infants

Clinical Reason	2021	2022	2023	2024	2025
Respiratory	394 35%	402 40%	381 37%	440 40%	503 42%
Prematurity	248 22%	134 13%	145 14%	112 10%	143 12%
Gastroenterology	109 10%	77 8%	70 7%	43 4%	52 4%
Suspected/Proven Infection	111 10%	39 4%	83 8%	188 17%	215 18%
Small for Dates	81 7%	135 13%	138 13%	142 13%	127 10%
Conwgenital Anomalies	37 3%	26 3%	31 3%	19 2%	21 2%
Cardiac	41 4%	33 3%	29 3%	33 3%	43 4%
Birth Depression	17 2%	8 1%	4 <1%	12 1%	13 1%
Other Neurological	20 2%	11 1%	14 1%	25 2%	15 1%
Surgical	6 <1%	2 <1%	2 <1%	6 <1%	2 <1%
Haematological	14 1%	7 1%	6 1%	11 1%	9 <1%
Other	41 4%	140 14%	130 13%	72 7%	67 6%
Total	**1119**	**1014**	**1033**	**1103**	**1210**

Levels of Neonatal Care

Year	2021	2022	2023	2024	2025
Number of Intensive Care Days	1295	1208	1299	1444	1397
Number of High Dependency Care Days	3142	2659	3201	3423	4033
Number of Special Care Days	5440	4563	4646	4107	4460

**British Association of Perinatal Medicine. Categories of Care 2011 (August 2011). https://www.bapm.org/resources/34-categories-of-care-2011*

Outpatient Clinic Attendances

Year	2021	2022	2023	2024	2025
Actual clinics	250	249	360	377	408
New patients (first visits)	1827	1784	1650	1821	1895
Return visits	1332	1031	1348	1307	1188
Total visits	**3159**	**2815**	**2998**	**3128**	**3083**

Summary of Infants reported to VON

Year	All Cases	Number of cases excluding congenital anomalies
Infants <401g	5	3
Infants 401-500g	2	2
Infants 501-1500g	104	92
Infants >1500g but ≤29 wks gestation	2	2
Total	**113**	**99**

Survival Rate to Discharge of VLBW Infants reported to VON according to Gestational Age (n=113)

Gestational Age	Inborn Infants	Survival to Discharge	Outborn Infants	Survival to Discharge	Total Survival to Discharge
<20 wks	2	0 (0%)	0	0 (0%)	0 (0%)
20 wks	2	0 (0%)	0	0 (0%)	0 (0%)
21 wks	0	0 (0%)	0	0 (0%)	0 (0%)
22 wks	2	0 (0%)	1	0 (0%)	0 (0%)
23 wks	4	1 (25%)	0	0 (0%)	1 (25%)
24 wks	3	1 (33%)	0	0 (0%)	1 (33%)
25 wks	10	8 (80%)	1	1 (100%)	9 (82%)
26 wks	7	7 (100%)	1	0 (0%)	7 (88%)
27 wks	11	10 (91%)	1	1 (100%)	11 (92%)
28 wks	11	10 (91%)	2	2 (100%)	12 (92%)
29 wks	22	22 (100%)	2	2 (100%)	24 (100%)
30 wks	12	11 (92%)	0	0 (0%)	11 (92%)
31 wks	8	8 (100%)	0	0 (0%)	8 (100%)
32 wks	9	8 (89%)	0	0 (0%)	8 (89%)
>32 wks	2	2 (100%)	0	0 (0%)	2 (100%)
Total	**105**	**88 (84%)**	**8**	**6 (75%)**	**94 (83%)**

Survival Rate to Discharge of VLBW Infants reported to VON according to Birthweight (n=113)

Birthweight	Inborn Infants	Survival to Discharge	Outborn Infants	Survival to Discharge	Total Survival to Discharge
<501g	7	0 (0%)	0	0 (0%)	0 (0%)
501-600g	4	2 (50%)	1	0 (0%)	2 (40%)
601-700g	13	10 (77%)	1	1 (100%)	11 (79%)
701-800g	10	10 (100%)	0	0 (0%)	10 (100%)
801-900g	7	5 (71%)	1	0 (0%)	5 (63%)
901-1000g	8	7 (88%)	1	1 (100%)	8 (89%)
1001-1100g	9	8 (89%)	0	0 (0%)	8 (89%)
1101-1200g	11	11 (100%)	2	2 (100%)	13 (100%)
1201-1300g	13	12 (92%)	0	0 (0%)	12 (92%)
1301-1400g	11	11 (100%)	0	0 (0%)	11 (100%)
1401-1500g	11	11 (100%)	1	1 (100%)	12 (100%)
>1500g	1	1 (100%)	1	1 (100%)	2 (100%)
Total	**105**	**88 (84%)**	**8**	**6 (75%)**	**94 (83%)**

Sheila Cuidno, Staff Nurse and Ber Ryan, Radiographer with baby Elliott Bulgari in the Neonatal Intensive Care Unit.

Outcomes of VLBW Infants reported to VON (n=113)

	2021	2022	2023	2024	2025	
NMH VLBW Infants	**n=121**	**n=120**	**n=119**	**n=113**	**n=113**	
Inborn	85.1%	92.5%	97.5%	85.8%	105/113	92.9%
Male	45.5%	54.2%	51.3%	53.1%	55/113	48.7%
Chorioamnionitis	22.5%	28.4%	35.1%	27.9%	32/113	28.3%
Maternal Hypertension	18.2%	26.9%	22.7%	25.7%	31/113	27.4%
Maternal Diabetes	8.3%	12.6%	7.6%	10.6%	20/113	17.7%
Antenatal Steroids - All Infants	94.2%	93.3%	84.0%	89.3%	100/112	89.3%
C-Section	71.1%	70.8%	66.4%	63.7%	75/113	66.4%
Antenatal Magnesium Sulfate	78.2%	72.6%	63.9%	67.9%	86/111	77.5%
Multiple Gestation	33.9%	33.3%	19.3%	30.1%	27/113	23.9%
Any Major Anomaly	5.0%	7.5%	16.0%	13.3%	14/109	12.8%
Small for Gestational Age	16.7%	18.6%	27.4%	29.0%	24/108	22.2%
Initial Resuscitation - Surfactant	11.6%	7.5%	8.4%	15.0%	17/113	15.0%
Initial Resuscitation - ETT Ventilation	22.3%	18.3%	25.2%	22.1%	15/113	13.3%
Conventional Ventilation - After Initial Resuscitation	64.0%	59.1%	57.4%	54.4%	60/105	57.1%
High Frequency Ventilation - After Initial Resuscitation	18.4%	15.5%	14.9%	11.7%	8/102	7.8%
Any Ventilation	64.0%	59.1%	57.4%	54.4%	60/105	57.1%
Nasal Ventilation - After Initial Resuscitation	35.1%	37.3%	51.5%	43.7%	48/105	45.7%
Nasal CPAP - After Initial Resuscitation	76.3%	71.8%	76.2%	84.5%	87/104	83.7%
Conventional Ventilation - After Early CPAP	63.3%	61.0%	60.0%	51.3%	47/83	56.6%
Surfactant - After 2 Hours	51.5%	50.0%	48.2%	47.4%	30/60	50.0%
Surfactant - After 2 Hours (501-1250g)	49.1%	38.6%	52.2%	42.9%	22/44	50.0%
Surfactant - At Any Time	56.2%	49.2%	47.1%	50.4%	60/113	53.1%
Steroids for CLD - Any Location	8.8%	17.3%	19.8%	17.5%	17/104	16.3%
Inhaled Nitric Oxide - Any Location	21.1%	13.6%	20.8%	14.6%	10/105	9.5%
Caffeine for Any Reason	88.6%	95.5%	86.1%	87.4%	98/105	93.3%
Respiratory Distress Syndrome	78.9%	59.1%	67.3%	79.6%	91/105	86.7%
Pneumothorax - Any Location	10.5%	10.0%	5.0%	3.9%	4/105	3.8%
Chronic Lung Disease	17.6%	17.1%	19.0%	19.3%	12/80	15.0%
CLD: Infants < 33 Weeks	19.0%	17.1%	22.7%	22.7%	12/78	15.4%
Early Bacterial Sepsis	3.5%	0.0%	5.0%	1.9%	0/105	0.0%
Late Bacterial Infection - Any Location	9.6%	6.8%	9.2%	7.2%	11/94	11.7%
Coagulase Negative Staph Infection - Any Location	10.6%	6.8%	7.1%	4.1%	6/94	6.4%
Nosocomial Infection - Any Location	19.2%	13.6%	15.3%	9.3%	15/95	15.8%
Fungal Infection - Any Location	0.0%	1.0%	0.0%	0.0%	0/93	0.0%
Any Late Infection - Any Location	19.2%	14.6%	15.3%	9.3%	15/95	15.8%
PDA Surgery - Any Location	0.9%	0.0%	0.0%	0.0%	0/101	0.0%
ROP Surgery - Any Location	4.4%	0.9%	4.0%	2.9%	0/101	0.0%
Any PIH - Any Location	31.1%	33.0%	39.8%	32.3%	24/98	24.5%
Severe IVH	12.6%	8.7%	13.3%	7.3%	5/98	5.1%
Cystic PVL	2.8%	0.0%	1.0%	0.0%	0/93	0.0%
Any ROP	39.1%	17.3%	28.9%	19.3%	13/80	16.3%
Severe ROP	11.5%	3.7%	5.3%	2.4%	3/80	3.8%
Anti-VEGF Drug	11.4%	3.6%	3.0%	2.9%	5/101	5.0%
NEC - Any Location	7.9%	6.4%	7.9%	4.9%	0/100	0.0%
Patent Ductus Arteriosus	28.9%	20.9%	25.7%	17.5%	25/102	24.5%
Indomethacin for Any Reason	0.0%	0.0%	0.0%	0.0%	0/101	0.0%

	2021	2022	2023	2024	2025	
NMH VLBW Infants	**n=121**	**n=120**	**n=119**	**n=113**	**n=113**	
Ibuprofen for PDA	4.4%	5.5%	3.0%	0.0%	1/101	1.0%
Acetaminophen for PDA	8.8%	6.4%	6.9%	8.7%	12/103	11.7%
Probiotics	0.0%	0.0%	0.0%	0.0%	0/101	0.0%
Died In DR	5.8%	8.3%	15.1%	8.8%	8/113	7.1%
Died within 12 Hours	1.8%	2.7%	0.0%	1.0%	5/105	4.8%
Mortality	26.4%	25.8%	31.9%	19.1%	19/94	20.2%
Mortality Excluding Early Deaths	20.5%	16.8%	19.8%	10.1%	7/82	8.5%
Survival	73.6%	74.2%	68.1%	80.9%	75/94	79.8%
Survival without Morbidities	47.1%	51.7%	47.1%	60.9%	59/94	62.8%
Conventional Ventilation - At 36 Weeks	0.0%	0.0%	1.8%	1.8%	0/49	0.0%
High Frequency Ventilation - At 36 Weeks	0.0%	0.0%	0.0%	0.0%	0/49	0.0%
Initial Resuscitation - CPAP	76.9%	64.2%	63.0%	67.3%	83/113	73.5%
Initial Resuscitation - Epinephrine	1.7%	0.0%	2.5%	0.0%	3/113	2.7%
Initial Resuscitation - None	9.1%	13.3%	20.2%	16.8%	17/113	15.0%
Initial Resuscitation - Oxygen	90.9%	84.0%	79.0%	82.3%	95/113	84.1%
Nasal CPAP - At 36 Weeks	5.9%	13.5%	10.9%	30.4%	13/49	26.5%
Nasal Ventilation - At 36 Weeks	0.0%	0.0%	0.0%	5.4%	1/49	2.0%
Oxygen - At 36 Weeks	25.5%	27.0%	23.6%	28.6%	10/49	20.4%

Nosocomial Infection: *defined as any late bacterial infection or coagulase negative staphylococcus infection after D3.*

Any late Infection: *defined as any late bacterial infection, coagulase negative staphylococcus infection and/or fungal infection after D3.*

Mortality: *is defined as death at any time prior to discharge home or first birthday. It is applicable to all infants for whom survival status is known. This table includes all VLBW infants and also includes infants with major congenital anomalies.*

Mortality excluding Early Deaths: *excludes infants who die within the first 12 hours of birth.*

Survival: *Indicates whether the infant survived to discharge home or first birthday.*

Survival without Specified Morbidities: *Indicates whether the infant survived with none of the following key morbidities: Severe IVH, CLD <33wks, NEC, pneumothorax, any late infection or PVL. Prior to 2011, extreme length of stay was included in the definition. IN 2013, CLD changed to CLD in infants <33 wks.*

Source: *Vermont Oxford Network Annual Report and Nightingale, the Vermont Oxford Network Internet Reporting Tool.*

Advanced Nurse Practitioner (Neonatology)

Neonatal Advanced Nurse Practitioners (ANP) are senior nurses with advanced clinical skills working with high autonomy within the neonatal team. The NICU has a registered ANP and a candidate ANP working alongside consultants to manage, treat and care for premature and sick new-borns.

Shirley Moore (RANP) has worked in the NICU for many years and Linda Smiles (cANP) is currently undertaking an education programme in preparation for registration.

The role involves providing comprehensive care, assessing, diagnosing and treating neonates. They manage the care of sick and convalescent babies and are members of the National Neonatal Transport Programme (NNTP).

Forming a part of the working day is providing expert assistance including resuscitation and stabilisation of infants as required both within the NICU and at high risk deliveries.

Complex procedures such as central line insertion and endotracheal intubation are performed and taught to the NCHDs as a pivotal part of the role.

Our neonatal ANPs provide clinical leadership, mentorship and training to junior staff and members of the multidisciplinary teams thus contributing to improved care standards.

They are also actively contributing to clinical audits, research and quality improvement initiatives.

Shirley is a member of a number of committees both locally and nationally. She has undertaken national projects at HSE level including tendering projects. She is also involved with the development and delivery of national neonatal nurse education.

Linda has led a National Neonatal Nurse airway management study day providing a combination of theory and workshops to assist nursing staff particularly in lower acuity units with the care and management of infants requiring escalation of respiratory support. She has also provided out-reach NRP and resuscitation skills workshops.

Our ANPs have presented academically both locally and nationally. They are both NRP instructors providing mandatory training to staff in the hospital.

Shirley Moore
Neonatology ANP

Neonatal Speech and Language Therapy (SLT)

The Clinical Specialist Neonatal SLT provides inpatient and outpatient clinical services. Two key oral feeding policies were agreed and implemented on the NICU across 2025. The Baby Bookworms Bookclub is running well and the SLT participates in supporting national breastfeeding week, kangaroo care week and World Prematurity Day. The SLT works with all members of the neonatal multidisciplinary team and see families on the postnatal wards if required e.g. diagnosis cleft lip/palate, Down Syndrome.

Inpatient Service

Services were provided for 205 eligible inpatients during the year, which is an increase since 2024; this reflects an increasing awareness of the service. A total of 61 babies requiring ongoing SLT input were transferred back to their referring hospitals and Children's Health Ireland (table 2). Of these, 39 were high risk infants. Many of the hospitals have no SLT service so there is no appropriate SLT follow up for many of these high risk babies and families.

Outpatient Service

Due to the increased inpatient service demand the SLT outpatient service to the ACORN programme was withdrawn in April. Up to mid-April there were 11 clinics completed for one year corrected age Bayley developmental assessments. Sixteen high risk infants were assessed jointly with Neonatal Occupational Therapy. This completed 2 years of data collection for this high risk group. The ACORN surveillance

clinic programme established in 2022 revealed a number of feeding/speech and language issues that could be addressed earlier during the inpatient stay and just post discharge hence the reprioritisation of SLT time.

Developmental surveillance for high risk infants remains however an essential service and is an internationally recommended standard. More SLT staffing is required to reinstate this. SLT continues to deal with consultant referrals and queries from the baby clinic on a case by case basis for now.

Education & Research

The SLT continues to be involved in a number of national programmes:

- As adjunct assistant professor in the School of Clinical Speech and Language Studies at University of Dublin, Trinity College (TCD), the SLT contributes to teaching the MSc course in TCD on neurodevelopmental assessment of feeding and swallowing and in assessment and management of paediatric tracheostomy and supports a student MSc clinical placement.
- Contributes to the development of national standards and guidelines with the Irish Association of Speech and Language Therapists (IASLT) in relation to feeding and swallowing disorders.
- Involved in a working group for IASLT, developing an advanced practice guideline for SLTs
- Contributed to a consensus document for the Royal College of Physicians of Ireland 'The Assessment and Management of Ankyloglossia (Tongue Tie) in Babies - a Consensus Statement' which was published in January.
- Member of the Dublin South Infant Mental Health Network.

Zelda Greene

Neonatal Speech & Language Therapist

Table 1: Inpatient information

	Inpatients	Inpatients transferred to other hospital	Total
VON (ACORN) babies	64	39	103
Cleft lip/palate	7	0	7
Neonatal Encephalopathy	4	1	5
Other conditions	69	21	91
Total	**144**	**61**	**205**
Not seen by SLT before discharge	*16*	*14*	*30 (15%)*

Table 2: Referrals back to other hospitals requiring SLT follow up

	No.	SLT Service
Children's Health Ireland	13	Yes
Letterkenny	10	No
Mullingar	11	No
Kilkenny	6	No
Sligo	4	No
Waterford	4	No
Wexford	3	No
Galway	3	No
Limerick	1	Yes
Portiuncula	2	No
Drogheda	2	No*
Portlaoise	1	No
Coombe	1	Yes
Total	**61**	

**since early 2025*

Neonatal Occupational Therapy

The Senior Occupational Therapist continues to deliver evidence-based neurodevelopmental care to support infants and their families on the NICU. There was a shift in the prioritisation criteria for neonatal occupational therapy and neonatal speech and language therapy during the year, whereby early intervention on the neonatal unit across a broad range of infant presentations was optimised.

Revised referral criteria for inpatient neonatal occupational therapy now incorporates preterm infants born 32 - 36 estimated gestational age in addition to the previously established blanket referral system for all infants born ≤32 weeks or ≤1500kg and infants with genetic / mitochondrial / neurological / developmental or social concerns. Evidence based categories of core neonatal occupational therapy interventions include occupation based assessment, developmentally supportive care, pain management, skin-to-skin (kangaroo) care, touch, postural support, infant feeding, parent engagement, parent support, identification of developmental concerns, and early intervention (RCOT, 2022).

A key component of the role with neonatal infants and their families is supporting infant mental health; the OT is co-chair of the Dublin South City Infant Mental Health Network which aims to support the translation and implementation of infant mental health skills into frontline practice across acute and community services. Other focus areas for neonatal occupational therapy in 2025 included the promotion of FiCARE initiatives on the NICU and researching and resourcing developmentally supportive tools/equipment. The neonatal OT played a key role in setting up and implementing the 'NICU Parents Café' on the NICU which supported 14 families from its inauguration from November to December 2025, and to sourcing a large number of incubator covers for the neonatal unit with funding from the Toy Show Appeal.

Aoife Tonge
Neonatal Occupational Therapist

Neonatal Inpatient Activity

Intervention Category	Number
NICU contacts	452 (average 28 minutes duration)
Number of infants	212 (average 2.13 contacts per infant)
Swaddled bathing education sessions	68 families
Developmental round with ACORN Team	45 families
FiCare initiatives	May-Dec 2025

Neonatal Outpatient Activity

Clinic	
3 month screening assessment	2 infants*
6 month screening assessment	22 infants*
12 month screening Bayley Assessment	16 infants*
Upper limb, Neonatal Abstinence Syndrome (NAS)	6
follow-up, other	15 infants
Telephone / online consultations	11 families
ACORN 'Thrive' class - OT led	9 in person classes
ACORN weaning webinars	11 online classes

**paused during the year due to a change in prioritisation criteria*

Neonatal Discharge Planning

The Neonatal Discharge Planning service continues to play a vital role in the care of the high risk infant and family in the Neonatal Unit by streamlining each infant's discharge. This has been achieved by supporting and building a rapport with the family from admission until discharge and thereafter. The service offers support to parents as well as anticipating their needs pre and post discharge home. The Clinical Nurse Specialist (CNS) collaborates early with the multidisciplinary team (MDT) and Community Support Services so that the best possible support is made available to the high-risk infant and their family while an inpatient and post discharge home.

Caseload & Activity

High risk infants include all preterm infants with birth weight <1500g or <32 weeks gestational age, infants with Neonatal Abstinence Syndrome, complex social admissions, life-shortening Illnesses, those requiring palliative care as well as infants with congenital abnormalities and brain injury.

Total discharges involving CNS: *207*
Discharged Home on Tube feeding: *1*

Training and Education

Staff are continually updated and advised regarding changes to discharge policies and procedures. Students, midwives, NCHD's, Allied Health Professionals and Student Public Health Nurses are also updated by the CNS.

Education and Information

A Basic Life Support class and preparing for home class is regularly provided and also available online for families and carers of high risk infants and also on 1:1 basis.

- Follow-up calls are made to parents following their infant's discharge providing advice and support to families.
- Continues to be the link person with the HSE appointed Northgate Hearing Screening Service that provide a national hearing screening programme for all infants.
- Chairs the Inter Hospital Neonatal Clinical Nurse Specialist Group
- Involved in Quality Improvement Initiative in safe sleep practices in NICU.
- Conducted audit on safe sleep practices in NICU and collaborating with MDT to improve these practices.
- Initiating and attending MDT meetings for vulnerable babies and their families.
- Hosted a PHN Community Discharge Information sharing Day in May 2025
- The service is represented on the Feeding and FICARE Committees and Substance Use Working Group.

Caroline McCafferty / Ciara Murphy CNS
Neonatal Discharge Planning Coordinators.

ACORN Programme – Neonatology Health and Social Care Professionals (HSCPs)

This is the third year of the **ACORN** Unit (**A**llied **C**are **O**f at **R**isk **N**ewborns) programme in the Neonatal Intensive Care. The team includes neonatal physiotherapy, dietitians, occupational therapy (OT), speech and language therapy (SLT) and pharmacy.

Developmental ward round

The team has established this successful initiative where we meet 1 - 2 families per week cot side to focus on supporting baby development in the NICU and agree a 'My NICU Plan' cot card with parents and staff. The team supported 45 families on the developmental ward round this year.

'Little Feet Big Steps'

This online neonatal physiotherapy class continues to run monthly for NICU graduates. It focuses on supporting baby's movement and early development at home after NICU. This class covers a range of topics including baby carrying, feeding, sleeping positions and activities for awake, sleep and play times, milestones, baby cues and navigating baby equipment.

'Feeding my Baby at Home: The Early Days'

This pilot online class is hosted by neonatal SLT, dietitian and lactation midwife, twice a month. Thirty-five families attended this class in 2025. Originally designed for families post discharge from the neonatal unit, it was decided to offer it to all NMH families. In conjunction with the communications team we have redesigned the poster and will launch whole hospital advertising campaign in 2026.

'Introducing Solids and Textures to my Baby after the Neonatal Unit'

This monthly online class is hosted by neonatal dietitian, SLT and OT and supports parents with transitioning to solid foods once their baby reaches 4-6 months (corrected) age. This has become a solid fixture in the diary for many ACORN families. This year 55 families attended this class.

THRIVE Class

THRIVE (**Th**erapy supported **R**elationship based sensorimotor **I**nter**V**ention **E**arly) is a therapist led in person class for infants born prematurely. Every month, families of eligible babies are invited to attend over 3 weeks when their baby is 9-12 weeks corrected gestational age. In 2025, 18 families (24 babies) attended these classes with parents and grandparents. 24 sessions were held over 8 months.

Parent Lab – FICARE

The ACORN team continue to support FICARE (Family Integrated Care) on the neonatal unit. At the end of this year we established the NICU Parents' Cafe for families. This is a chance for our NICU parents to get together for a chat facilitated by NICU staff members. It supported 14 families from Nov - Dec 2025.

Irish Neonatal Therapy Study Day

The NMH neonatal therapy team hosted this study day for the third year. In attendance were 47 neonatal therapists from all over Ireland. The themes this year included HIE and late premature infants. We had 2 international speakers and short papers from Irish therapists. Participant feedback was overwhelmingly positive.

Education and Teaching

The neonatal therapy team contribute to teaching and policy development on the neonatal unit. The team support initiatives including kangaroo care day, world prematurity day, national breastfeeding week, national HSCP day and the international babies with books neonatal read-a-thon.

ACORN Team

Liadh Timmons, Neonatal Dietitian, Zelda Greene, Neonatal Speech & Language Therapist, Aoife Tonge, Neonatal Occupational Therapist and Joanne Egan, Neonatal Physiotherapist.

Neurodevelopmental Follow-Up Report

Our neurodevelopmental follow-up of infants born preterm has included all infants born <1500g and/or <29+6 weeks (both inborn and outborn) assessed at two years' corrected age. It spans 25 years (DOB 1997- 2023). Our follow-up of term infants diagnosed with neonatal encephalopathy (NE) is in its 16th year. The Bayley 4 Scales is our preferred measurement of developmental outcome being a face-to-face assessment. The PARCA-R – a parent report questionnaire is used for families who did not wish to travel to Dublin for a Bayley Assessment.

Preterm Babies

A total of 81 NMH preterm infants were referred for assessment. To date 64 (79%) children have been assessed, 60 using the Bayley assessment and 4 the PARCA-R questionnaire. Seven babies (8.6%) are pending assessment (2 in NMH and 5 in Donegal). Seven babies did not attend and won't be attending, 3 are living abroad one with a normal outcome at 18 months corrected age.

Assessments pending are due to family circumstances and age of babies but will be completed in due course. Two babies who did not attend had global developmental delay. Follow-up reports were charted.

Eight children due for assessment were living in the Donegal area – given distance required to travel an agreement was made this year with the regional CDNT teams (PT and SLTs) in Donegal to assess these children locally. Three children have been assessed to date. Their results have been included in the table below. Five assessments are pending.

NMH Term Babies – Neonatal Encephalopathy Group

Eight term babies were referred for assessment. Seven were assessed in NMH and one in Limerick indicating follow-up at 100%.

The NE children did very well overall this year in terms of their individual profile scores. Five children (62.5%) showed Normal and Advanced profiles (some very advanced) across all parameters measured for their Cognitive, Language and Motor Development which was very encouraging. Two children (25%) showed Mild Gross Motor Delay but had Normal and above Cognitive, Language and Fine Motor Development. One child had severe global developmental delay.

Independent Referrals – for HRCP Babies and for other developmental concerns

Of the 12 babies referred 9 were assessed all showing average and above average outcomes apart from one child with moderate speech delay. Three assessments are pending.

Waterford Referrals

Of the 8 referred 8 were assessed, 7 using the Bayley Scales and 1 using the PARCA-R. 5 with normal outcomes, 1 with normal cognitive and gross motor development but with language delay, 1 with moderate delay across all parameters apart from speech, and 1 with extreme gross motor delay.

It is good to see that receptive speech delay is lower for the 2025 cohort of babies compared to previous years. There was a remarkable improvement in fine motor outcomes, while gross motor delay has been increasing since 2021, the degree of delay being continuous. These outcomes provide information for outcomes at two years corrected age but the outcomes at school age are more informative of life long functioning for these children.

In 2022 the NWIHP (National Women and Infants Health Programme) formed the National Neonatal Psychology Forum to ensure a Bayley assessment is made available for all preterm (< 1500g /<29 wks) and NE infants at two years of age (corrected age for preterm babies). The collection of this National data using REDCap* has just commenced on 01.03.2026 to facilitate ongoing national data collection for future planning of services.

Marie Slevin
Senior Clinical Psychologist in Neonatology

Table 1: Summary of neurodevelopmental follow-up assessments

Cohort	NMH VON babies (Preterm)	NMH NE/HIE (Term)	NMH referrals (Late preterm/ term)	Waterford (Preterm)	Total
Total Referred	81	8	12	8	109
Total Assessed	64 (79%)	8 (100%)	9 (67%)	8 (100%)	89 (82%)
Bayley	60	8	9	7	84
PARCA-R	4	0	0	1	5
Assessment Pending	7 (8.6%)	0 (0%)	3 (33%)	0 (0%)	10 (9%)
NMH Bayley	2	0	0	0	2
Donegal Bayley	5	0	0	0	5
Did not attend	10 (12%)	0 (0%)	0 (0%)	0 (0%)	10 (9%)
DNA'd	7	0	0	0	7
Living abroad	3	0	0	0	3

Table 2: NMH Bayley outcomes for preterm babies born in 2023 followed-up in 2025 (n= 60)

Table shows the number of babies with Above Average/Average Performance and degree of Developmental Delay – note assessments still pending

Bayley Scales	Above Average	Average	Mild Delay	Moderate Delay	Extreme Delay
Cognitive	25 (42%)	19 (32%)	7 (12%)	5 (8%)	4 (7%)
Receptive Communication	28 (47%)	15 (25%)	8 (13%)	2 (3%)	7 (12%)
Expressive Communication	25 (42%)	14 (23%)	6 (10%)	10 (17%)	5 (8%)
Fine Motor	29 (48%)	28 (47%)	1 (2%)	1 (2%)	1 (2%)
Gross Motor	5 (8%)	32 (53%)	14 (23%)	5 (8%)	4 (7%)

**Please note that this table refers only to the NMH Preterm Cohort*

Table 3: Developmental delay for the NMH total group 2021 – 2025

	2025	2024	2023	2022	2021
Cognitive Delay	27%	19%	16%	22%	26%
Receptive Speech Delay	28%	33%	34%	31%	24%
Expressive Speech Delay	35%	35%	39%	52%	33%
Fine Motor Delay	5%	13%	17%	14%	19%
Gross Motor Delay	38%	31%	32%	29%	27%

Neonatal Mortality

All liveborn deaths

Year	2021	2022	2023	2024	2025
Total number of liveborn deaths	50	50	51	43	40
Inborn deaths	48	46	48	39	35
Deaths in infants with congenital anomalies	15	15	18	22	19
Deaths in normally formed infants	35	34	33	21	21
Deaths in normally formed infants < 1500g	31	28	28	16	12
Deaths occurring in first 7 days	33	33	34	32	25
Deaths occurring in first 28 days	45	41	46	36	30
Deaths occurring in NMH	40	40	46	34	25

This table includes all deaths of liveborn infants irrespective of gestational age or birthweight. A liveborn infant is defined as any infant who breathes or has any evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. Any death that is reported to the staff of the NICU, irrespective of the place or timing of death (i.e. the death may occur after discharge from the NICU), is also included in the above table. It should be noted that complete ascertainment of deaths that occur post-discharge from NMH, particularly after 28 days of age, cannot be guaranteed as NMH relies on other institutions/agencies to be notified of such deaths.

Perinatal mortality rates for all inborn babies born ≥400g and/or 23 wks gestation including stillbirths

Perinatal Mortality Rates	2021	2022	2023	2024	2025
Overall perinatal mortality rate per 1000 births	8.1	7.6	6.1	6.7	7.5
Perinatal mortality rate corrected for lethal congenital anomalies	5.7	5.1	2.6	4.0	5.4
Overall perinatal mortality rate including late neonatal deaths	9.7	8.5	7.7	7.1	8.2
Overall perinatal mortality rate excluding external referrals	6.6	5.1	3.8	5.4	4.4
Perinatal mortality rate corrected for lethal congenital anomalies and excluding early deaths and stillbirth external referrals	4.2	3.5	1.6	3.4	3.6

Overall perinatal mortality rate (PMR): Number of stillbirths and early neonatal deaths per 1,000 total births (live births and stillbirths from 23 weeks gestation and/or weighing ≥400g). Late neonatal deaths are not included in the PMR.
Corrected PMR: Perinatal mortality rate excluding perinatal deaths associated with or due to a major congenital anomaly per 1,000 total births (livebirths and stillbirths from 23 weeks gestation and/or weighing ≥400g).

Deaths of liveborn infants with congenital anomalies: n = 19

Case No.	EGA	BW	Gender	Inborn	External referral	Delivery mode	Apgars	Day of death	Place of death	Placental histology	Cause of death	PM
1	16+5	100	Male	Yes	No	Vaginal	1, 1	1	NMH LBU	Gross only.	Renal agenesis and anhydramnios	No
2	24+1	1090	Male	Yes	Yes	Vaginal	1, 1	1	NMH LBU	Gross only.	Multiple congenital anomalies including congenital diaphragmatic hernia, genetic syndrome identified	No
3	25+5	810	Male	Yes	No	Vaginal	2, 1, 1	1	NMH LBU	Moderate chorioamnionitis with fetal response.	Thanatophoric dysplasia	No
4	27+2	360	Female	Yes	No	C-Section	2, 4, 6	1	NMH NICU	High grade MVM. Low grade FVM and SUA.	Trisomy 18	No
5	30+5	1275	Male	Yes	Yes	C-Section	1, 1, 2	1	NMH NICU	Velamentous cord. High grade MVM.	Multiple congenital anomalies including trachea-oesophageal fistula, pulmonary hypoplasia, abnormal heart	Yes
6	32+3	900	Female	Yes	Yes	C-Section	1, 1, 1	1	NMH NICU	Moderate chorioamnionitis.	Multiple congenital anomalies including lethal pulmonary hypoplasia, arthrogryposis, airway anomaly, polysplenia, IUGR	Yes
7	33+3	2625	Male	Yes	Yes	C-Section	3, 7	1	NMH NICU	Hypocoiled cord.	Pulmonary hypoplasia, fetal hydrops	No
8	35+5	2080	Male	Yes	Yes	Vaginal	7, 8, 9	57	Paediatric Hospital	Gross only.	Hypoplastic left heart syndrome	No
9	35+6	2905	Male	Yes	Yes	C-Section	9, 9	36	Regional Hospital	Hypercoiled cord.	Acute pulmonary emboli, background history of neck and chest venolymphatic malformations.	Yes, Coroner's PM
10	36+0	2385	Female	Yes	No	C-Section	7, 7	104	Paediatric Hospital	MCDA. Velamentous cord.		Yes, Coroner's PM
11	37+6	3099	Male	Yes	Yes	Vaginal	1, 6, 8	4	NMH NICU	Mild DVM with low grade FVM.	Autosomal recessive polycystic kidney disease	Yes
12	38+2	4565	Female	No	Yes	C-Section	7, 6, 8	130	Paediatric Hospital	Outborn (Perinatal)	Dysmorphic features, congenital heart disease and arrhythmia, pulmonary hypertension	No
13	38+6	2980	Female	Yes	No	Vaginal	7, 9	47	Paediatric Hospital	Hypocoiled cord.	Complex congenital cardiac anomaly – tricuspid dysplasia, pulmonary atresia	No
14	39+0	2600	Male	Yes	No	C-Section	7, 9	9	Paediatric Hospital	Chorangiosis.	Complex congenital cardiac anomaly – tricuspid dysplasia, pulmonary atresia	No
15	39+0	3200	Male	Yes	Yes	Vaginal	9, 9	7	Paediatric Hospital	Gross only.	Complex congenital cardiac anomaly – HLHS	No
16	39+0	3610	Female	Yes	Yes	Vaginal	9, 9	32	Paediatric Hospital	Gross only.	Complex congenital cardiac anomaly – HLHS, DORV	No
17	39+2	3465	Male	No	Yes	C-Section	3, 9	82	Paediatric Hospital	Outborn (Perinatal)	Multiple congenital anomalies, complex cardiac anomalies, dysmorphic features	No
18	39+4	3310	Male	Yes	Yes	C-Section	9, 9	11	Home	Gross only.	Complex congenital cardiac anomaly – Coarctation, HLHS	No
19	41+5	2790	Male	Yes	No	Vaginal	5, 7	7	Home	Gross only.	Trisomy 18	No

Deaths of liveborn normally formed infants: n = 21

Case No.	EGA	BW	Gender	Inborn	External referral	Delivery mode	Apgars	Day of death	Place of death	Placental histology	Cause of death	PM
1	17+1	123	Female	Yes	No	Vaginal	3, 0	1	NMH LBU	Severe chorioamnionitis.	Extreme prematurity secondary to ascending infection	No
2	20+1	385	Male	Yes	No	Vaginal	1, 1, 0	1	NMH LBU	DCDA. Acute choriamnionitis with fetal response.	Extreme prematurity	No
3	20+1	325	Female	Yes	No	Vaginal	2, 1, 1	1	NMH LBU	DCDA.	Extreme prematurity	No
4	22+0	450	Male	Yes	No	Vaginal	2, 1, 1	1	NMH LBU	Acute chorioamnionitis.	Extreme prematurity secondary to ascending infection	No
5	22+5	622	Female	Yes	No	Vaginal	2, 1	1	NMH LBU	Severe acue chorioamnionitis with fetal response.	Extreme prematurity secondary to ascending infection	No
6	22+6	600	Male	BBA	No	Vaginal	NR	1	NMH NICU	MVM.	Extreme prematurity	No
7	23+5	510	Female	Yes	Yes	Vaginal	4, 6, 8	6	NMH NICU	DCDA. No abnormal histology reported.	E.Coli sepsis, extreme prematurity	No
8	23+5	470	Female	Yes	Yes	Vaginal	3, 6, 7	8	NMH NICU	DCDA. Low grade FVM.	E.Coli sepsis, extreme prematurity	No
9	24+0	650	Male	Yes	No	Vaginal	7, 9	9	NMH NICU	Chorioamnionitis.	Proteus sepsis, extreme prematurity secondary to ascending infection	No
10	25+0	655	Female	Yes	Yes	C-Section	1, 7	1	NMH NICU	MCDA. TTTS. High grade MVM.	TTTS, pulmonary hypoplasia, extreme prematurity	No
11	26+2	900	Male	No	Yes	C-Section	3, 7	4	NMH NICU	Outborn (Perinatal)	Complications of extreme prematurity, bilateral severe IVH, RDS; placental abruption	No
12	28+3	950	Male	Yes	No	Vaginal	0, 0, 0, 1	1	NMH LBU	Hypercoiled cord. DCH; low grade MVM and low grade FVM.	Prematurity secondary to placental disease.	Yes
13	33+5	2345	Female	Yes	Yes	C-Section	8, 9	42	Regional Hospital	MCDA. No abnormal histology reported.		Yes, Coroner's PM
14	33+5	2100	Female	No	Yes	C-Section	1, 2, 1	3	NMH NICU	DCDA.	Preterm DCDA twin, multi-organ failure and severe neonatal encephalopathy	Yes, Coroner's PM
15	38+1	3125	Female	Yes	No	C-Section	4, 5	6	NMH NICU	Hypercoiled cord with strictures and high grade FVM.	Severe neonatal encephalopathy	Yes, Coroner's PM
16	38+1	3300	Female	BBA	No	Vaginal	NR	16	Children's Hospital	Hypercoiled cord with low grade FVM.		Yes, Coroner's PM
17	38+2	3785	Female	Yes	No	C-Section	1, 5, 6	6	NMH NICU			Yes, Coroner's PM

Case No.	EGA	BW	Gender	Inborn	External referral	Delivery mode	Apgars	Day of death	Place of death	Placental histology	Cause of death	PM
18	39+2	3420	Male	No	Yes	C-Section	0, 0, 0, 3	3	NMH NICU	Outborn (Perinatal)	Severe neonatal encephalopathy, placental abruption	No
19	40+0	4010	Female	Yes	No	C-Section	9, 9	58	Home	Low grade FVM.	SIDS	Yes, Coroner's PM
20	40+1	4100	Male	Yes	No	Vaginal	5, 4, 7	5	NMH NICU	Mild chorioamnionitis with no fetal response. Chorangiosis.		Yes, Coroner's PM
21	41+3	3615	Female	Yes	No	C-Section	8, 9	37	Home	Moderate MVM, high grade villitis. Meconium induced vascular necrosis.		Yes, Coroner's PM

Stillbirths of normally formed inborn infants: n = 30

Case No.	EGA	BW	Gender	External Referral	Delivery mode	IUGR	Placental Histology	Cause of death	PM
1	21+5	400	Male	Yes	Spontaneous vaginal	No	MCDA. Severe acute chorioamionitis with fetal response.	Ascending infection	No
2	21+5	425	Male	Yes	Spontaneous vaginal	No	MCDA. Severe acute chorioamionitis with fetal response.	Ascending infection	No
3	22+1	550	Male	Yes	Spontaneous vaginal	No	Hydrops due to parvovirus.	Infection	No
4	22+4	470	Male	No	Spontaneous vaginal	No	Severe acute chorioamnionitis with fetal response.	Ascending infection	No
5	22+6	610	Male	No	Spontaneous vaginal	No	Severe chorioaminionitis with fetal response. DCH.	Ascending infection	No
6	23+0	352	Female	Yes	Spontaneous breech with MSV	Yes	Severe chorioamnionitis with fetal response. Background DCH.	Ascending infection	No
7	23+3	565	Male	Yes	Spontaneous breech with MSV	No	Severe chorioamnionitis.	Ascending infection	No
8	23+3	590	Female	Yes	Spontaneous vaginal	No	Severe Chorioamnionitis with fetal vasculitis. Hypercoiled cord.	Ascending infection	Yes
9	23+6	638	Male	Yes	Spontaneous vaginal	No	CMV villitis.	Congenital CMV infection	Yes
10	24+4	290	Male	No	Spontaneous vaginal	Yes	High grade MVM.	Placental disease	Yes
11	24+5	755	Male	Yes	Spontaneous vaginal	No	Severe acute chorioamnionitis with fetal response.	Ascending infection	No
12	24+6	227	Female	No	Spontaneous vaginal	Yes	High grade MVM and High grade FVM.	Placental disease	No
13	25+0	710	Female	No	Spontaneous vaginal	No	Acute necrotising funisitis. Severe acute chorioamnionitis.	Ascending infection	Yes
14	25+2	413	Male	Yes	Spontaneous vaginal	Yes	High grade MVM.	Placental disease	No
15	26+1	562	Male	No	Spontaneous vaginal	Yes	Retroplacental haemorrhage.	Abruption	No
16	27+5	492	Female	No	C-Section Pre Labour/no induction	Clinical	MCTA. High grade FVM and hypercoiled cord.	Placental disease	No
17	28+0	170	Female	No	Spontaneous vaginal	Yes	High grade MVM. FVM. Severe chronic hystiocytic intervillositis.	Placental disease	No

Case No.	EGA	BW	Gender	External Referral	Delivery mode	IUGR	Placental Histology	Cause of death	PM
18	28+1	750	Female	No	Spontaneous vaginal	Yes	Massive periillous fibrin deposition	Placental disease	Yes
19	29+1	870	Male	No	Spontaneous vaginal	Yes	Hypercoiled cord with high grade FVM.	Placental disease	Yes
20	31+3	840	Female	No	C-Section Pre Labour/no induction		MCTA. High grade FVM secondary to laser.	Placental disease	No
21	32+0	1400	Female	No	Spontaneous vaginal	CA?	CMV villitis.	Infection	No
22	32+0	1865	Female	No	Spontaneous vaginal	No	No abnormal histology reported.	FMH	Yes
23	36+2	3200	Male	No	Spontaneous vaginal	No	High grade villitis with stem vessel obliteration and clinical cord entanglement.	Cord pathology	No
24	36+3	2420	Male	Yes	Spontaneous vaginal	No	Long cord with segmental hypercoiling.	Cord pathology	No
25	37+2	2465	Female	No	Spontaneous vaginal	No	High grade FVM.	FMH	Yes
26	37+4	2630	Female	No	Spontaneous vaginal	No	Tight nuchal cord.	Cord pathology	No
27	37+4	2995	Female	No	Spontaneous vaginal	No	Long hypercoiled cord with high grade FVM.	Placental disease	Yes
28	39+1	3275	Male	Yes	Spontaneous vaginal	No	MVM (60% retroplacental haemorrhage)	Placental disease	No
29	40+4	4000	Male	No	Spontaneous vaginal	No	Segmentally hypercoiled cord.	Placental disease	No
30	41+1	3315	Male	No	Spontaneous vaginal	No	Small placenta with DVM and FVM. Long two vessel cord with meconium associated vascular necrosis.	Placental disease	Yes

Stillbirths of inborn infants with congenital anomalies: n = 6

Case No.	EGA	BW	Gender	External Referral	Delivery mode	Placental histology	Cause of death	PM
1	25+4	415	Female	Yes	Spontaneous vaginal	Hypercoiled cord.	Anomalies	No
2	28+0	1800	Male	No	C-Section –In Labour/after Induction	Gross only.	Anomalies	No
3	29+1	405	Male	Yes	Spontaneous vaginal	Abnormal villous maturation with oedema.	Trisomy 18	No
4	34+5	2165	Male	No	Spontaneous vaginal	Oedema.	Genetic abnormality	No
5	35+6	1860	Female	Yes	Spontaneous breech with MSV	Small placenta with hypercoiled cord, MVM and high grade villitis.	Anomalies	Yes
6	36+6	2520	Female	No	C-Section Pre Labour/no induction	FVM and DVM.	Trisomy 21	No

Hypoxic Ischaemic Encephalopathy, Neonatal Encephalopathy & Seizures

NMH reports on all infants ≥35 weeks' gestation, who, during the first week of life have:

- Signs of Neonatal Encephalopathy (NE) which are defined as abnormal clinical findings in 3 or more of the following domains, present for at least 24 hrs:
  - Seizures
  - Level of consciousness
  - Spontaneous activity when awake or aroused
  - Posture
  - Tone
  - Primitive reflexes
  - Automonic system

Or

- Seizures alone

All NE and seizure cases are reviewed and classified as Hypoxic-Ischaemic Encephalopathy (HIE) based on the presence of one or more of the following physiological criteria:

- Apgar score ≤5 at 10 mins of age
- Continued need for resuscitation (endotracheal intubation or PPV) at 10 mins after birth.
- Acidosis within 60 mins of birth (defined as a pH < 7.0 in an umbilical cord or any neonatal arterial, venous or capillary blood sample)
- Base deficit ≥ 16 mmol/L in an umbilical cord or any neonatal blood sample (arterial, venous or capillary) within 60 mins of birth

Reported cases are therefore classified into one of 6 groups:

- HIE inborn
- HIE outborn
- NE without HIE inborn
- NE without HIE outborn
- Isolated seizure without NE or HIE inborn
- Isolated seizures without NE or HIE outborn

Reference is also made to which cases undergo therapeutic hypothermia. If pertinent obstetric details surrounding the delivery are not available (as in the case of some outborn infants), then, the case, by default is reported as a case of Neonatal Encephalopathy without HIE. In all reported cases, it is assumed that there is no evidence of an infectious cause, a congenital malformation of the brain or an inborn error of metabolism that could explain the encephalopathy.

All cases (both neonatal encephalopathy cases and hypoxic-ischaemic encephalopathy cases) are further categorised according to severity of presentation. The most severe stage observed during the first 7 days following birth is recorded based on the infant's level of consciousness and response to arousal manoeuvres such as persistent gentle shaking, shining a light or ringing of a bell. Infants are considered to fall into the 'mild' category if they are alert or hyperalert with either a normal or exaggerated response to arousal, infants fall into the 'moderate' category if they are arousable but are lethargic and have a diminished response to arousal manoeuvres and infants fall into the 'severe' category if they are stuporous or comatose and are difficult to arouse or are not arousable. If further clarification regarding any of these clinical terms or definitions is required, please refer to the appendix.

Summary of cases

In 2026, 5 cases born in NMH were classified as HIE. Three were classified as TGCS Group 2a, 1 was TGCS Group 4a and 1 was TGCS Group 4b. All 5 were managed with therapeutic hypothermia. Three cases had severe encephalopathy and resulted in neonatal death (TGCS Groups 4b, 2a, 2a), 2 survived (TGCS Group 4a, 2a). Both survivors had moderate HIE and normal MRI brain imaging after treatment. An additional 7 cases were referred to NMH for therapeutic hypothermia after birth in other hospitals. Four were classified as HIE outborn. One of these 4 cases had severe encephalopathy and resulted in a neonatal death, 3 survived. All 3 survivors had moderate encephalopathy and mild abnormalities on MRI brain. Three of the 7 cases referred to NMH were classified as NE with seizures outborn and all 3 survived. All three had moderate encephalopathy, 1 had a normal MRI brain and 2 had minor abnormalities, after treatment.

Dr Eoin Ó Curraín
Consultant Neonatologist

Table 1: Number of Cases 2025

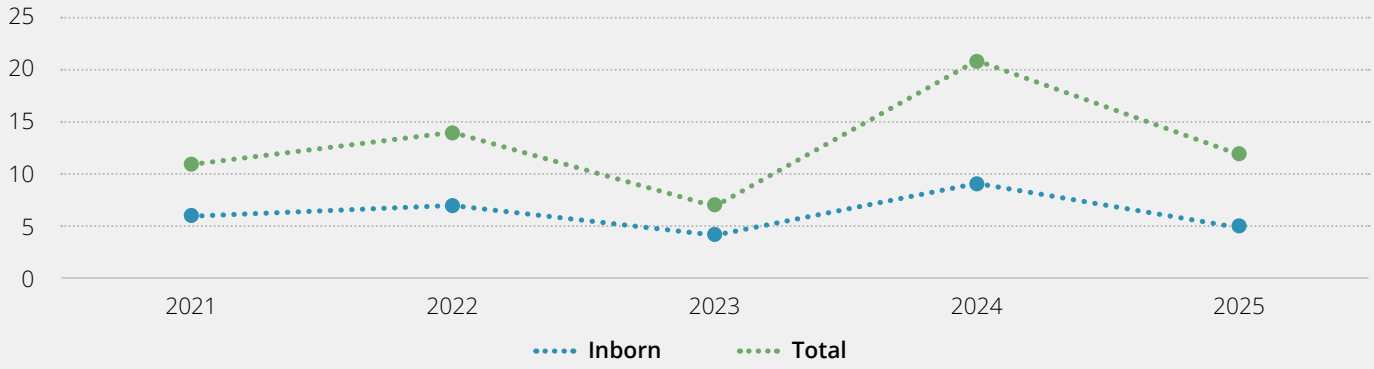
	Inborns	Outborns
Neonatal Encephalopathy - with HIE	5	4
• Mild HIE (Grade 1)	0	0
• Moderate HIE (Grade 2)	2	3
• Severe HIE (Grade 3)	3	1
Neonatal Encephalopathy	0	3
Seizures – No Encephalopathy	0	0
Therapeutic Hypothermia	5	7

Table 2: Infants undergoing therapeutic hypothermia in the NMH

	2021	2022	2023	2024	2025
Inborn					
HIE cases reported	6	4	2	7	5
NE cases reported	*0*	*3*	*2*	*2*	*0*
Total	**6**	**7**	**4**	**9**	**5**
Outborn					
HIE cases reported	2	4	3	12	4
NE cases reported	*3*	*3*	*0*	*0*	*3*
Total	**5**	**7**	**3**	**12**	**7**
Total Inborn and Outborn Cases	**11**	**14**	**7**	**21**	**12**

**All HIE and NE cases for the years above were cooled*

Graph 1: Infants undergoing therapeutic hypothermia in the NMH 2021–2025



	2021	2022	2023	2024	2025
Inborn	*6*	*7*	*4*	*9*	*5*
Total	**11**	**14**	**7**	**21**	**12**

Hypoxic Ischaemic Encephalopathy: Inborn (5)

Case No.	EGA	BW (g)	Delivery Method	Delivery Method Indication	Apgars 1, 5, 10	PPV at 10 mins	Min pH within 60 min	Max BE within 60 min	Seizures Y/N	TH	Grade of NE	Summary of MRI brain	Organ Involvement	Outcome	Placental Histology	Classification
1	38+1	3125	C-Section	Reduced fetal movements, abnormal CTG Group 4b	4, 5	No	7.38	-0.4	Yes	Yes	Severe	Abnormal global pattern of ischaemia/ infarction	Ventilated, multi-organ involvement	Died day 5 of life, coronial postmortem directed	Hypercoiling of umbilical cord wih strictures, high grade fetal vascular malperfusion	1 HIE inborn
2	38+2	3785	C-Section	Reduced fetal movements, abnormal CTG Group 2a	1, 5, 6	No	6.95	-12.6	Yes	Yes	Severe	Postmortem MRI. Normally formed brain, non specific postmortem changes	Ventilated, multi-organ involvement	Died day 6 of life, coronial postmortem directed	Delayed villous maturation	3 HIE inborn
3	39+0	2890	C-Section	Abnormal CTG, meconium stained liquor Group 4a	1, 2, 4	Yes	6.99	-13.1	No	Yes	Moderate	Normal	Ventilated, multi-organ involvement	Discharged day 16 of life	Hypercoiling of umbilical cords, high grade fetal vascular malperfusion and delayed villous maturation	1, 2, 3 HIE inborn
4	40+1	4100	Vaginal	Prolonged rupture of membranes 25 hours, no fetal concerns, spontaneous vaginal delivery Group 2a	5, 4, 7	No	6.99	-15.5	Yes	Yes	Severe	Abnormal global pattern of ischaemia/ infarction	Ventilated, multi-organ involvement	Died day 4 of life, coronial postmortem directed	Acute chorioamnionitis without fetal response. Meconium present.	3 HIE inborn
5	41+1	4500	Vaginal	Maternal pyrexia in labour, abnormal CTG, shoulder dystocia Group 2a	1, 4, 7	Yes	7.25	-11.6	Yes	Yes	Moderate	No MRI findings of HIE, Small intraventricular haemorrhagee, normal parenchyma	Ventilated	Discharged day 8 of life	Long hypocoiled cord. Severe acute choriamnionitis with fetal response.	2 HIE inborn

Neonatal Encephalopathy: Inborn (0)

No cases to report

Hypoxic Ischaemic Encephalopathy: Outborn (4)

Case No.	EGA	BW (g)	Delivery Method	Delivery Method Indication	Apgars 1, 5, 10	PPV at 10 mins	Min pH within 60 min	Max BE within 60 min	Seizures Y/N	TH	Grade of NE	Summary of MRI brain	Organ Involvement	Outcome	Placental Histology	Classification
1	37+0	2940	C-Section	Elective, maternal request, no fetal concerns	5, 6	Yes	6.89	-16	Yes	Yes	Moderate	Abnormal, bilateral peritrigonal pattern of ischaemia/ infarction right>left, loss of normal signal of PLIC bilaterally	Ventilated, renal dysfunction	Transferred back to referring hospital on day7 of life	Normal histology (external)	2, 3, 4 HIE outborn
2	38+3	3500	C-Section	Elective for breech	7, 7, 8	No	6.96	-13.8	Yes	Yes	Moderate	Abnormal small unilateral area of right periventricular ischaemia/infarction	Ventilated	Transferred back to referring hospital on day 9 of life	No placenta in NMH	3 HIE outborn
3	39+2	3420	C-Section	Placental abruption	0, 0, 0	Yes	6.8	<16	Yes	Yes	Severe	None	Ventilated, multi-organ involvement	Died day 2 of life, coroner's postmortem not directed	Hypoplastic placenta, villous chorangiosis, features of placental abruption (external)	1, 2, 3, 4 HIE outborn
4	41+2	4600	Vaginal	Pyrexia in labourm shoulder dystocia	1, 6, 7	Yes	7.18	-12.5	No	Yes	Moderate	Abnormal, subtle area of ischaemia/infarction optic radiations bilaterally, otherwise normal parenchyma	No	Discharged day 7 of life	No placenta in NMH	2 HIE outborn

Neonatal Encephalopathy: Outborn (3)

Case No.	EGA	BW (g)	Delivery Method	Delivery Method Indication	Apgars 1, 5, 10	PPV at 10 mins	Min pH within 60 min	Max BE within 60 min	Seizures Y/N	TH	Grade of NE	Summary of MRI brain	Organ Involvement	Outcome	Placental Histology	Classification
1	39+1	2795	Vaginal	Induction of labour for small for gestational age. Abnormal CTG.	3, 6, 9	No	7.026	-9.9	Yes	Yes	Moderate	Normal	No	Transferred back to referring hospital on day 5 of life	No placenta in NMH	NE with seizures outborn, no HIE
2	40+1	3470	Vaginal	Inducton of labour for reduced fetal movements, abnormal CTG	3, 5, 7	No	7.08	no result	Yes	Yes	Moderate	No MRI findings of HIE, bilateral small cerebellar and intraventricular haemorrhages	Ventilated	Transferred back to referring hospital on day 8 of life	No placenta in NMH	NE with seizures outborn, no HIE
3	40+2	3690	C-Section	Abnormal CTG, meconium, maternal pyrexia	1, 5, 8	No	7.01	-10.4	Yes	Yes	Moderate	Mild abnormality, subtle blateral thalamic ischaemia/ infarction, otherwise normal parenchyma	Ventilated	Transferred back to referring hospital on day 14 of life.	No placenta in NMH	NE with seizures outborn, no HIE

Maternity and Obstetrics

Antenatal Education

The parent education team in collaboration with the multidisciplinary team, continue to develop and create resources and supports which promote improvements in the health and wellbeing of babies, pregnant women, and their partners throughout the antenatal and postnatal periods. We continue to revise the suite of antenatal education classes using a Universal Design for Learning (UDL) approach to parenthood education. A comprehensive, inclusive, interactive programme of in-person and virtual antenatal education classes using this approach is used to teach, reassure and empower women and partners. It is a key part of our antenatal education vision for all: to improve parent's knowledge and understanding of preparation for childbirth and parenthood.

National antenatal education standards continue to guide our service and the development of resources. Continuous review of all class material and class structure exists in the NMH. Feedback from parents is sought after all classes. The next national antenatal education audit is expected early 2026. The NMH was consistently found to be demonstrating a "commitment towards developing a quality service" in previous audits. The team are members of the National Antenatal Education Forum and attend national meetings.

We continue to provide a broad range of midwifery led and multidisciplinary online and in-person classes. Classes include:

- A course of four 'Pregnancy Wellbeing' classes facilitated by the multidisciplinary team. This is open to women at any stage of their pregnancy but ideally the earlier the better.
- A course of three classes for first time parents (online or in person).
- A refresher class for women/partners who have had previous vaginal births (online or in person).
- A VBAC (vaginal birth after caesarean) class for women who wish to have a vaginal birth in their current pregnancy (online or in person).
- A 'Preparation for Elective Caesarean Birth' class for women with a booked elective caesarean section (online and in person). In person has re-commenced this year.
- A Twins class, for women/partners expecting twins (online).
- 'Young Mums and Dads' classes which include "hands on" baby care (in person).
- 'Partners Only' class once a month (online).
- 'An Introduction to Hypnobirthing' class (online).
- 'Mental Wellbeing in Pregnancy and Beyond' and 'Postnatal mental wellbeing' classes-facilitated by mental health midwives
- 'Healthy Bodies After Birth' class facilitated by physiotherapists.
- Individual classes for vulnerable women/couples

We receive referrals from colleagues in Medical Social Work, Perinatal Mental Health, FAU, Bereavement Services and clinics to provide specialist and individual classes for vulnerable women. In person evening classes re-commenced this year.

Antenatal education continues to develop and monitor the NMH eLearning Hub which is integral to our classes. We continue to develop resources to meet parent expectations.

The Hub was updated by a multidisciplinary team in the NMH this year. This team was chaired by E. Durkin.

Co-facilitation was a key outcome this year as we now have a member of the Lactation Team join us on the Twins Class and a member of the Anaesthesia Team join us on the Elective Planned Caesarean Section Class. Feedback from parents re-inforce the value of co-facilitation.

Thank you to the administration support team who provide valuable support to staff and parents.

Theresa Barry and Eleanor Durkin
Parent Education Managers

Bereavement

The vast majority of babies born at the NMH are healthy and well. However, when the death of a baby occurs it is the most difficult experience expectant parents can face. Over the years, we have developed a comprehensive holistic service for bereaved families attending The National Maternity Hospital.

The Bereavement Midwives care for couples who experience miscarriage, stillbirth, neonatal death and couples who have termination in the case of life limiting conditions or in maternal interest.

Bereavement Clinics

Specialist Clinics are supported by the Consultant Pathologists, who provide valuable information through rapid histological placental examination and post-mortem examination. Our Consultant Geneticist provides expertise and counsels couples in cases where genetic assessment is required.

There are four bereavement clinics led by Consultant Obstetrician and Neonatologists. The Recurrent Pregnancy Loss clinical service continues to be unique in Ireland by having consultant genetics input. A fortnightly multidisciplinary team meeting occurs between the teams from Genetics, Recurring Miscarriage and Bereavement, where 178 cases were reviewed and individualised plans agreed. This approach has led to targeted interventions thus benefitting patients and reducing hospital costs. A significant increase of 55% in the number of cases seen in the Miscarriage Clinic with 121 couples investigated, including 15 couples counselled at the late miscarriage clinic.

Our Consultant Obstetrician and Gynaecologist specialist in preterm birth met with 19 couples whose pregnancy loss was related to Preterm Labour/Prolonged Spontaneous Rupture of Membranes in which a comprehensive individualised care pathway was outlined for future pregnancies. 14 couples were counselled in our Stillbirth Clinic.

Follow up was also arranged with individual consultants for a further 30 couples that required joint obstetric and neonatal appointments.

Bereavement Counselling

The bereavement counselling service commenced in 2024 in response to the National Maternity Bereavement Survey (NMBES) 2022, and has highlighted the need for hospital based psychological support following spontaneous pregnancy loss. 115 appointments were offered in 2025. 51% attended in-person and 48% online.46% of attendees experienced recurrent miscarriage, 38% experienced a miscarriage/ectopic pregnancy, 8% experienced mid-trimester loss and 8% stillbirth. Feedback has been very positive with 100% attendance at appointments.

Internment

The Bereavement Midwives arranged a hospital burial for 52 babies < 16 weeks' gestation.

Annual Service of Remembrance

The Annual Remembrance Service was held on the 2nd Sunday in October, coinciding with Pregnancy Loss Awareness week. Bereaved parents, their families and hospital staff came together in remembering all babies that have died during pregnancy and around the time of birth.

Pregnancy After Loss Support Group

The online support group continued in 2025. This collaboration with the Perinatal Mental Health Team provides targeted psychological support for women experiencing the anticipated anxiety following loss in a subsequent pregnancy 35 women attended the online support groups in February, May, September and November Funding and ethical approval was granted in November to evaluate the service in conjunction with the Joint Research Network at University College Dublin.

Bereavement Care Education

Bereavement Education remains a priority, for staff and student midwives within the hospital, UCD and the Centre for Midwifery Education. Workshop were facilitated for each of these groups throughout the year. Our CNM2 was invited to develop and facilitate an annual National Grief in Maternity Settings Workshop, in conjunction with the Hospice Foundation in March 2025, which is open to all disciplines involved with perinatal bereavement care.

Brenda Casey
CMS Bereavement

Birth Reflections

The Birth Reflections Service was established in April 2023. It is a Midwifery led listening and debriefing service for women who wish to explore and reflect on their birth experience in a confidential and supportive environment.

Many women find that they wish to talk about their birth experience; women and their partners may wish to gain greater clarity and understanding about the events surrounding their birth and to reflect on their birth experience.

Some women can feel worried or anxious about giving birth in a subsequent pregnancy and exploring this with the Birth Reflections Midwife can help allay those fears and prepare for the upcoming labour and birth.

The Birth Reflections Service is available to anyone who has given birth in The National Maternity Hospital within the last year, and anyone who is currently pregnant and attending the Hospital. We meet women in person but virtual meetings are also offered.

At the appointment, women are given the opportunity to review their birth notes and answer any questions relating to their antenatal, intrapartum and postnatal events.

The Birth Reflections Service is not a complaints or counselling service. If a woman requires counselling or wishes to make a complaint, referrals are made to the appropriate services.

Total referrals	**406**
Appointments made	379
Women seen in person	315
Women referred, assessed and not for Birth Reflections and/or referred onto more appropriate service	8
Unable to contact	14
Did not attend	7
Appointments cancelled and rescheduled	49

Women can self-refer or can be referred by any NMH clinician, by their GP or Public Health Nurse.

A Birth Reflections evaluation study is due for publication in 2026. This study will evaluate the woman's experience of the Birth Reflections Service and ways to continuously improve the service in the hospital.

Helen McHale
CMM2 Birth Reflections

Helen McHale, CMS Birth Reflections.

Community Midwifery Service

The Community Midwifery Service is now entering its 27th year at the National Maternity Hospital, marking more than a quarter century of dedicated, community based maternity care. Since the programme began, our midwifery teams have supported over 36,000 women and their families, providing compassionate, evidence based care across pregnancy, birth, and the postnatal period. Within this, our Domino and Homebirth Services alone have cared for more than 10,500 women and have facilitated more than 830 homebirths to date—reflecting the strong and growing demand for personalised, midwifery led care.

Our services are delivered across three core areas:

- Domino and Homebirth Service offering continuity of midwifery led care throughout pregnancy, labour, birth, and the early postnatal period, ensuring women receive consistent support from a known team.
- Antenatal Care in Outlying Clinics providing supported or assisted care pathways in community based primary care centres. Several clinics also offer access to a liaison Consultant Obstetrician if required ensuring timely review.
- Early Transfer Home (ETH) Programme delivering postnatal midwifery care in the comfort of the woman's home, supporting early discharge from hospital and enabling ongoing community based follow up.

Domino and Homebirth Service

The primary aim of the Domino and Homebirth Service is to deliver continuity of midwifery led care for women on the supported care pathway throughout pregnancy, labour, and the postnatal period. Women booked to the scheme have access to 24 hour midwifery support. Domino midwives provide intrapartum care both at home and in hospital. Facilitating early discharge home, where care continues through scheduled home visits and ongoing community based support.

Domino and Homebirth Antenatal Clinics

Antenatal clinics are held in primary care centres across South County Dublin and the Wicklow region, enabling women to access care closer to home. Women are encouraged to engage in combined care with their GP, promoting a collaborative, community centred model. The team works closely with a Consultant Obstetrician & Gynaecologist, who provides clinical oversight and review when needed. All women attending the service are offered a dating scan and post dates point of care ultrasound scan to assess amniotic fluid volume, supporting safe and timely decision making.

Domino Homebirth Service Bookings

In 2025, 591 women expressed interest in the service, and we supported the births of 406 babies. The reduction in bookings reflects several factors, including miscarriage and changes in clinical risk profile, resulting in some women no longer meeting criteria for the supported care pathway or choosing obstetric led care.

Intrapartum Care in the Domino Service

Of the 406 women who birthed through the scheme, 30.0% required induction of labour. Using the Robson 10 Group Classification of Caesarean Section, the Domino/Homebirth service had an overall caesarean section rate of 18.0%. This must be viewed within the broader national and international context, where Caesarean Section rates continue to rise annually. Despite this trend, 68.0% of Domino women achieved a spontaneous vaginal birth, with 14.0% having an assisted vaginal delivery.

Hydrotherapy Birthing Pool

In 2025, use of the hydrotherapy pool increased significantly, with 1 in 3 Domino women choosing to labour in water. A total of 48 women achieved a waterbirth; this is the second year that waterbirth has be facilitated in the NMH and we have noted an increase of women opting for this service. While hydrotherapy is actively promoted, some women are excluded due to the need for continuous fetal monitoring, often linked to rising induction rates. The expansion of waterbirth has been an extremely positive development, enhancing women's choice and supporting midwives in facilitating a broader range of birthing options (2025 had an overall epidural rate of 44.8%).

The success of the Hydrotherapy/birthing pool service is largely attributed to the close, working relationship between the midwives in the Labour and Birthing Unit and the community midwifery team. The shared approach of support ensures that women who wish to use the pool are identified, consented and cared for seamlessly. The collaborative approach continues to underpin the services success and high levels of user satisfaction.

Perineal Outcomes

- 33.5% of all births resulted in an intact perineum.
- 42.4% of births involved a 1st or 2nd degree laceration.
- With an overall episiotomy rate of 20.7%, of which 14% were instrumental deliveries.
- There was a drop in the OASI (Obstetric Anal Sphincter Injury) rate from 2.5% in 2024 to 2.2% in 2025.

Breastfeeding Rates

Breastfeeding rates at birth were 90.4%, reflecting strong engagement with postnatal support and community based follow up.

Homebirths

In 2025, there were 32 planned homebirths, with 23 women ultimately birthing at home. Of these, 9 were waterbirths. As in previous years, the majority of homebirth clients were multiparous women. There was one transfer to hospital for a manual removal of placenta, which falls below the expected transfer rates for planned homebirth.

Birth Preparation and Breastfeeding Classes

The Domino and Homebirth services deliver in person antenatal education across Dublin and Wicklow, focusing on birth preparation and breastfeeding. Attendance remains high, with more than 98% of women signed up to attend our birth preparation classes, which support and encourage physiological birth. We also host dedicated homebirth information evenings, which are consistently well received. Following these sessions, we have observed a clear rise in enquiries about homebirth.

Antenatal Care in Outlying Clinics

Outlying antenatal clinics deliver accessible, community based care for women on the supported and assisted care pathways. Women can attend for both midwifery led and obstetric led care, depending on their needs. Midwives provide most routine assessments, while obstetricians attend regularly to review women who require specialist input. These combined clinics ensure continuity of care closer to home and are available in Loughlinstown, Bray, Greystones Newtownmountkennedy, Wicklow and Arklow.

Postnatal Care

In 2025, mothers and babies received a total of 10,388 home visits. This number represents the combined efforts of the Early Transfer Home Programme and the DOMINO Homebirth Service. Both teams coordinate their visits based on geographical location, an approach that helps manage traffic congestion and ensures their time and resources are used as efficiently as possible.

The Early Transfer Home Programme

This programme continues to be a valued service, with midwives assessing and recruiting suitable women on the postnatal ward prior to discharge. Each woman is evaluated for eligibility and interest to ensure safe and appropriate participation. Feedback from those who have used the service remains consistently positive, reflecting strong satisfaction with early supported discharge and community based postnatal care

Affirmation Cards

Following the successful introduction of our positive affirmation cards, we expanded the initiative in 2025 with a new set of breastfeeding affirmation cards. These cards offer supportive and educational messages to guide women through the early stages of their breastfeeding journey. Their impact has been significant, and they continue to be widely requested by women across the country.

Postnatal Hub

During the year significant work went into developing community based postnatal hubs, supporting the national move toward accessible, midwifery led care in local settings. The hub's vision is to provide a warm, supportive space where mothers and babies receive reassurance, guidance, and midwifery expertise for non urgent postnatal concerns, with clear referral pathways to the wider multidisciplinary team. The service is scheduled to launch in early 2026, marking an exciting milestone in the development of community based maternity services.

Jean Kavanagh
CMM3 Community Midwifery Manager

Table 1: Community Midwives Robson Ten Groups Classification of Caesarean Section (C/S)

	All Sections	Births	Size of Group %	C/S Rate in Group	Contribution of each Group %
1. Nulliparous, single cephalic, >=37 weeks, in spontaneous labour	13	108	26.6%	12.0%	3.2%
2. Nulliparous, single cephalic, >=37 weeks, induced and CS before labour	36	89	21.9%	40.4%	8.9%
2a. Induced labour	*31*	*84*	*20.7%*	*36.9%*	*7.6%*
2b. CS before labour	*5*	*5*	*1.2%*	*100.0%*	*1.2%*
3. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, in spontaneous labour	3	142	35.0%	2.1%	0.7%
4. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, induced and CS before labour	4	42	10.3%	9.5%	1.0%
4a. Induced labour	*0*	*38*	*9.4%*	*0.0%*	*0.0%*
4b.CS before labour	*4*	*4*	*1.0%*	*100.0%*	*1.0%*
5. Previous CS, single cephalic, >= 37 weeks	0	0	0.0%	0.0%	0.0%
6. All nulliparous breeches	12	12	3.0%	100.0%	3.0%
7. All multiparous breeches (including prev. CS)	3	3	0.7%	100.0%	0.7%
8. All multiple pregnancies (including prev. CS)	0	0	0.0%	0.0%	0.0%
9. All abnormal lies (including prev. CS)	2	2	0.5%	100.0%	0.5%
10. All single cephalic,<=36 weeks (including prev. CS)	0	8	2.0%	0.0%	0.0%
Total	**73**	**406**		**18.0%**	**18.0%**

Table 2: Epidural Rate

	Nullip		Multip		Total	
Epidural	143	66.8%	39	20.3%	182	44.8%
No Epidural	71	33.2%	153	79.7%	224	55.2%
Total	**214**		**192**		**406**	

Table 3: Hydrotherapy use and Waterbirths

	Nullip		Multip		Total	
Waterbirth	10	4.7%	38	19.8%	48	11.8%
No Waterbirth	204	95.3%	154	80.2%	358	88.2%
Total	**214**		**192**		**406**	

Table 4a: Perineum outcome (all birth modes)

	Nullip		Multip		Total	
1st Degree Tear	11	5.1%	47	24.5%	58	14.3%
2nd Degree Tear	39	18.2%	58	30.2%	97	23.9%
3rd Degree Tear	6	2.8%	3	1.6%	9	2.2%
Episiotomy	63	29.4%	4	2.1%	67	16.5%
Episiotomy + 1st	1	0.5%	0	0.0%	1	0.3%
Episiotomy + 2nd	14	6.6%	2	1.0%	16	3.9%
Grazes	9	4.2%	13	6.8%	22	5.4%
Intact	71	33.2%	65	33.8%	136	33.5%
Total	**214**		**192**		**406**	

Table 4b: Perineum outcome (SVDs only)

	Nullip		Multip		Total	
1st Degree Tear	11	7.2%	47	26.1%	58	17.4%
2nd Degree Tear	39	25.5%	58	32.2%	97	29.2%
3rd Degree Tear	6	3.9%	3	1.7%	9	2.7%
Episiotomy	63	41.2%	4	2.3%	67	20.1%
Episiotomy + 1st	1	0.7%	0	0.0%	1	0.3%
Episiotomy + 2nd	14	9.1%	2	1.1%	16	4.8%
Grazes	9	5.9%	13	7.2%	22	6.6%
Intact	10	6.5%	53	29.4%	63	18.9%
Total	**153**		**180**		**333**	

Diabetes Clinic

The NMH provides a multidisciplinary diabetes in pregnancy service, delivering specialised care across two primary categories: women with Pre-Gestational Diabetes Mellitus (PGDM) and women with Gestational Diabetes Mellitus (GDM).

Table 1 below outlines the service activity over the past 5 years.

Table 1: Diabetes Clinic Activity

Year	Type 1 diabetes	Type 2 diabetes	GDM	Cystic Fibrosis Related Diabetes	MODY/ LADA/ Other*	Total
2021	47	17	774	6	0	844
2022	50	21	561	3	3	637
2023	43	22	525	2	14	606
2024	43	26	535	2	23	629
2025	47	31	615	1	26	720

Pre-Gestational Diabetes Mellitus (PGDM)

Women with PGDM, Cystic Fibrosis-Related Diabetes, MODY, LADA, and other forms of diabetes comprised approximately 15% of the total diabetes service population. The complexity of care continues to increase, with a growing number of patients experiencing chronic kidney disease and retinopathy. MODY=Maturity Onset Diabetes of the Young; LADA = Latent autoimmune diabetes in adults, Insulin Resistance.

Advancements in Diabetes Technology

The multidisciplinary team (MDT) provides comprehensive care for women utilising Continuous Subcutaneous Insulin Infusion (CSII) and continuous glucose monitoring (sensor) technology. The introduction of Hybrid Closed-Loop CSII systems has significantly improved diabetes management during pregnancy. Additionally, the use of smart insulin pens has enhanced insulin safety.

As a tertiary referral centre, the NMH remains committed to staying at the forefront of diabetes technology. In 2025, 75% of the PGDM population utilised Hybrid Closed Loop Technology, marking the first full year of hybrid closed-loop system adoption and an increase from 2024. The majority of women with PGDM also benefited from sensor technology.

Gestational Diabetes Mellitus (GDM)

The midwifery-led GDM service, supported by dietitians, offers a unique and patient-centred care pathway. The virtual GDM service has gained national and international recognition through presentations at midwifery and medical conferences.

With robust support from endocrinology, obstetrics, dietetics, and the wider MDT, the AMP led service has successfully reduced overall pharmacological treatment rates. In 2025, of the 615 women diagnosed with GDM (85% of total referrals), 239 required pharmacological therapy (121 insulin, 118 metformin), representing a treatment rate of 38%.

Role of Diabetes Dietitians

Dietitians play an essential role in the MDT, providing patient-centred nutritional guidance through face-to-face consultations, virtual classes, and phone reviews. Their collaboration with other healthcare professionals ensures optimal management of complex medical conditions during pregnancy.

Key Statistics

- A retrospective view of a subset of those with pre-existing diabetes who were seen by the dietitian show that women with T2DM had higher booking BMI (31.6 vs. 27.3 kg/m^2, p=0.018) and lower adherence to folic acid and pregnancy planning guidelines compared to those with T1DM.
- 66% of women diagnosed with GDM received individual dietitian consultations.
- 90% of women requiring pharmacological treatment were seen by a dietitian

Dietitians support patients with carbohydrate counting, nutritional adequacy, and managing conditions such as cystic fibrosis related diabetes, nausea, coeliac disease, excessive weight gain, and anaemia, particularly in the context of increasing insulin pump and glucose sensor usage.

Goals and Targets

The NMH Diabetes Team remains firmly committed to delivering high quality, evidence based, person centred

care for women with complex medical needs. Through ongoing innovation, multidisciplinary collaboration, and continued professional development, the service continues to evolve to meet the needs of pregnant women with diabetes.

In 2025, team members contributed to both national and international policies, including involvement in the HSE tendering process to enable free access to glucose testing strips for women with gestational diabetes. Prof Mary Higgins, Prof Mensud Hatunic, Ciara Coveney and Catherine Chambers also contributed to the development of the national Diabetes in Pregnancy (DIP) guideline, with publication anticipated in 2026.

A significant milestone in 2025 was the first year of initiating hybrid closed-loop insulin pump therapy during pregnancy. Eligible women were successfully on boarded during pregnancy and benefitted from the latest advances in diabetes technology, in line with international best practice recommendations.

Prof Mary Higgins, **Consultant Obstetrician & Gynaecologist and** ***Ciara Coveney,*** **AMP Diabetes**

Diabetes Team.

Labour and Birthing Unit

Throughout 2025, staff in the Labour and Birthing Unit (LBU) continued to deliver care and support to women and their partners during labour. Of the 7,096 women who gave birth to their baby at The National Maternity Hospital (NMH) in 2025, 4,278 (60.3%) were born vaginally in the LBU. While vaginal birth is encouraged where feasible, respect for maternal choice remains a core principle of Hospital practice.

Although the total number of women presenting to the LBU in labour decreased, increasing clinical complexity and a high rate of induction of labour (IOL) continue to present challenges. The overall IOL rate increased to 41.6% in 2025. Nulliparous women are now more likely to undergo induction of labour or pre-labour caesarean section than to experience spontaneous onset of labour. Decisions regarding induction are guided by national and international recommendations, maternal co-morbidities, and individual patient preference.

Birth in water offers women more birth options while also enabling midwives to provide care in line with the supportive care pathway; 80 women gave birth in water while 182 women used hydrotherapy as pain relief/support in labour.

Staff Retention

Staff retention continues to be a challenge. 2025 saw the departure of many senior managers from the LBU who moved to promotional posts within the organisation. Despite the challenges posed to the remaining managers and midwives, there is a continued strong commitment to delivering safe, patient-centred, and compassionate care. The LBU team continues to mentor student midwives, medical students, general student nurses, paramedic students and physiotherapy students as part of their daily role while being committed to providing care to women that is high quality, evidence based and respectful of the woman's individual choice and needs.

Martina Cronin, **CMM3 Labour and Birth & Antenatal Inpatient Services**

Labour and Delivery (including Caesarean Section)

Audit of maternal and fetal outcome following labour and delivery in this chapter is based on a standardised prospective framework consisting of the four obstetric concepts within which there are different parameters. The obstetric concepts are **Previous record of the pregnancy** *(nulliparous, multiparous without a uterine scar, multiparous with a uterine scar)* **Category of pregnancy** *(single cephalic pregnancy, single breech pregnancy, single oblique or transverse lie, or multiple pregnancy)* **pathway to delivery** *(spontaneous labour, induced labour or pre labour caesarean)* and **gestational age in completed weeks at the time of delivery**. These concepts are mutually exclusive and totally inclusive.

Population changes of nulliparous women and multiparous women

Year	1999				2023			
	Number in group	Number of C/S	Contribution to total population	% C/S	Number in group	Number of C/S	Contribution to total population	% C/S
Nullip	3465	562	3465/7533 (46.0%)	562/3465 (16.2%)	3084	1195	3084/6764 (45.6%)	1195/3084 (38.7%)
Multip no scars	3559	185	3559/7533 (47.2%)	185/3559 (5.2%)	2567	293	2567/6764 (38.0%)	293/2567 (11.4%)
Multip + 1 scar	450	169	450/7533 (6.0%)	169/450 (37.6%)	883	730	883/6764 (13.1%)	730/883 (82.7%)
Multip + 2 or more scars	59	58	59/7533 (8.0%)	58/59 (98.3%)	230	225	230/6764 (3.4%)	225/230 (97.8%)
Totals	**7533**	**974**		**974/7533 (12.9%)**	**6764**	**2443**		**2443/6764 (36.1%)**

Year	2024				2025			
	Number in group	Number of C/S	Contribution to total population	% C/S	Number in group	Number of C/S	Contribution to total population	% C/S
Nullip	3172	1266	3172/6599 (48.1%)	1266/3172 (39.9%)	3471	1388	3471/7096 (48.9%)	1388/3471 (40.0%)
Multip no scars	2304	280	2304/6599 (34.9%)	280/2304 (12.2%)	2448	288	2448/7096 (34.5%)	288/2448 (11.8%)
Multip + 1 scar	878	743	878/6599 (13.3%)	743/878 (84.6%)	927	784	927/7096 (13.1%)	784/927 (84.6%)
Multip + 2 or more scars	245	240	245/6599 (3.7%)	240/245 (98.0%)	250	244	250/7096 (3.5%)	244/250 (97.6%)
Totals	**6599**	**2529**		**2529/6599 (38.3%)**	**7096**	**2704**		**2704/7096 (38.1%)**

Comment: *There has been an increase in total deliveries.*

Pathway to Delivery

	1999	%	2013	%	2023	%	2024	%	2025	%
Spontaneous	5062	67.2%	5214	59.6%	2578	38.1%	2267	34.4%	2383	33.6%
Induced	2006	26.6%	2323	26.5%	2604	38.5%	2669	40.4%	2950	41.6%
Pre-labour CS	466	6.2%	1218	13.9%	1582	23.4%	1663	25.2%	1763	24.8%
Total Deliveries	**7534**		**8755**		**6764**		**6599**		**7096**	

Comment: *The incidence of IOL and pre-labour CS remains high*

Overall Delivery Method

	2017	%	2019	%	2023	%	2024	%	2025	%
Spontaneous Vaginal Delivery	5048	59.9%	4498	57.1%	3502	51.8%	3366	51.0%	3547	50.0%
Vaginal Operative Delivery	1094	13.0%	989	12.6%	819	12.1%	704	10.7%	845	11.9%
Caesarean Section	2291	27.2%	2384	30.3%	2443	36.1%	2529	38.3%	2704	38.1%
Total	**8433**		**7871**		**6764**		**6599**		**7096**	

C-Section Rate by Pathway to Delivery

	Number in group	Number of C/S	Contribution to total population	% C/S
Spontaneous labour	2383	156	2383/7096 (33.6%)	156/7096 (2.2%)
Induced labour	2950	785	2950/7096 (41.6%)	785/7096 (11.1%)
Pre labour c-section	1763	1763	1763/7096 (24.8%)	1763/7096 (24.8%)
Totals	**7096**	**2704**		**2704/7096 (38.1%)**

Oxytocin Rates 2540/7096 (35.8%)

	Nullip	Multip no scar	Multip +scar	Total
No Oxytocin	1590 (45.8%)	1806 (73.8%)	1160 (98.6%)	4556 (64.2%)
Oxytocin	1881 (54.2%)	642 (26.2%)	17 (1.4%)	2540 (35.8%)
Total	**3471**	**2448**	**1177**	**7096**

Table I: The overall caesarean section rate as classified by the 10 groups (total numbers)

Year	1974*	1984*	1994*	2019	2020	2021	2022	2023	2024	2025
Totals	377/7546	330/7758	551/6244	2384/7871	2279/7263	2411/7694	2341/6815	2443/6764	2529/6599	2704/7096
1	46/2020	63/2259	80/1771	127/1468	113/1283	137/1322	118/992	108/1006	102/957	87/962
2	68/555	41/378	104/566	697/1544	646/1531	645/1527	694/1525	802/1690	881/1826	988/2059
2a				490/1336	449/1334	436/1318	515/1346	555/1443	593/1538	691/1762
2b				207/208	197/197	209/209	179/179	247/247	288/288	297/297
3	24/3217	15/3739	25/2467	20/1946	11/1567	24/1700	15/1358	14/1258	16/1028	13/1079
4	88/967	19/562	38/622	152/1053	177/1112	179/1281	181/1230	174/1112	154/1091	157/1153
4a				46/947	50/985	58/1160	74/1123	76/1014	58/995	63/1059
4b				106/106	127/127	121/121	107/107	98/98	96/96	94/94
5	32/196	74/332	108/321	816/1024	792/979	858/1041	812/955	825/964	871/1003	887/1027
6	26/79	27/79	65/99	176/191	143/152	170/181	166/177	146/158	166/170	166/175
7	7/105	14/98	40/78	143/156	123/133	110/120	76/87	84/96	76/78	112/117
8	10/93	18/96	25/78	87/129	93/136	105/156	101/130	79/107	90/117	86/108
9	20/20	23/23	15/15	32/32	45/45	40/40	27/27	37/37	38/38	37/37
10	56/294	36/192	51/227	134/328	136/325	143/326	151/334	174/336	135/291	171/379

** Years 1974, 1984 and 1994 were not split up into 2a, 2b and 4a, 4b. The numbers are inclusive of inductions and pre labour caesarean sections*

Table II: The contribution that each group makes to the overall hospital population (percentages)

Year	1974	1984	1994	2019	2020	2021	2022	2023	2024	2025
Totals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	26.7%	29.1%	28.4%	18.7%	17.7%	17.2%	14.6%	14.9%	14.5%	13.6%
2	7.4%	4.9%	9.1%	19.6%	21.1%	19.8%	22.4%	25.0%	27.7%	29.0%
2a				17.0%	18.4%	17.1%	19.8%	21.3%	23.3%	24.8%
2b				2.6%	2.7%	2.7%	2.6%	3.7%	4.4%	4.2%
3	42.6%	48.2%	39.5%	24.7%	21.6%	22.1%	19.9%	18.6%	15.6%	15.2%
4	12.8%	7.2%	10.0%	13.4%	15.3%	16.6%	18.0%	16.4%	16.5%	16.2%
4a				12.0%	13.6%	15.1%	16.5%	15.0%	15.1%	14.9%
4b				1.3%	1.7%	1.6%	1.6%	1.4%	1.5%	1.3%
5	2.6%	4.3%	5.1%	13.0%	13.5%	13.5%	14.0%	14.3%	15.2%	14.5%
6	1.1%	1.0%	1.6%	2.4%	2.1%	2.4%	2.6%	2.3%	2.6%	2.5%
7	1.4%	1.3%	1.2%	2.0%	1.8%	1.6%	1.3%	1.4%	1.2%	1.7%
8	1.2%	1.2%	1.2%	1.6%	1.9%	2.0%	1.9%	1.6%	1.8%	1.5%
9	0.3%	0.3%	0.2%	0.4%	0.6%	0.5%	0.4%	0.5%	0.6%	0.5%
10	3.9%	2.5%	3.6%	4.2%	4.5%	4.2%	4.9%	5.0%	4.4%	5.3%

Table III: The caesarean section rate within each of the 10 groups (percentages)

Year	1974	1984	1994	2019	2020	2021	2022	2023	2024	2025
Totals	5.0%	4.3%	8.8%	30.3%	31.4%	31.3%	34.4%	36.1%	38.3%	38.1%
1	2.3%	2.8%	4.5%	8.7%	8.8%	10.4%	11.9%	10.7%	10.7%	9.0%
2	12.3%	10.8%	18.3%	45.1%	42.2%	42.2%	45.5%	47.5%	48.2%	48.0%
2a				36.7%	33.7%	33.1%	38.3%	38.5%	38.6%	39.2%
2b				99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	0.7%	0.4%	1.0%	1.0%	0.7%	1.4%	1.1%	1.1%	1.6%	1.2%
4	9.1%	3.4%	6.1%	14.4%	15.9%	14.0%	14.7%	15.6%	14.1%	13.6%
4a				4.9%	5.1%	5.0%	6.6%	7.5%	5.8%	5.9%
4b				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	16.3%	22.3%	33.5%	79.7%	80.9%	82.4%	85.0%	85.6%	86.8%	86.4%
6	32.9%	34.2%	65.0%	92.1%	94.1%	93.9%	93.8%	92.4%	97.6%	94.9%
7	6.7%	14.3%	50.6%	91.7%	92.5%	91.7%	87.4%	87.5%	97.4%	95.7%
8	10.8%	18.8%	31.6%	67.4%	68.4%	67.3%	77.7%	73.8%	76.9%	79.6%
9	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
10	19.0%	18.8%	22.4%	40.9%	41.8%	43.9%	45.2%	51.8%	46.4%	45.1%

Table IV: The absolute contribution of each group to the overall caesarean section rate (percentages)

Year	1974	1984	1994	2019	2020	2021	2022	2023	2024	2025
Totals	5.0%	4.3%	8.8%	30.3%	30.4%	31.3%	34.4%	36.1%	38.3%	38.1%
1	0.7%	0.8%	1.7%	1.6%	1.6%	1.8%	1.7%	1.6%	1.5%	1.2%
2	0.9%	0.5%	0.4%	8.9%	8.9%	8.4%	10.2%	11.9%	13.4%	13.9%
2a				6.2%	6.2%	5.7%	7.6%	8.2%	9.0%	9.7%
2b				2.6%	2.7%	2.7%	2.6%	3.7%	4.4%	4.2%
3	0.3%	0.2%	0.4%	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%	0.2%
4	1.2%	0.2%	0.6%	1.9%	2.4%	2.3%	2.7%	2.6%	2.3%	2.2%
4a				0.6%	0.7%	0.8%	1.1%	1.1%	0.8%	0.9%
4b				1.3%	1.7%	1.6%	1.6%	1.4%	1.5%	1.3%
5	0.4%	1.0%	1.7%	10.4%	10.9%	11.2%	11.9%	12.2%	13.2%	12.5%
6	0.3%	0.3%	1.0%	2.2%	2.0%	2.2%	2.4%	2.2%	2.5%	2.4%
7	0.1%	0.2%	0.6%	1.8%	1.7%	1.4%	1.1%	1.2%	1.2%	1.6%
8	0.1%	0.2%	0.4%	1.1%	1.3%	1.4%	1.5%	1.2%	1.4%	1.2%
9	0.3%	0.3%	0.2%	0.4%	0.6%	0.5%	0.4%	0.5%	0.6%	0.5%
10	0.7%	0.5%	0.8%	1.7%	1.9%	1.9%	2.2%	2.6%	2.0%	2.4%

Robson Ten Groups Classification of Caesarean Section 2025

	CS No. / No. of Deliveries 2704 / 7096 38.1%	Size of Group % (100%)	CS rate in Group%	Contribution of each Group % (38.1%)
1. Nulliparous, single cephalic, >=37 weeks, in spontaneous labour	87 / 962	13.6%	9.0%	1.2%
2. Nulliparous, single cephalic, >=37 weeks, induced and CS before labour	988 / 2059	29.0%	48.0%	13.9%
3. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, in spontaneous labour	13 / 1079	15.2%	1.2%	0.2%
4. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, induced and CS before labour *	157 / 1153	16.2%	13.6%	2.2%
5. Previous CS, single cephalic, >= 37 weeks	887 / 1027	14.5%	86.4%	12.5%
6. All nulliparous breeches	166 / 175	2.5%	94.9%	2.4%
7. All multiparous breeches (including prev. CS)	112 / 117	1.7%	95.7%	1.6%
8. All multiple pregnancies (including prev. CS)	86 / 108	1.5%	79.6%	1.2%
9. All abnormal lies (including prev. CS)	37 / 37	0.5%	100.0%	0.5%
10. All single cephalic,<=36 weeks (including prev. CS)	171 / 379	5.3%	45.1%	2.4%

Indications for Caesarean Section by Pathway to Delivery

Tables 1 and 2 show the indications for CS within the TGCS. A different classification is used for pre labour CS and those carried out after either spontaneous or induced labour. A great deal of effort is needed to ensure that the classification is correctly applied and the data validated and quality controlled. In these tables although the quality is good there remain discrepancies which we continue to seek to improve.

Table 1: Spontaneous/Induced Caesarean Section Reason 941/7096 (13.3%)

	Fetal reason (no oxytocin)	% of Group	IUA - Inability to treat fetal intolerance	% of Group	IUA - Inability to treat over contracting	% of Group	IUA - Poor response	% of Group	IUA - No oxytocin given	% of Group	EUA - Persistent malposition	% of Group	EUA - Cephalopelvic disproportion	% of Group	Total	% of Group
Total	**197**	***2.8%***	**327**	***4.6%***	**51**	***0.7%***	**210**	***3.0%***	**88**	***1.2%***	**60**	***0.8%***	**8**	***0.1%***	**941/7096**	***13.3%***
Group 1	28	2.9%	28	2.9%	8	0.8%	6	0.6%	1	0.1%	14	1.5%	2	0.2%	87/962	9.0%
Group 2a	95	5.4%	274	15.6%	41	2.3%	178	10.1%	63	3.6%	36	2.0%	4	0.2%	691/1762	39.2%
Group 2b	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/297	0.0%
Group 3	9	0.8%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	3	0.3%	0	0.0%	13/1079	1.2%
Group 4a	16	1.5%	19	1.8%	1	0.1%	17	1.6%	5	0.5%	4	0.4%	1	0.1%	63/1059	5.9%
Group 4b	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/94	0.0%
Group 5	20	1.9%	2	0.2%	0	0.0%	3	0.3%	10	1.0%	2	0.2%	1	0.1%	38/1027	3.7%
Group 6	6	3.4%	0	0.0%	0	0.0%	0	0.0%	3	1.7%	0	0.0%	0	0.0%	9/175	5.1%
Group 7	9	7.7%	1	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	10/117	8.5%
Group 8	4	3.7%	0	0.0%	0	0.0%	2	1.9%	3	2.8%	0	0.0%	0	0.0%	9/108	8.3%
Group 9	3	8.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3/37	8.1%
Group 10	7	1.8%	2	0.5%	1	0.3%	4	1.1%	3	0.8%	1	0.3%	0	0.0%	18/379	4.7%

Table 2: Pre-labour Caesarean Section Reason: 1763/7096 (24.8%)

	Fetal reason	% of Group	Maternal medical reason/pains	% of Group	Maternal request	% of Group	PET/ Hypertension	% of Group	Postdates	% of Group	Previous caesarean section	% of Group	SROM	% of Group	Total	% of Group
Total	**591**	***8.3%***	**130**	***1.8%***	**272**	***3.8%***	**68**	***1.0%***	**11**	***0.2%***	**637**	***9.0%***	**54**	***0.8%***	**1763/7096**	***24.8%***
Group 1	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/962	0.0%
Group 2a	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1762	0.0%
Group 2b	85	28.6%	42	14.1%	155	52.2%	7	2.4%	1	0.3%	0	0.0%	7	2.4%	297/297	100.0%
Group 3	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1079	0.0%
Group 4a	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1059	0.0%
Group 4b	28	29.8%	27	28.7%	35	37.2%	2	2.1%	0	0.0%	0	0.0%	2	2.1%	94/94	100.0%
Group 5	83	8.1%	20	1.9%	74	7.2%	13	1.3%	9	0.9%	619	60.3%	31	3.0%	849/1027	82.7%
Group 6	146	83.4%	1	0.6%	0	0.0%	6	3.4%	0	0.0%	0	0.0%	4	2.3%	157/175	89.7%
Group 7	90	76.9%	5	4.3%	0	0.0%	0	0.0%	0	0.0%	6	5.1%	1	0.9%	102/117	87.2%
Group 8	58	53.7%	3	2.8%	5	4.6%	6	5.6%	0	0.0%	3	2.8%	2	1.9%	77/108	71.3%
Group 9	23	62.2%	5	13.5%	0	0.0%	1	2.7%	1	2.7%	2	5.4%	2	5.4%	34/37	91.9%
Group 10	78	20.6%	27	7.1%	3	0.8%	33	8.7%	0	0.0%	7	1.8%	5	1.3%	153/379	40.4%

Groups 1 and 2

Total single cephalic nulliparous pregnancies at greater than or equal to 37 weeks' gestation (n=3021)

Spontaneous labour	Induced labour	Pre labour C/S
962/3021 (31.9%)	1762/3021 (58.3%)	297/3021 (9.8%)

Caesarean section contribution according to pathway to delivery, in single cephalic nulliparous pregnancies at greater than or equal to 37 weeks' gestation 1075/3021 (35.6%)

Spontaneous labour	87/3021	2.9%
Induced labour	691/3021	22.9%
Pre labour C/S	297/3021	9.8%

Group 1

Caesarean section rate of single cephalic nulliparous pregnancies at greater than or equal to 37 weeks gestation in spontaneous labour 87/962 (9.0%)

Fetal reason (no oxytocin)	28/962	2.9%
IUA - Inability to treat fetal intolerance	28/962	2.9%
IUA - Inability to treat over contracting	8/962	0.8%
IUA - Poor response	6/962	0.6%
IUA - No oxytocin given	1/962	0.1%
EUA - Persistent malposition	14/962	1.5%
EUA - Cephalopelvic disproportion	2/962	0.2%

Group 1 Events and Outcomes

Group 1	2025		2024	2023	2022	2021
ARM	417/962	43.3%	45.7%	47.2%	45.8%	49.8%
Prostaglandin/Propess	0/962	0.0%	0.0%	0.0%	-	-
Oxytocin	454/962	47.2%	48.8%	47.6%	44.2%	53.8%
Epidural	757/962	78.7%	75.2%	75.4%	66.9%	76.0%
Electronic monitoring	902/962	93.8%	90.9%	91.9%	85.0%	91.4%
Fetal blood sample	61/962	6.3%	4.2%	5.3%	8.3%	13.1%
Vaginal operative delivery	270/962	28.1%	23.8%	28.8%	28.9%	29.2%
Apgars <7 at 5 mins	7/962	0.7%	1.3%	0.9%	1.1%	0.5%
Cord pH < 7.0	7/962	0.7%	0.9%	0.4%	-	0.0%
Overall caesarean section	87/962	9.0%	10.7%	10.7%	10.4%	8.8%
Caesarean section at VE=10	18/962	1.9%	0.6%	1.3%	1.3%	0.9%
Admitted to Neonatal Unit	118/962	12.3%	11.7%	8.7%	8.9%	8.6%
*Episiotomy	494/962	51.4%	44.9%	49.8%	48.8%	49.0%
*OASIS	44/962	4.6%	3.2%	3.4%	2.2%	3.0%
Length of labour >= 12 hrs	38/962	4.0%	1.9%	2.8%	2.8%	2.4%
Babies >=4.0kg	96/962	10.0%	8.5%	8.3%	12.4%	12.2%
Aged >=35	261/962	27.1%	27.4%	25.0%	26.5%	31.3%
BMI >=30	199/962	20.7%	19.1%	13.6%	9.1%	9.4%
PPH >= 1000mls	65/962	6.8%	6.4%	7.1%	3.9%	3.4%
HIE	0/962	0.0%	0.3%	0.2%	0.0%	0.0%
Blood transfusion	20/962	2.1%	0.9%	2.5%	2.0%	1.6%

** includes Episiotomy and Sphincter Damage (n=20)*

Age Range	Number	%
<20	10	1.0%
20 - 24	64	6.7%
25 - 29	177	18.4%
30 - 34	450	46.8%
35 - 39	235	24.4%
>=40	26	2.7%
Unrecorded	0	0.0%
Total	**962**	

Body Mass Index	Number	%
Underweight: <18.5	25	2.6%
Healthy: 18.5 - 24.9	526	54.7%
Overweight: 25 - 29.9	274	28.5%
Obese class 1: 30 - 34.9	79	8.2%
Obese class 2: 35 - 39.9	17	1.8%
Obese class 3: >= 40	10	1.0%
Unrecorded	31	3.2%
Total	**962**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	1	0.1%
2,000 - 2,499 g	5	0.5%
2,500 - 2,999 g	138	14.3%
3,000 - 3,499 g	404	42.0%
3,500 - 3,999 g	318	33.1%
4,000 - 4,499 g	88	9.2%
4,500 - 4,999 g	8	0.8%
>= 5,000 g	0	0.0%
Total	**962**	

Labour Duration	Number	%
0 - 2 hrs	121	12.6%
2 - 4 hrs	177	18.4%
4 - 6 hrs	199	20.7%
6 - 8 hrs	235	24.4%
8 - 10 hrs	126	13.1%
10 - 12 hrs	65	6.8%
>= 12 hrs	34	3.5%
Unrecorded	5	0.5%
Total	**962**	

Group 2a

Single cephalic nulliparous pregnancies at greater than or equal to 37 weeks' gestation. Indications for induction of labour 1762/3021 (58.3%). (Group 1 & 2 as the denominator)

Fetal	570/3021	18.9%
SROM not in labour	458/3021	15.2%
Postdates (>40 and less than 42 weeks)	405/3021	13.4%
PET/Hypertension	146/3021	4.8%
Maternal medical reason/pains	138/3021	4.6%
Maternal request	38/3021	1.2%
Postterm (>= 42 weeks)	7/3021	0.2%
Total	**1762/3021**	**58.3%**

Comment: *Many of the maternal indications, when reviewed, are actually really fetal. This requires continuous validation.*

Indications for Induction by Gestational Age for single cephalic nulliparous pregnancies: 1792/3227 (55.5%)

	Fetal	% of Group	SROM not in labour	% of Group	Postdates (>40 and less than 42 weeks)	% of Group	Maternal medical reason/ pains	% of Group	PET/ Hypertension	% of Group	Maternal Request	% of Group	Postterm (>= 42 weeks)	% of Group	Total	% of Group
Total	**574**	***17.8%***	**469**	***14.5%***	**405**	***12.6%***	**147**	***4.6%***	**150**	***4.6%***	**40**	***1.2%***	**7**	***0.2%***	**1792/3227**	***55.5%***
22	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1	0.0%
23	0	0.0%	0	0.0%	0	0.0%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	1/3	33.3%
24	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/2	0.0%
25	0	0.0%	0	0.0%	0	0.0%	2	25.0%	0	0.0%	1	12.5%	0	0.0%	3/8	37.5%
26	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/4	0.0%
27	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/3	0.0%
28	0	0.0%	0	0.0%	0	0.0%	1	20.0%	0	0.0%	0	0.0%	0	0.0%	1/5	20.0%
29	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/5	0.0%
30	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/9	0.0%
31	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/5	0.0%
32	0	0.0%	0	0.0%	0	0.0%	1	6.7%	0	0.0%	0	0.0%	0	0.0%	1/15	6.7%
33	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/12	0.0%
34	0	0.0%	2	9.1%	0	0.0%	1	4.5%	0	0.0%	0	0.0%	0	0.0%	3/22	13.6%
35	1	2.3%	0	0.0%	0	0.0%	1	2.3%	0	0.0%	0	0.0%	0	0.0%	2/44	4.5%
36	3	4.4%	9	13.2%	0	0.0%	2	2.9%	4	5.9%	1	1.5%	0	0.0%	19/68	27.9%
37	45	25.0%	36	20.0%	0	0.0%	2	1.1%	21	11.7%	0	0.0%	0	0.0%	104/180	57.8%
38	85	19.6%	77	17.7%	0	0.0%	11	2.5%	39	9.0%	2	0.5%	0	0.0%	214/434	49.3%
39	177	21.8%	135	16.6%	0	0.0%	38	4.7%	43	5.3%	7	0.9%	0	0.0%	400/813	49.2%
40	216	21.8%	148	14.9%	71	7.2%	63	6.3%	37	3.7%	27	2.7%	0	0.0%	562/993	56.6%
41	47	8.1%	61	10.5%	326	56.2%	24	4.1%	6	1.0%	2	0.3%	0	0.0%	466/580	80.3%
42	0	0.0%	1	4.8%	8	38.1%	0	0.0%	0	0.0%	0	0.0%	7	33.3%	16/21	76.2%

Group 2a

Caesarean section rates according to indication for induction in single cephalic nulliparous pregnancies at greater than or equal to 37 weeks gestation 691/1762 (39.2%).

	Fetal reason (no oxytocin)		IUA - Inability to treat fetal intolerance		IUA - Inability to treat over contracting		IUA - Poor response		IUA - No oxytocin given		EUA - Cephalopelvic disproportion		EUA - Persistent malposition	
Fetal 214/570 (37.5%)	40	7.0%	64	11.2%	12	2.1%	48	8.4%	34	6.0%	2	0.3%	14	2.5%
SROM not in labour 191/458 (41.7%)	3	0.7%	84	18.3%	16	3.5%	74	16.2%	1	0.2%	1	0.2%	12	2.6%
Postdates (>40 and less than 42 weeks) 152/405 (37.5%)	33	8.1%	53	13.1%	9	2.2%	37	9.1%	14	3.5%	0	0.0%	6	1.5%
PET/Hypertension 60/146 (41.1%)	11	7.5%	26	17.8%	0	0.0%	13	8.9%	7	4.8%	1	0.7%	2	1.4%
Maternal medical reason/pains 58/138 (42.0%)	5	3.6%	38	27.5%	4	2.9%	3	2.2%	6	4.3%	0	0.0%	2	1.5%
Maternal request 16/38 (42.1%)	3	7.9%	9	23.7%	0	0.0%	3	7.9%	1	2.6%	0	0.0%	0	0.0%
Postterm (>= 42 weeks) 0/7 (0.0%)	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total 691/1762 (39.2%)	**95**	**5.4%**	**274**	**15.6%**	**41**	**2.3%**	**178**	**10.1%**	**63**	**3.6%**	**4**	**0.2%**	**36**	**2.0%**

Group 2a Events and Outcomes

Group 2a	2025		2024	2023	2022	2021
ARM	1002/1762	56.9%	57.7%	56.3%	48.2%	52.6%
Prostaglandin/Propess	947/1762	53.7%	56.6%	57.9%	39.2%	50.4%
Oxytocin	1381/1762	78.4%	78.0%	80.1%	70.9%	81.3%
Epidural	1499/1762	85.1%	84.6%	85.0%	73.2%	82.8%
Electronic monitoring	1738/1762	98.6%	98.8%	98.5%	87.3%	98.7%
Fetal blood sample	127/1762	7.2%	5.7%	6.7%	-	19.6%
Vaginal operative delivery	421/1762	23.9%	22.2%	25.6%	-	27.0%
Apgars <7 at 5 mins	26/1762	1.5%	1.4%	0.8%	1.0%	1.6%
Cord pH < 7.0	12/1762	0.7%	0.3%	0.3%	-	0.0%
Overall caesarean section	691/1762	39.2%	38.6%	38.5%	33.1%	33.7%
Caesarean section at VE=10	46/1762	2.6%	1.8%	1.8%	2.0%	1.8%
Admitted to Neonatal Unit	293/1762	16.6%	18.4%	15.6%	14.0%	13.2%
*Episiotomy	659/1762	37.4%	36.3%	39.8%	39.8%	42.0%
*OASIS	40/1762	2.3%	2.1%	2.1%	1.7%	1.6%
Length of labour >= 12 hrs	301/1762	17.1%	3.8%	3.9%	4.7%	3.8%
Babies >=4.0kg	256/1762	14.5%	13.3%	15.0%	16.3%	17.5%
Aged >=35	588/1762	33.4%	35.0%	33.8%	36.6%	41.5%
BMI >=30	540/1762	30.6%	31.7%	21.3%	18.5%	19.9%
PPH >= 1000mls	188/1762	10.7%	11.5%	8.1%	6.6%	6.2%
HIE	3/1762	0.2%	0.1%	0.1%	0.4%	0.3%
Blood transfusion	62/1762	3.5%	3.9%	2.1%	2.2%	1.6%

**includes Episiotomy and Sphincter Damage (n=21).*

The 3 cases of HIE in Group 2a were Grade 2 (n=1) and Grade 3 (n=2).

Age Range	Number	%
<20	17	0.9%
20 - 24	100	5.7%
25 - 29	266	15.1%
30 - 34	791	44.9%
35 - 39	493	28.0%
>=40	95	5.4%
Unrecorded	0	0.0%
Total	**1762**	

Body Mass Index	Number	%
Underweight: <18.5	19	1.1%
Healthy: 18.5 - 24.9	771	43.7%
Overweight: 25 - 29.9	586	33.3%
Obese class 1: 30 - 34.9	230	13.0%
Obese class 2: 35 - 39.9	84	4.8%
Obese class 3: >= 40	30	1.7%
Unrecorded	42	2.4%
Total	**1762**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	2	0.1%
2,000 - 2,499 g	39	2.2%
2,500 - 2,999 g	228	12.9%
3,000 - 3,499 g	633	35.9%
3,500 - 3,999 g	604	34.3%
4,000 - 4,499 g	221	12.6%
4,500 - 4,999 g	31	1.8%
>= 5,000 g	4	0.2%
Total	**1762**	

Labour Duration	Number	%
0 - 2 hrs	101	5.7%
2 - 4 hrs	176	10.0%
4 - 6 hrs	265	15.1%
6 - 8 hrs	337	19.1%
8 - 10 hrs	313	17.8%
10 - 12 hrs	268	15.2%
>= 12 hrs	180	10.2%
Unrecorded	122	6.9%
Total	**1762**	

Group 2b

Pre labour caesarean section in single cephalic nulliparous pregnancies at greater than or equal to 37 weeks gestation 297/3021 (9.8%)

Maternal request	155/3021	5.1%
Fetal reason	85/3021	2.8%
Maternal medical reason/pains	42/3021	1.4%
PET/Hypertension	7/3021	0.2%
SROM	7/3021	0.2%
Postdates	1/3021	0.1%
Previous caesarean section	0/3021	0.0%
Total	**297/3021**	**9.8%**

Comment: *More detailed information is needed in pre-labour indications*

Group 2b Events and Outcomes

Group 2b	2025		2024	2023	2022	2021
Spinal	284/297	95.6%	94.8%	94.7%	89.4%	-
GA	8/297	2.7%	3.1%	1.6%	5.0%	-
Apgars <7 at 5 mins	3/297	1.0%	0.7%	2.0%	1.1%	-
Cord pH < 7.0	0/297	0.0%	0.7%	0.4%	0.0%	-
Admitted to Neonatal Unit	41/297	13.8%	19.4%	10.9%	15.1%	-
Babies >=4.0kg	41/297	13.8%	13.2%	13.4%	14.0%	-
Aged >=35	175/297	58.9%	60.8%	58.7%	62.6%	-
BMI >=30	101/297	34.0%	25.0%	34.8%	18.4%	-
PPH >= 1000mls	27/297	9.1%	6.9%	5.7%	8.4%	-
HIE	0/297	0.0%	0.7%	0.0%	1.1%	-
Blood transfusion	2/297	0.7%	1.0%	0.8%	1.7%	-

Age Range	Number	%
<20	1	0.3%
20 - 24	3	1.0%
25 - 29	19	6.4%
30 - 34	99	33.3%
35 - 39	108	36.4%
>=40	67	22.6%
Unrecorded	0	0.0%
Total	**297**	

Body Mass Index	Number	%
Underweight: <18.5	8	2.7%
Healthy: 18.5 - 24.9	125	42.1%
Overweight: 25 - 29.9	93	31.3%
Obese class 1: 30 - 34.9	46	15.5%
Obese class 2: 35 - 39.9	8	2.7%
Obese class 3: >= 40	5	1.7%
Unrecorded	12	4.0%
Total	**297**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	0	0.0%
2,000 - 2,499 g	3	1.0%
2,500 - 2,999 g	49	16.5%
3,000 - 3,499 g	108	36.4%
3,500 - 3,999 g	96	32.3%
4,000 - 4,499 g	32	10.8%
4,500 - 4,999 g	8	2.7%
>= 5,000 g	1	0.3%
Total	**297**	

Labour Duration	Number	%
0 - 2 hrs	1	0.3%
2 - 4 hrs	4	1.4%
4 - 6 hrs	2	0.7%
6 - 8 hrs	0	0.0%
8 - 10 hrs	0	0.0%
10 - 12 hrs	0	0.0%
>= 12 hrs	0	0.0%
Unrecorded	290	97.6%
Total	**297**	

Group 3 and 4

Total single cephalic multiparous pregnancies at greater than or equal to 37 weeks gestation (n=2232)

Spontaneous labour	Induced labour	Pre labour C/S
1079/2232 (48.3%)	1059/2232 (47.5%)	94/2232 (4.2%)

Caesarean section contribution according to pathway to delivery of single cephalic multiparous pregnancies without a previous section at greater than or equal to 37 weeks' gestation 170/2232 (7.6%)

Spontaneous labour	13/2232	0.6%
Induced labour	63/2232	2.8%
Pre labour C/S	94/2232	4.2%

Group 3

Caesarean section rate of single cephalic multiparous pregnancies without a previous caesarean section at greater than or equal to 37 weeks gestation in spontaneous labour 13/1079 (1.2%)

Fetal reason (no oxytocin)	9/1079	0.8%
IUA - Inability to treat fetal intolerance	1/1079	0.1%
IUA - Inability to treat over contracting	0/1079	0.0%
IUA - Poor response	0/1079	0.0%
IUA - No oxytocin given	0/1079	0.0%
EUA - Persistent malposition	3/1079	0.3%
EUA - Cephalopelvic disproportion	0/1079	0.0%

Group 3

Single cephalic multiparous pregnancies without a previous caesarean section at greater than or equal to 37 weeks' gestation in spontaneous labour

Group 3 Events and Outcomes

Group 3	2025		2024	2023	2022	2021
ARM	500/1079	46.3%	45.4%	47.0%	46.4%	51.8%
Prostaglandin/Propess	0/1079	0.0%	0.1%	0.0%	-	-
Oxytocin	31/1079	2.9%	4.8%	3.6%	3.8%	3.6%
Epidural	510/1079	47.3%	49.2%	46.1%	37.9%	39.8%
Electronic monitoring	865/1079	80.2%	81.2%	78.2%	74.4%	77.6%
Fetal blood sample	9/1079	0.8%	0.9%	0.9%	0.8%	2.1%
Vaginal operative delivery	38/1079	3.5%	3.4%	3.6%	3.7%	3.3%
Apgars <7 at 5 mins	20/1079	1.9%	0.1%	0.2%	0.3%	1.5%
Cord pH < 7.0	3/1079	0.3%	0.2%	0.2%	-	0.0%
Overall caesarean section	13/1079	1.2%	1.6%	1.1%	1.4%	1.7%
Caesarean section at VE=10	3/1079	0.3%	0.2%	0.2%	0.2%	0.0%
Admitted to Neonatal Unit	65/1079	6.0%	4.7%	4.4%	4.7%	6.1%
*Episiotomy	93/1079	8.6%	7.8%	8.6%	10.2%	8.1%
*OASIS	21/1079	1.9%	0.9%	1.6%	1.1%	1.0%
Length of labour >= 12 hrs	37/1079	3.4%	0.5%	0.6%	0.4%	1.2%
Babies >=4.0kg	184/1079	17.1%	16.5%	19.1%	20.1%	21.1%
Aged >=35	597/1079	55.3%	52.7%	54.4%	56.5%	59.9%
BMI >=30	228/1079	21.1%	23.2%	16.0%	11.9%	12.6%
PPH >= 1000mls	29/1079	2.7%	3.0%	3.2%	2.0%	1.2%
HIE	0/1079	0.0%	0.0%	0.1%	0.1%	0.0%
Blood transfusion	5/1079	0.5%	0.7%	0.4%	0.4%	0.7%

**includes Episiotomy and Sphincter Damage (n=3)*

Age Range	Number	%
<20	0	0.0%
20 - 24	30	2.8%
25 - 29	112	10.4%
30 - 34	340	31.5%
35 - 39	519	48.1%
>=40	78	7.2%
Unrecorded	0	0.0%
Total	**1079**	

Body Mass Index	Number	%
Underweight: <18.5	12	1.1%
Healthy: 18.5 - 24.9	580	53.8%
Overweight: 25 - 29.9	307	28.4%
Obese class 1: 30 - 34.9	113	10.5%
Obese class 2: 35 - 39.9	33	3.1%
Obese class 3: >= 40	10	0.9%
Unrecorded	24	2.2%
Total	**1079**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	0	0.0%
2,000 - 2,499 g	4	0.4%
2,500 - 2,999 g	86	8.0%
3,000 - 3,499 g	365	33.8%
3,500 - 3,999 g	440	40.8%
4,000 - 4,499 g	163	15.1%
4,500 - 4,999 g	21	1.9%
>= 5,000 g	0	0.0%
Total	**1079**	

Labour Duration	Number	%
0 - 2 hrs	573	53.1%
2 - 4 hrs	304	28.2%
4 - 6 hrs	117	10.8%
6 - 8 hrs	35	3.2%
8 - 10 hrs	8	0.7%
10 - 12 hrs	4	0.4%
>= 12 hrs	6	0.6%
Unrecorded	32	3.0%
Total	**1079**	

Group 4a

Single cephalic multiparous pregnancies section at greater than or equal to 37 weeks' gestation. Indications for induction of labour 1059/2232 (47.4%). (Group 3 and 4 as the denominator)

Fetal	453/2232	20.3%
SROM not in labour	186/2232	8.3%
Maternal medical reason/pains	165/2232	7.4%
Postdates (>40 and less than 42 weeks)	132/2232	5.9%
Maternal request	78/2232	3.5%
PET/Hypertension	42/2232	1.9%
Postterm (>= 42 weeks)	3/2232	0.1%
Total	**1059/2232**	**47.4%**

Comment: *Many of maternal indications when reviewed are actually really fetal. This requires continuous validation.*

Indications for Induction by Gestational Age for single cephalic multiparous pregnancies without a previous caesarean section: 1085/2341 (46.3%)

	Fetal	% of Group	SROM not in labour	% of Group	Postdates (>40 and less than 42 weeks)	% of Group	Maternal medical reason/ pains	% of Group	PET/ Hypertension	% of Group	Maternal Request	% of Group	Postterm (>= 42 weeks)	% of Group	Total	% of Group
Total	**459**	***19.6%***	**143**	***6.1%***	**186**	***7.9%***	**173**	***7.4%***	**43**	***1.8%***	**78**	***3.3%***	**3**	***0.1%***	**1085/2341**	***46.3%***
22	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1/2	50.0%
23	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1	0.0%
24	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1/1	100.0%
25	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1	0.0%
26	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
27	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/3	0.0%
28	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1/2	50.0%
29	0	0.0%	0	0.0%	0	0.0%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	1/3	33.3%
30	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1	0.0%
31	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/4	0.0%
32	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/6	0.0%
33	0	0.0%	0	0.0%	0	0.0%	1	16.7%	0	0.0%	0	0.0%	0	0.0%	1/6	16.7%
34	0	0.0%	1	10.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1/10	10.0%
35	1	5.6%	1	5.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2/18	11.1%
36	5	9.8%	9	17.6%	0	0.0%	3	5.9%	1	2.0%	0	0.0%	0	0.0%	18/51	35.3%
37	30	21.1%	21	14.8%	0	0.0%	15	10.6%	6	4.2%	2	1.4%	0	0.0%	74/142	52.1%
38	102	27.1%	37	9.8%	0	0.0%	36	9.5%	14	3.7%	9	2.4%	0	0.0%	198/377	52.5%
39	186	24.2%	38	4.9%	0	0.0%	69	9.0%	13	1.7%	42	5.5%	0	0.0%	348/768	45.3%
40	118	16.8%	28	4.0%	67	9.5%	40	5.7%	9	1.3%	25	3.6%	0	0.0%	287/702	40.9%
41	17	7.2%	8	3.4%	118	50.0%	5	2.1%	0	0.0%	0	0.0%	0	0.0%	148/236	62.7%
42	0	0.0%	0	0.0%	1	14.3%	0	0.0%	0	0.0%	0	0.0%	3	42.9%	4/7	57.1%

Group 4a

Caesarean section rates according to indication for induction in single cephalic multiparous pregnancies without a previous caesarean section at greater than or equal to 37 weeks' gestation 63/1059 (5.9%)

	Fetal reason (no oxytocin)		IUA - Inability to treat fetal intolerance		IUA - Inability to treat over contracting		IUA - Poor response		IUA - No oxytocin given		EUA - Cephalopelvic disproportion		EUA - Persistent malposition	
Fetal 33/453 (7.3%)	11	2.4%	11	2.4%	0	0.0%	5	1.1%	5	1.1%	1	0.3%	0	0.0%
Maternal medical reason/pains 11/165 (6.7%)	2	1.2%	4	2.4%	0	0.0%	4	2.4%	0	0.0%	0	0.0%	1	0.6%
Maternal request 3/78 (3.8%)	1	1.3%	0	0.0%	1	1.3%	0	0.0%	0	0.0%	0	0.0%	1	1.3%
PET/Hypertension 3/42 (7.1%)	0	0.0%	0	0.0%	0	0.0%	2	4.8%	0	0.0%	0	0.0%	1	2.4%
Postdates (>40 and less than 42 weeks) 5/186 (2.7%)	2	1.1%	0	0.0%	0	0.0%	2	1.1%	0	0.0%	0	0.0%	1	0.5%
Postterm (>= 42 weeks) 0/3 (0.0%)	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SROM not in labour 8/132 (6.1%)	0	0.0%	4	3.0%	0	0.0%	4	3.0%	0	0.0%	0	0.0%	0	0.0%
Total 63/1059 (5.9%)	**16**	**1.5%**	**19**	**1.8%**	**1**	**0.1%**	**17**	**1.6%**	**5**	**0.4%**	**1**	**0.1%**	**4**	**0.4%**

Group 4a Events and Outcomes

Group 4a	2025		2024	2023	2022	2021
ARM	828/1059	78.2%	76.7%	78.2%	65.7%	77.1%
Prostaglandin/Propess	467/1059	44.1%	43.5%	43.5%	36.8%	-
Oxytocin	578/1059	54.6%	54.7%	57.8%	44.3%	49.1%
Epidural	801/1059	75.6%	72.7%	71.0%	57.7%	60.7%
Electronic monitoring	1041/1059	98.3%	97.9%	98.1%	87.0%	98.7%
Fetal blood sample	28/1059	2.6%	1.7%	1.5%	2.4%	5.7%
Vaginal operative delivery	59/1059	5.6%	5.0%	5.8%	6.6%	5.8%
Apgars <7 at 5 mins	5/1059	0.5%	1.1%	0.2%	0.5%	0.7%
Cord pH < 7.0	7/1059	0.7%	0.2%	0.1%	-	0.0%
Overall caesarean section	63/1059	5.9%	5.8%	7.5%	5.0%	5.1%
Caesarean section at VE=10	6/1059	0.6%	0.6%	0.8%	0.3%	0.2%
Admitted to Neonatal Unit	100/1059	9.4%	9.2%	10.0%	9.4%	11.1%
Episiotomy	125/1059	11.8%	9.6%	9.4%	12.5%	10.3%
OASIS	3/1059	0.3%	0.5%	0.8%	0.6%	0.6%
Length of labour >= 12 hrs	42/1059	4.0%	1.1%	1.0%	0.7%	1.3%
Babies >=4.0kg	202/1059	19.1%	20.7%	19.4%	25.7%	25.1%
Aged >=35	636/1059	60.1%	63.8%	62.6%	62.6%	64.4%
BMI >=30	346/1059	32.7%	32.1%	28.1%	20.0%	22.2%
PPH >= 1000mls	55/1059	5.2%	5.9%	5.5%	2.5%	2.1%
HIE	1/1059	0.1%	0.0%	0.0%	0.0%	0.0%
Blood transfusion	10/1059	0.9%	0.8%	1.0%	0.3%	0.6%

The 1 case of HIE in Group 4a was Grade 2.
Comment: *increase in oxytocin over the years.*

Age Range	Number	%
<20	0	0.0%
20 - 24	23	2.2%
25 - 29	96	9.1%
30 - 34	304	28.7%
35 - 39	448	42.3%
>=40	188	17.7%
Unrecorded	0	0.0%
Total	**1059**	

Body Mass Index	Number	%
Underweight: <18.5	12	1.1%
Healthy: 18.5 - 24.9	439	41.5%
Overweight: 25 - 29.9	324	30.6%
Obese class 1: 30 - 34.9	156	14.7%
Obese class 2: 35 - 39.9	55	5.2%
Obese class 3: >= 40	33	3.1%
Unrecorded	40	3.8%
Total	**1059**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	0	0.0%
2,000 - 2,499 g	17	1.6%
2,500 - 2,999 g	89	8.4%
3,000 - 3,499 g	343	32.4%
3,500 - 3,999 g	408	38.5%
4,000 - 4,499 g	177	16.7%
4,500 - 4,999 g	25	2.4%
>= 5,000 g	0	0.0%
Total	**1059**	

Labour Duration	Number	%
0 - 2 hrs	289	27.3%
2 - 4 hrs	259	24.4%
4 - 6 hrs	226	21.3%
6 - 8 hrs	129	12.2%
8 - 10 hrs	77	7.3%
10 - 12 hrs	36	3.4%
>= 12 hrs	21	2.0%
Unrecorded	22	2.1%
Total	**1059**	

Group 4b

Pre labour caesarean section in single cephalic multiparous pregnancies at greater than or equal to 37 weeks without a previous caesarean section 94/2232 (4.2%). (Group 3 and 4 as the denominator)

Maternal request	35/2232	1.6%
Fetal reason	28/2232	1.2%
Maternal medical reason/pains	27/2232	1.2%
PET/Hypertension	2/2232	0.1%
SROM	2/2232	0.1%
Postdates	0/2232	0.0%
Previous caesarean section	0/2232	0.0%
Total	**94/2232**	**4.2%**

Comment: *more detailed information on pre-labour indications is needed.*

Group 4b Events and Outcomes

Group 4b	2025		2024	2023	2022	2021
Spinal	87/94	92.6%	95.8%	98.0%	97.2%	-
GA	3/94	3.2%	0.0%	2.0%	1.9%	-
Apgars <7 at 5 mins	3/94	3.2%	0.0%	1.0%	1.9%	-
Cord pH < 7.0	1/94	1.1%	0.0%	0.0%	0.0%	-
Admitted to Neonatal Unit	16/94	17.0%	16.7%	17.3%	17.8%	-
Babies >=4.0kg	19/94	20.2%	22.9%	21.4%	17.8%	-
Aged >=35	66/94	70.2%	72.9%	66.3%	69.2%	-
BMI >=30	32/94	34.0%	25.0%	28.6%	22.4%	-
PPH >= 1000mls	12/94	12.8%	5.2%	8.2%	12.1%	-
HIE	1/94	1.1%	0.0%	0.0%	0.0%	-
Blood transfusion	1/94	1.1%	0.0%	1.0%	0.9%	-

Age Range	Number	%
<20	0	0.0%
20 - 24	1	1.1%
25 - 29	3	3.2%
30 - 34	24	25.5%
35 - 39	49	52.1%
>=40	17	18.1%
Unrecorded	0	0.0%
Total	**94**	

Body Mass Index	Number	%
Underweight: <18.5	0	0.0%
Healthy: 18.5 - 24.9	41	43.6%
Overweight: 25 - 29.9	28	29.8%
Obese class 1: 30 - 34.9	18	19.1%
Obese class 2: 35 - 39.9	4	4.3%
Obese class 3: >= 40	2	2.1%
Unrecorded	1	1.1%
Total	**94**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	0	0.0%
2,000 - 2,499 g	0	0.0%
2,500 - 2,999 g	10	10.6%
3,000 - 3,499 g	37	39.4%
3,500 - 3,999 g	28	29.8%
4,000 - 4,499 g	16	17.0%
4,500 - 4,999 g	2	2.1%
>= 5,000 g	1	1.1%
Total	**94**	

Labour Duration	Number	%
0 - 2 hrs	2	2.1%
2 - 4 hrs	1	1.1%
4 - 6 hrs	0	0.0%
6 - 8 hrs	0	0.0%
8 - 10 hrs	0	0.0%
10 - 12 hrs	0	0.0%
>= 12 hrs	0	0.0%
Unrecorded	91	96.8%
Total	**94**	

Group 5

Single cephalic multiparous pregnancies (with at least one previous caesarean section) at greater than or equal to 37 weeks' gestation (n=1027)

Spontaneous labour	Induced labour	Pre labour C/S
130/1027 (12.6%)	48/1027 (4.7%)	849/1027 (82.7%)

Caesarean Section contribution according to pathway to delivery in single cephalic multiparous pregnancies with at least one previous section at greater than or equal to 37 weeks' gestation: 887/1027 (86.4%)

Spontaneous labour	23/1027	2.2%
Induced labour	15/1027	1.5%
Pre labour C/S	849/1027	82.7%

Group 5 Events and Outcomes

Group 5 Overall	2025		2024	2023	2022	2021
ARM	89/1027	8.7%	10.2%	9.5%	10.5%	15.6%
Prostaglandin/Propess	2/1027	0.2%	0.0%	0.1%	0.0%	0.0%
Oxytocin	16/1027	1.6%	2.3%	2.2%	2.6%	3.4%
Epidural	130/1027	12.7%	13.2%	13.1%	14.1%	16.5%
Electronic monitoring	341/1027	33.2%	35.1%	33.4%	36.4%	46.0%
Fetal blood sample	1/1027	0.1%	0.1%	0.2%	0.1%	0.3%
Vaginal operative delivery	32/1027	3.1%	3.4%	4.0%	4.3%	5.3%
Apgars <7 at 5 mins	6/1027	0.6%	0.7%	0.4%	0.2%	1.1%
Cord pH < 7.0	0/1027	0.0%	0.2%	0.2%	-	0.0%
Overall caesarean section	887/1027	86.4%	86.8%	85.6%	82.4%	80.9%
Caesarean section at VE=10	2/1027	0.2%	0.3%	0.2%	0.2%	0.4%
Admitted to Neonatal Unit	103/1027	10.0%	9.2%	8.1%	8.8%	11.3%
Episiotomy	51/1027	5.0%	5.4%	5.5%	6.7%	9.0%
OASIS	1/1027	0.1%	0.4%	0.3%	0.5%	0.3%
Length of labour >= 12 hrs	853/1027	83.1%	0.4%	0.1%	0.2%	0.2%
Babies >=4.0kg	174/1027	16.9%	17.8%	14.4%	16.9%	19.5%
Aged >=35	666/1027	64.8%	65.1%	66.3%	66.6%	67.5%
BMI >=30	401/1027	39.0%	35.8%	31.0%	26.7%	21.2%
PPH >= 1000mls	57/1027	5.6%	4.1%	3.6%	2.7%	2.2%
HIE	0/1027	0.0%	0.0%	0.0%	0.0%	0.0%
Blood transfusion	8/1027	0.8%	1.1%	0.5%	0.9%	4.2%

Age Range	Number	%
<20	0	0.0%
20 - 24	12	1.2%
25 - 29	71	6.9%
30 - 34	278	27.1%
35 - 39	473	46.0%
>=40	193	18.8%
Unrecorded	0	0.0%
Total	**1027**	

Body Mass Index	Number	%
Underweight: <18.5	6	0.6%
Healthy: 18.5 - 24.9	388	37.8%
Overweight: 25 - 29.9	327	31.8%
Obese class 1: 30 - 34.9	168	16.4%
Obese class 2: 35 - 39.9	68	6.6%
Obese class 3: >= 40	20	1.9%
Unrecorded	50	4.9%
Total	**1027**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	1	0.1%
2,000 - 2,499 g	12	1.2%
2,500 - 2,999 g	91	8.9%
3,000 - 3,499 g	377	36.7%
3,500 - 3,999 g	372	36.2%
4,000 - 4,499 g	153	14.9%
4,500 - 4,999 g	17	1.6%
>= 5,000 g	4	0.4%
Total	**1027**	

Labour Duration	Number	%
0 - 2 hrs	59	5.7%
2 - 4 hrs	52	5.1%
4 - 6 hrs	31	3.0%
6 - 8 hrs	17	1.7%
8 - 10 hrs	11	1.1%
10 - 12 hrs	2	0.2%
>= 12 hrs	1	0.1%
Unrecorded	854	83.1%
Total	**1027**	

Group 5a

Caesarean section rate of single cephalic pregnancies with only one previous caesarean section, at greater than or equal to 37 weeks gestation in spontaneous labour 21/122 (17.2%)*

Fetal reason (no oxytocin)	11/122	9.0%
IUA - Inability to treat fetal intolerance	0/122	0.0%
IUA - Inability to treat over contracting	0/122	0.0%
IUA - Poor response	1/122	0.8%
IUA - No oxytocin given	7/122	5.8%
EUA - Persistent malposition	1/122	0.8%
EUA - Cephalopelvic disproportion	1/122	0.8%

** Does not include 8 pregnancies that had more than one previous caesarean section.*

Group 5a Spontaneous Labour Events and Outcomes

Group 5a	2025		2024	2023	2022	2021
ARM	52/130	40.0%	47.3%	39.9%	39.0%	49.7%
Prostaglandin/Propess	0/130	0.0%	0.0%	0.0%	-	0.5%
Oxytocin	3/130	2.3%	5.3%	2.9%	4.8%	2.7%
Epidural	80/130	61.5%	62.6%	58.7%	55.1%	56.2%
Electronic monitoring	115/130	88.5%	91.6%	89.1%	82.4%	91.9%
Fetal blood sample	1/130	0.8%	0.0%	1.4%	0.5%	0.5%
Vaginal operative delivery	25/130	19.2%	22.1%	23.9%	19.8%	22.7%
Apgars <7 at 5 mins	1/130	0.8%	0.0%	0.0%	0.0%	0.5%
Cord pH < 7.0	0/130	0.0%	0.8%	0.0%	-	0.0%
Overall caesarean section	23/130	17.7%	16.8%	18.8%	18.2%	18.9%
Caesarean section at VE=10	2/130	1.5%	2.3%	1.4%	1.1%	2.2%
Admitted to Neonatal Unit	14/130	10.8%	6.1%	5.8%	10.7%	9.7%
Episiotomy	41/130	31.5%	32.1%	34.1%	33.7%	38.9%
OASIS	0/130	0.0%	3.1%	0.7%	-	1.6%
Length of labour >= 12 hrs	4/130	3.1%	2.3%	0.7%	0.5%	0.5%
Babies >= 4.0kg	19/130	14.6%	22.9%	14.5%	15.0%	18.9%
Aged >= 35	70/130	53.8%	53.4%	55.8%	61.0%	60.5%
BMI >= 30	30/130	23.1%	26.7%	19.6%	14.4%	16.8%
PPH >= 1000mls	9/130	6.9%	6.9%	4.3%	3.7%	3.8%
HIE	0/130	0.0%	0.0%	0.0%	0.0%	0.0%
Blood transfusion	1/130	0.8%	3.8%	0.7%	1.6%	2.7%

Age Range	Number	%
< 20	0	0.0%
20 - 24	4	3.1%
25 - 29	11	8.5%
30 - 34	45	34.6%
35 - 39	61	46.9%
>= 40	9	6.9%
Unrecorded	0	0.0%
Total	**130**	

Body Mass Index	Number	%
Underweight: <18.5	1	0.8%
Healthy: 18.5 - 24.9	64	49.2%
Overweight: 25 - 29.9	44	33.9%
Obese class 1: 30 - 34.9	14	10.8%
Obese class 2: 35 - 39.9	2	1.5%
Obese class 3: >= 40	0	0.0%
Unrecorded	5	3.8%
Total	**130**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	0	0.0%
2,000 - 2,499 g	2	1.5%
2,500 - 2,999 g	15	11.6%
3,000 - 3,499 g	52	40.0%
3,500 - 3,999 g	42	32.3%
4,000 - 4,499 g	19	14.6%
4,500 - 4,999 g	0	0.0%
>= 5,000 g	0	0.0%
Total	**130**	

Labour Duration	Number	%
0 - 2 hrs	49	37.7%
2 - 4 hrs	39	30.0%
4 - 6 hrs	20	15.4%
6 - 8 hrs	10	7.7%
8 - 10 hrs	6	4.6%
10 - 12 hrs	1	0.8%
>= 12 hrs	0	0.0%
Unrecorded	5	3.8%
Total	**130**	

Group 5b

Single cephalic multiparous pregnancies with only one previous caesarean section at greater than or equal to 37 weeks gestation. Indications for induction of labour 48/1027 (4.7%)* (Group 5 as denominator)

Fetal	17/1027	1.6%
Maternal medical reason/pains	11/1027	1.1%
Postdates (>40 and less than 42 weeks)	10/1027	1.0%
SROM not in labour	8/1027	0.8%
PET/Hypertension	1/1027	0.1%
Maternal request	1/1027	0.1%
Postterm (>= 42 weeks)	0/1027	0.0%
Total	**48/1027**	**4.7%**

** All Group 5b caesarean section deliveries had only 1 previous caesarean section*

Indications for Induction by Gestational Age for single cephalic multiparous pregnancies with a previous caesarean section: 50/1091 (4.6%)

	Fetal	*% of Group*	SROM not in labour	*% of Group*	Postdates (>40 and less than 42 weeks)	*% of Group*	Maternal medical reason/ pains	*% of Group*	PET/ Hypertension	*% of Group*	Maternal Request	*% of Group*	Postterm (>= 42 weeks)	*% of Group*	Total	*% of Group*
Total	**17**	***1.6%***	**8**	***0.7%***	**10**	***0.9%***	**13**	***1.2%***	**1**	***0.1%***	**1**	***0.1%***	**0**	***0.0%***	**50/1091**	***4.6%***
22	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/2	0.0%
23	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/0	0.0%
24	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/0	0.0%
25	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/0	0.0%
26	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1	0.0%
27	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/1	0.0%
28	0	0.0%	0	0.0%	0	0.0%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	1/3	33.3%
29	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/0	0.0%
30	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/3	0.0%
31	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/3	0.0%
32	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/4	0.0%
33	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/5	0.0%
34	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/5	0.0%
35	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/13	0.0%
36	0	0.0%	0	0.0%	0	0.0%	1	4.2%	0	0.0%	0	0.0%	0	0.0%	1/24	4.2%
37	3	3.2%	1	1.1%	0	0.0%	2	2.1%	0	0.0%	0	0.0%	0	0.0%	6/95	6.3%
38	3	1.1%	2	0.8%	0	0.0%	2	0.8%	1	0.4%	0	0.0%	0	0.0%	8/266	3.0%
39	4	0.8%	3	0.6%	0	0.0%	5	1.0%	0	0.0%	0	0.0%	0	0.0%	12/506	2.4%
40	7	5.6%	2	1.6%	4	3.2%	2	1.6%	0	0.0%	1	0.8%	0	0.0%	16/126	12.7%
41	0	0.0%	0	0.0%	6	18.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6/32	18.8%
42	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0/2	0.0%

Group 5b

Caesarean section rates according to indication for induction in single cephalic multiparous pregnancies with a previous caesarean section at greater than or equal to 37 weeks' gestation 15/48 (31.3%).

	Fetal reason (no oxytocin)		IUA - Inability to treat fetal intolerance		IUA - Inability to treat over contracting		IUA - Poor response		IUA - No oxytocin given		EUA - Cephalopelvic disproportion		EUA - Persistent malposition	
Fetal 5/17 (29.4%)	4	23.5%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	0	0.0%
Maternal medical reason/pains 2/11 (18.2%)	2	18.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Postdates (>40 and less than 42 weeks) 2/10 (20.0%)	1	10.0%	0	0.0%	0	0.0%	0	0.0%	1	10.0%	0	0.0%	0	0.0%
SROM not in labour 4/8 (50.5%)	0	0.0%	2	25.0%	0	0.0%	2	25.0%	0	0.0%	0	0.0%	0	0.0%
PET/Hypertension 1/1 (100.0%)	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%
Maternal request 1/1 (100.0%)	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Postterm (>= 42 weeks) 0/48 (0.0%)	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total 15/48 (31.3%)	**8**	**16.7%**	**2**	**4.2%**	**0**	**0.0%**	**2**	**4.2%**	**3**	**6.2%**	**0**	**0.0%**	**0**	**0.0%**

Group 5c

Pre labour caesarean sections in single cephalic multiparous pregnancies (with at least one previous section at greater than or equal to 37 weeks gestation), 849/1027 (82.7%).

76.0% (645/849) of the pre labour caesarean section group had only one previous caesarean section.

24.0% (204/849) of the pre labour caesarean sections had two or more caesarean sections prior to the index pregnancy.

80.3% (518/645) of the pre labour caesarean section group with only one previous caesarean section had a repeat procedure with no specific medical or obstetric reason recorded.

19.7% (127/645) of the pre labour caesarean section group with only one previous caesarean section had a repeat procedure for a specific medical or obstetric reason recorded.

The overall caesarean section rate in all single cephalic multiparous pregnancies with only one previous caesarean section was 83.6% (681/815), [(21 + 15 + 645) / (122 + 48 + 645)]

Group 5c Events and Outcomes

Group 5c	2025		2024	2023	2022	2021
Spinal	822/849	96.8%	10.7%	8.0%	11.0%	-
GA	15/849	1.8%	3.8%	0.7%	2.6%	-
Apgars <7 at 5 mins	4/849	0.5%	0.0%	0.0%	0.6%	-
Cord pH < 7.0	0/849	0.0%	0.8%	0.0%	0.6%	-
Admitted to Neonatal Unit	86/849	10.1%	6.1%	5.8%	7.7%	-
Babies >=4.0kg	143/849	16.8%	22.9%	14.5%	17.4%	-
Aged >=35	576/849	67.8%	53.4%	55.8%	54.2%	-
BMI >=30	354/849	41.7%	26.7%	19.6%	20.0%	-
PPH >= 1000mls	45/849	5.3%	6.9%	4.3%	8.4%	-
HIE	0/849	0.0%	0.0%	0.0%	0.0%	-
Blood transfusion	7/849	0.8%	3.8%	0.7%	3.2%	-

Age Range	Number	%
<20	0	0.0%
20 - 24	7	0.8%
25 - 29	50	5.9%
30 - 34	216	25.4%
35 - 39	396	46.7%
>=40	180	21.2%
Unrecorded	0	0.0%
Total	**849**	

Body Mass Index	Number	%
Underweight: <18.5	5	0.6%
Healthy: 18.5 - 24.9	309	36.4%
Overweight: 25 - 29.9	261	30.7%
Obese class 1: 30 - 34.9	148	17.4%
Obese class 2: 35 - 39.9	62	7.3%
Obese class 3: >= 40	20	2.4%
Unrecorded	44	5.2%
Total	**849**	

Birthweight Range	Number	%
500 - 999 g	0	0.0%
1000 - 1499 g	0	0.0%
1,500 - 1,999 g	1	0.1%
2,000 - 2,499 g	10	1.2%
2,500 - 2,999 g	70	8.2%
3,000 - 3,499 g	309	36.4%
3,500 - 3,999 g	316	37.2%
4,000 - 4,499 g	123	14.5%
4,500 - 4,999 g	16	1.9%
>= 5,000 g	4	0.5%
Total	**849**	

Labour Duration	Number	%
0 - 2 hrs	2	0.2%
2 - 4 hrs	2	0.2%
4 - 6 hrs	0	0.0%
6 - 8 hrs	1	0.1%
8 - 10 hrs	0	0.0%
10 - 12 hrs	0	0.0%
>= 12 hrs	1	0.1%
Unrecorded	843	99.3%
Total	**849**	

Pre labour caesarean sections in single cephalic multiparous pregnancies with only one previous caesarean section at greater than or equal to 37 weeks gestation (n=645).

Previous caesarean section	446/645	69.2%
Maternal Request	72/645	11.2%
Fetal reason	64/645	9.9%
SROM	26/645	4.0%
Maternal medical reason/pains	19/645	2.9%
PET/Hypertension	10/645	1.6%
Postdates	8/645	1.2%

Repeat pre labour caesarean section in single cephalic multiparous pregnancies, with only one previous caesarean section, for a specific medical, obstetrical, or maternal reason by gestation in completed weeks (n=199)

GA (weeks)	Total
37	35
38	51
39	89
40	19
41	5
42	0
Totals	**199**

Repeat pre labour caesarean section in single cephalic multiparous pregnancies, with only one previous caesarean section and no specific medical, obstetrical, or maternal reason, other than one previous caesarean section by gestation in completed weeks (n=446)

GA (weeks)	Total
37	18
38	106
39	258
40	53
41	10
42	1
Totals	**446**

Comment: *Deliveries at 39 weeks or less should have another indication recorded apart from one previous C-Section.*

Group 6
All nulliparous pregnancies with a breech presentation (n=175)

	Number in group	Number of C/S	Contribution to total population	% C/S
Spontaneous labour	12	7	12/175 (6.9%)	7/175 (4.0%)
Induced labour	6	2	6/175 (3.4%)	2/175 (1.1%)
Pre labour c-section	157	157	157/175 (89.7%)	157/175 (89.7%)
Totals	**175**	**166**		**166/175 (94.8%)**

Group 7
All multiparous pregnancies with a breech presentation (including pregnancies with previous caesarean sections) (n=117)

	Number in group	Number of C/S	Contribution to total population	% C/S
Spontaneous labour	13	8	13/117 (11.1%)	8/117 (6.8%)
Induced labour	2	2	2/117 (1.7%)	2/117 (1.7%)
Pre labour c-section	102	102	102/117 (87.2%)	102/117 (87.2%)
Totals	**117**	**112**		**112/117 (95.7%)**

Group 8
All multiple pregnancies including pregnancies with previous caesarean sections (n=108)

	Number in group	Number of C/S	Contribution to total population	% C/S
Spontaneous labour	16	4	16/108 (14.8%)	4/108 (3.7%)
Induced labour	15	5	15/108 (13.9%)	5/108 (4.6%)
Pre labour c-section	77	77	77/108 (71.3%)	77/108 (71.3%)
Totals	**108**	**86**		**86/108 (79.6%)**

Group 9
All pregnancies with abnormal lies (including previous caesarean section) (n=37)

	Number in group	Number of C/S	Contribution to total population	% C/S
Spontaneous labour	3	3	3/37 (8.1%)	3/37 (8.1%)
Induced labour	0	0	0/37 (0.0%)	0/37 (0.0%)
Pre labour c-section	34	34	34/37 (91.9%)	34/37 (91.9%)
Totals	**37**	**37**		**37/37 (100.0%)**

Group 10
Total single cephalic pregnancies at less than or equal to 36 weeks gestation (including pregnancies with previous caesarean sections) (n=379)

	Number in group	Number of C/S	Contribution to total population	% C/S
Spontaneous labour	168	11	168/379 (44.3%)	11/379 (2.9%)
Induced labour	58	7	58/379 (15.3%)	7/379 (1.8%)
Pre labour c-section	153	153	153/379 (40.4%)	153/379 (40.4%)
Totals	**379**	**171**		**171/379 (45.1%)**

Groups 6–10 Events and Outcomes

	Group 6		Group 7		Group 8		Group 9		Group 10		Groups 6-10 Total	
Apgars <7 at 5 mins	7/175	4.0%	6/117	5.1%	12/108	11.1%	2/37	5.4%	46/379	12.1%	73/816	8.9%
Cord pH < 7.0	0/175	0.0%	0/117	0.0%	1/108	0.9%	1/37	2.7%	4/379	1.1%	6/816	0.7%

Group 10 by pathway and gestation

GA (weeks)	Spontaneous labour	Induced labour	Pre labour C-section	Total
21	0	0	0	0
22	4	1	0	5
23	3	1	0	4
24	1	1	1	3
25	4	3	2	9
26	2	0	3	5
27	1	0	6	7
28	5	3	2	10
29	3	1	4	8
30	4	0	9	13
31	6	0	6	12
32	8	1	16	25
33	10	1	12	23
34	16	4	17	37
35	43	4	28	75
36	58	38	47	143
Total	**168**	**58**	**153**	**379**

All deliveries equal to or less than 36 weeks gestational age by pathway and gestation

GA (weeks)	Spontaneous labour	Induced labour	Pre labour C-section	Total
21	1	0	0	1
22	5	1	0	6
23	5	2	0	7
24	3	2	1	6
25	6	3	3	12
26	2	1	4	7
27	1	0	9	10
28	7	3	3	13
29	4	2	13	19
30	6	0	11	17
31	8	0	12	20
32	9	1	26	36
33	12	1	19	32
34	24	4	28	56
35	46	7	48	101
36	58	40	65	163
Total	**197**	**67**	**242**	**506**

Incidence of preterm delivery <37 weeks = 506/7096 (7.1%)
Incidence of preterm delivery <=34 weeks = 242/7096 (3.4%)
Incidence of preterm delivery <34 weeks = 186/7096 (2.6%)
Incidence of preterm spontaneous labour <37 weeks = 197/7096 (2.8%)
Incidence of preterm spontaneous labour <=34 weeks = 93/7096 (1.3%)
Incidence of preterm spontaneous labour <34 weeks = 69/7096 (1.0%)

Age Range by Group

	Group 1		Group 2a		Group 3		Group 4a		Group 5 Overall		Group 5a	
<20	10	1.0%	17	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
20 - 24	64	6.7%	100	5.7%	30	2.8%	23	2.2%	12	1.2%	4	3.1%
25 - 29	177	18.4%	266	15.1%	112	10.4%	96	9.1%	71	6.9%	11	8.5%
30 -34	450	46.8%	791	44.9%	340	31.5%	304	28.7%	278	27.1%	45	34.6%
35 - 39	235	24.4%	493	28.0%	519	48.1%	448	42.3%	473	46.0%	61	46.9%
>=40	26	2.7%	95	5.4%	78	7.2%	188	17.7%	193	18.8%	9	6.9%
Total	**962**		**1762**		**1079**		**1059**		**1027**		**130**	

Body Mass Index Range by Group

	Group 1		Group 2a		Group 3		Group 4a		Group 5 Overall		Group 5a	
< 18.5	25	2.6%	19	1.1%	12	1.1%	12	1.1%	6	0.6%	1	0.8%
18.5-24.9	526	54.7%	771	43.7%	580	53.8%	439	41.5%	388	37.8%	64	49.2%
25-29.9	274	28.5%	586	33.3%	307	28.4%	324	30.6%	327	31.8%	44	33.9%
30-34.9	79	8.2%	230	13.0%	113	10.5%	156	14.7%	168	16.4%	14	10.8%
35-39.9	17	1.8%	84	4.8%	33	3.1%	55	5.2%	68	6.6%	2	1.5%
>=40	10	1.0%	30	1.7%	10	0.9%	33	3.1%	20	1.9%	0	0.0%
Unrecorded	31	3.2%	42	2.4%	24	2.2%	40	3.8%	50	4.9%	5	3.8%
Total	**962**		**1762**		**1079**		**1059**		**1027**		**130**	

Birthweight Range by Group

	Group 1		Group 2a		Group 3		Group 4a		Group 5 Overall		Group 5a	
500 - 999 g	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
1,000 - 1,499 g	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
1,500 - 1,999 g	1	0.1%	2	0.1%	0	0.0%	0	0.0%	1	0.1%	0	0.0%
2,000 - 2,499 g	5	0.5%	39	2.2%	4	0.4%	17	1.6%	12	1.2%	2	1.5%
2,500 - 2,999 g	138	14.3%	228	12.9%	86	8.0%	89	8.4%	91	8.9%	15	11.6%
3,000 - 3,499 g	404	42.0%	633	35.9%	365	33.8%	343	32.4%	377	36.7%	52	40.0%
3,500 - 3,999 g	318	33.1%	604	34.3%	440	40.8%	408	38.5%	372	36.2%	42	32.3%
4,000 - 4,499 g	88	9.2%	221	12.6%	163	15.1%	177	16.7%	153	14.9%	19	14.6%
4,500 - 4,999 g	8	0.8%	31	1.8%	21	1.9%	25	2.4%	17	1.6%	0	0.0%
>= 5,000 g	0	0.0%	4	0.2%	0	0.0%	0	0.0%	4	0.4%	0	0.0%
Total	**962**		**1762**		**1079**		**1059**		**1027**		**130**	

Labour Duration Range by Group

	Group 1		Group 2a		Group 3		Group 4a		Group 5 Overall		Group 5a	
0 - 2hrs	121	12.6%	101	5.7%	573	53.1%	289	27.3%	59	5.7%	49	37.7%
2 - 4hrs	177	18.4%	176	10.0%	304	28.2%	259	24.4%	52	5.1%	39	30.0%
4 - 6hrs	199	20.7%	265	15.1%	117	10.8%	226	21.3%	31	3.0%	20	15.4%
6 - 8hrs	235	24.4%	337	19.1%	35	3.2%	129	12.2%	17	1.7%	10	7.7%
8 - 10hrs	126	13.1%	313	17.8%	8	0.7%	77	7.3%	11	1.1%	6	4.6%
10 - 12hrs	65	6.8%	268	15.2%	4	0.4%	36	3.4%	2	0.2%	1	0.8%
>12hrs	34	3.5%	180	10.2%	6	0.6%	21	2.0%	1	0.1%	0	0.0%
Not Recorded	5	0.5%	122	6.9%	32	3.0%	22	2.1%	854	83.1%	5	3.8%
Total	**962**		**1762**		**1079**		**1059**		**1027**		**130**	

Episiotomy Rate by Group

Group 1	Group 2a	Group 3	Group 4a	Group 5 Overall	Group 5a
494/962	659/1762	93/1079	125/1059	51/1027	41/130
51.4%	37.4%	8.6%	11.8%	5.0%	31.5%

Perinatal Deaths by Robson Ten Group

Group	No. of Antepartum Still births	*Per '000 births*	No. of Intrapartum Stillbirths	*Per '000 births*	No. of Early Neonatal Deaths	*Per '000 births*	Total No. of Perinatal Deaths*	*Per '000 births*	*Contr of Each Group %*
Groups 1 & 2	4/3021	1.3	0/3021	0.0	2/3021	0.7	**6/3021**	2.0	**0.8**
Groups 3 & 4	1/2236	0.4	0/2236	0.0	1/2236	0.4	**2/2236**	0.9	**0.3**
Group 5	1/1027	1.0	0/1027	0.0	0/1027	0.0	**1/1027**	1.0	**0.1**
Group 8	3/224	13.4	1/224	4.5	2/224	8.9	**6/224**	26.8	**0.8**
Groups 6, 7, 9 & 10	14/710	19.7	6/710	8.5	4/710	5.6	**24/710**	33.8	**3.3**
Total	**23/7218**	**3.2**	**7/7218**	**1.0**	**9/7218**	**1.2**	**39/7218**	**5.4**	**5.4**

**excludes Congenital Anomaly (n=15)*

HIE Cases by Robson Ten Group

Group	No. of HIE Cases	Per '000 births	No. of Infants Cooled	Per '000 births
Groups 1 & 2	3/3021	1.0	3/3021	1.0
Groups 3 & 4	2/2236	0.9	2/2236	0.9
Group 5	0/1027	0.0	0/1027	0.0
Group 8	0/224	0.0	0/224	0.0
Groups 6, 7, 9 & 10	0/710	0.0	0/710	0.0
Total	**5/7218**	**0.7**	**5/7218**	**0.7**

The 3 cases of HIE in groups 1 and 2 were Grade 2 (n=1) and Grade 3 (n=2), The 2 cases of HIE in groups 3 and 4 were Grade 2 (n=1) and Grade 3 (n=1). For more information please refer to the Hypoxic Ischaemic Encephalopathy, Neonatal Encephalopathy & Seizures chapter.

Ten Groups by Estimated Blood Loss >= 1000mls

	EBL >= 1000mls / Deliveries (500 / 7096)	Size of Group % (100%)	EBL >= 1000mls rate in Group %	Contribution of each Group % (7.0%)
1. Nulliparous, single cephalic, >=37 weeks, in spontaneous labour	65 / 962	13.6%	6.8%	0.9%
2. Nulliparous, single cephalic, >=37 weeks, induced and CS before labour	215 / 2059	29.0%	10.4%	3.0%
2a. Induced labour	*188 / 1762*	*24.8%*	*10.7%*	*2.6%*
2b.CS before labour	*27 / 297*	*4.2%*	*9.1%*	*0.4%*
3. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, in spontaneous labour	29 / 1079	15.2%	2.7%	0.4%
4. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, induced and CS before labour	67 / 1153	16.2%	5.8%	0.9%
4a. Induced labour	*55 / 1059*	*14.9%*	*5.2%*	*0.8%*
4b.CS before labour	*12 / 94*	*1.3%*	*12.8%*	*0.2%*
5. Previous CS, single cephalic, >= 37 weeks	57 / 1027	14.5%	5.6%	0.8%
5a. Spontaneous labour	*9 / 130*	*1.8%*	*6.9%*	*0.1%*
5b. Induced labour	*3 / 48*	*0.7%*	*6.3%*	*0.0%*
5c.CS before labour	*45 / 849*	*12.0%*	*5.3%*	*0.6%*
6. All nulliparous breeches	9 / 175	2.5%	5.1%	0.1%
7. All multiparous breeches (including prev. CS)	10 / 117	1.7%	8.5%	0.1%
8. All multiple pregnancies (including prev. CS)	21 / 108	1.5%	19.4%	0.3%
9. All abnormal lies (including prev. CS)	4 / 37	0.5%	10.8%	0.1%
10. All single cephalic,<=36 weeks (including prev. CS)	23 / 379	5.3%	6.1%	0.3%
Total	**500 / 7096**		**7.0%**	**7.0%**

Ten Groups by Estimated Blood Loss >= 1500mls

	EBL >= 1500mls / Deliveries (173 / 7096)	Size of Group % (100%)	EBL >= 1500mls rate in Group %	Contribution of each Group % (2.4%)
1. Nulliparous, single cephalic, >=37 weeks, in spontaneous labour	22 / 962	13.6%	2.3%	0.3%
2. Nulliparous, single cephalic, >=37 weeks, induced and CS before labour	70 / 2059	29.0%	3.4%	1.0%
2a. Induced labour	*64 / 1762*	*24.8%*	*3.6%*	*0.9%*
2b.CS before labour	*6 / 297*	*4.2%*	*2.0%*	*0.1%*
3. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, in spontaneous labour	13 / 1079	15.2%	1.2%	0.2%
4. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, induced and CS before labour	21 / 1153	16.2%	1.8%	0.3%
4a. Induced labour	*18 / 1059*	*14.9%*	*1.7%*	*0.3%*
4b.CS before labour	*3 / 94*	*1.3%*	*3.2%*	*0.0%*
5. Previous CS, single cephalic, >= 37 weeks	18 / 1027	14.5%	1.8%	0.3%
5a. Spontaneous labour	*2 / 130*	*1.8%*	*1.5%*	*0.0%*
5b. Induced labour	*0 / 48*	*0.7%*	*0.0%*	*0.0%*
5c.CS before labour	*16 / 849*	*12.0%*	*1.9%*	*0.2%*
6. All nulliparous breeches	4 / 175	2.5%	2.3%	0.1%
7. All multiparous breeches (including prev. CS)	4 / 117	1.7%	3.4%	0.1%
8. All multiple pregnancies (including prev. CS)	10 / 108	1.5%	9.3%	0.1%
9. All abnormal lies (including prev. CS)	2 / 37	0.5%	5.4%	0.0%
10. All single cephalic,<=36 weeks (including prev. CS)	9 / 379	5.3%	2.4%	0.1%
Total	**173 / 7096**		**2.4%**	**2.4%**

Ten Groups by Transfusion Rate

	No. Transfused / Deliveries (135 / 7096)	Size of Group % (100%)	Transfusion rate in Group %	Contribution of each Group % (1.9%)
1. Nulliparous, single cephalic, >=37 weeks, in spontaneous labour	20 / 962	13.6%	2.1%	0.3%
2. Nulliparous, single cephalic, >=37 weeks, induced and CS before labour	64 / 2059	29.0%	3.1%	0.9%
2a. Induced labour	*62 / 1762*	*24.8%*	*3.5%*	*0.9%*
2b.CS before labour	*2 / 297*	*4.2%*	*0.7%*	*0.0%*
3. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, in spontaneous labour	5 / 1079	15.2%	0.5%	0.1%
4. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, induced and CS before labour	11 / 1153	16.2%	1.0%	0.2%
4a. Induced labour	*10 / 1059*	*14.9%*	*0.9%*	*0.1%*
4b.CS before labour	*1 / 94*	*1.3%*	*1.1%*	*0.0%*
5. Previous CS, single cephalic, >= 37 weeks	8 / 1027	14.5%	0.8%	0.1%
5a. Spontaneous labour	*1 / 130*	*1.8%*	*0.8%*	*0.0%*
5b. Induced labour	*0 / 48*	*0.7%*	*0.0%*	*0.0%*
5c.CS before labour	*7 / 849*	*12.0%*	*0.8%*	*0.1%*
6. All nulliparous breeches	5 / 175	2.5%	2.9%	0.1%
7. All multiparous breeches (including prev. CS)	4 / 117	1.7%	3.4%	0.1%
8. All multiple pregnancies (including prev. CS)	4 / 108	1.5%	3.7%	0.1%
9. All abnormal lies (including prev. CS)	1 / 37	0.5%	2.7%	0.0%
10. All single cephalic,<=36 weeks (including prev. CS)	13 / 379	5.3%	3.4%	0.2%
Total	**135 / 7096**		**1.9%**	**1.9%**

Transfusion Rates by Robson Ten Group

Group	1	2a	2b	3	4a	4b	5a	5b	5c	6	7	8	9	10	Total
Total in Group	**962**	**1762**	**297**	**1079**	**1059**	**94**	**130**	**48**	**849**	**175**	**117**	**108**	**37**	**379**	**7096**
Number Transfused	20	62	2	5	10	1	1	0	7	5	4	4	1	13	135
% Transfused	**2.1%**	**3.5%**	**0.7%**	**0.5%**	**0.9%**	**1.1%**	**0.8%**	**0.0%**	**0.8%**	**2.9%**	**3.4%**	**3.7%**	**2.7%**	**3.4%**	**1.9%**
Units crossmatched	**42**	**150**	**3**	**15**	**38**	**2**	**2**	**0**	**26**	**17**	**12**	**26**	**4**	**44**	**381**
Units Transfused	30	102	2	6	20	2	2	0	10	14	10	17	1	24	240
Patients transfused 4 or more units	0	2	0	0	1	0	0	0	0	1	0	1	0	0	5
% Patients transfused 4 or more units (group)	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.9%	0.0%	0.0%	0.1%
% Patients transfused who received 4 or more units	0.0%	3.2%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	25.0%	0.0%	0.0%	3.7%

Transfusion Rates by Robson Ten Group where EBL >= 1000mls

Group	1	2a	2b	3	4a	4b	5a	5b	5c	6	7	8	9	10	Total
EBL >= 1000 mls	**65**	**188**	**27**	**29**	**55**	**12**	**9**	**3**	**45**	**9**	**10**	**21**	**4**	**23**	**500**
Number Transfused	12	51	1	4	8	1	1	0	6	3	1	3	1	7	99
% Transfused	**18.5%**	**27.1%**	**3.7%**	**13.8%**	**14.5%**	**8.3%**	**11.1%**	**0.0%**	**13.3%**	**33.3%**	**10.0%**	**14.3%**	**25.0%**	**30.4%**	**19.8%**
Units crossmatched	**29**	**133**	**2**	**14**	**31**	**2**	**2**	**0**	**24**	**13**	**4**	**24**	**4**	**30**	**312**
Units Transfused	20	90	1	5	17	2	2	0	9	11	3	16	1	14	191
Patients transfused 4 or more units	0	2	0	0	1	0	0	0	0	1	0	1	0	0	5
% Patients transfused 4 or more units (group)	0.0%	1.1%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	4.8%	0.0%	0.0%	1.0%
% Patients transfused who received 4 or more units	0.0%	3.9%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	33.3%	0.0%	0.0%	5.1%

Transfusion Rates by Robson Ten Group where EBL >= 1500mls

Group	1	2a	2b	3	4a	4b	5a	5b	5c	6	7	8	9	10	Total
EBL >= 1500 mls	**22**	**64**	**6**	**13**	**18**	**3**	**2**	**0**	**16**	**4**	**4**	**10**	**2**	**9**	**173**
Number Transfused	11	31	1	2	4	1	1	0	4	3	1	1	1	6	67
% Transfused	**50.0%**	**48.4%**	**16.7%**	**15.4%**	**22.2%**	**33.3%**	**50.0%**	**0.0%**	**25.0%**	**75.0%**	**25.0%**	**10.0%**	**50.0%**	**66.7%**	**38.7%**
Units crossmatched	**28**	**94**	**2**	**9**	**22**	**2**	**2**	**0**	**20**	**13**	**4**	**20**	**4**	**26**	**246**
Units Transfused	19	60	1	3	10	2	2	0	7	11	3	12	1	12	143
Patients transfused 4 or more units	0	2	0	0	1	0	0	0	0	1	0	1	0	0	5
% Patients transfused 4 or more units (group)	0.0%	3.1%	0.0%	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	10.0%	0.0%	0.0%	2.9%
% Patients transfused who received 4 or more units	0.0%	6.5%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	100.0%	0.0%	0.0%	7.5%

Lactation Support

In 2025, the Lactation Team continued to deliver specialist, evidence based breastfeeding support across hospital and community settings. Activity across postnatal and neonatal areas increased markedly. Consultations on the postnatal ward increased by 34.5% to 4,000. Support within the NICU also increased by 4.7%, with 2,432 families receiving dedicated lactation care. These increases highlight both growing demand and the essential role of specialist lactation expertise in complex clinical environments.

Key service outcomes for 2025 included 632 families attending the clinic, 700 families participating in weekly Antenatal Colostrum Harvesting classes, and 1,522 parents attending antenatal breastfeeding education sessions which is an impressive 52% increase from 2024. Breastfeeding initiation at birth reached 75.8%, while 75% of families were combined feeding at discharge. Exclusive breastfeeding at discharge was 49.6%, reflecting informed parental choice for mixed feeding, alongside clinical factors such as prematurity, short postnatal stays, and temporary supplementation.

A major development in 2025 was the full integration of the Postnatal Traffic Light Referral Pathway for Breastfeeding Support, developed by the Lactation Team. Introduced in 2024, the pathway became fully embedded in practice during 2025, with ward staff gaining confidence in its use. This structured system improved prioritisation, enhanced consistency, and ensured timely reviews. Most referrals related to maternal reassurance and NICU support, reflecting ongoing demand for specialist guidance.

Antenatal education remained a cornerstone of early breastfeeding support. More than 700 families attended Colostrum Harvesting classes, supported by an updated patient information and a practical demonstration video. Parents reported increased confidence, reduced formula supplementation and improved infant outcomes. Twice monthly antenatal breastfeeding classes, offered both in person and virtually, had an increase of 52% in attendances last year (n=1,522).

Rachel Creevy breastfeeding her newborn daughter Georgia with Aoife Kenny, Lactation CMM2.

The team also contributed to research through participation in the MilkQPrem study, and continued to strengthen clinical knowledge through weekly teaching sessions across postnatal wards, theatre, gynaecology ward, and NICU. Their role in the National Infant Feeding Education Programme (NIFEP) further supported consistent, high quality breastfeeding education for public health nurses, community staff, and hospital colleagues.

Neonatal Lactation

Breastfeeding support is delivered by the Lactation Team and Clinical Nutrition and Dietetics Team. PRIME A (2017) and PRIME B (2019) studies reinforced the importance of early breast milk provision for preterm infants. In 2022, a specialised Neonatal Lactation post was established.

All NICU infants require breast milk due to its proven benefits, including reduced NEC, sepsis, and long term neurodevelopmental impairment. The neonatal lactation team works closely with mothers, NICU staff and a multi-disciplinary team to optimise early lactation and maternal support.

NICU breastfeeding rates continued to rise in 2025. Infants <33 weeks and <1.6 kg received 100% human milk, supplemented with donor milk when needed. Four mothers donated 3 - 18 litres to the Human Milk Bank. Fifty seven mothers received non hospital grade pumps through the NMH Foundation and 18 accessed hospital grade rentals via Medical Card.

Education initiatives included staff workshops, parent programmes, and twice monthly NICU breastfeeding sessions. A staff survey highlighted strong satisfaction with lactation support and guidelines.

Lactation Midwives

Table 1: Key Outcomes in 2025

Outcome	2025 Result
Postnatal reviews	4,000 (34.5% increase)
NICU reviews	2,432 (4.7% increase)
Clinic attendees	632 families
Weekly Antenatal Colostrum Harvesting class	700 families
Breastfeeding initiation at birth	75.8%
Combined breastfeeding at discharge	75.0%
Exclusive breastfeeding at discharge	49.6% (1.4% decrease from 2024)
Antenatal education attendance (in person and virtual)	1,522 (52% increase)

Robbie & Rachel Creevy with their newborn daughter Georgia.

Lactation support midwives: Aoife Kenny CMM2, Shayne Apon CNM2, Ramita Dangol CMM2 Neonatal Lactation, Harriet Kinsman CNM2.

Maternal Medicine Service

There is a weekly multidisciplinary clinic for women with medical disorders led by Prof Fionnuala McAuliffe, Prof Mary Higgins, Dr Siobhan Corcoran, and clinic midwives Ms Celine O'Brien, Dr Shauna Callaghan and Ms AnnMarie Cruse (haematology midwife). Ms Victoire Hurley, drug liaison nurse, advises on women with drug addiction.

The weekly maternal medicine MDT meeting (organised by Dr Gillian Corbett, Dr Ita Shanahan, Dr Fatema Al-Falahi, Ms Celine O'Brien and Dr Shauna Callaghan) continues to be very successful facilitating the development of multidisciplinary individualised patient plans.

There is a monthly combined obstetric – anaesthetic review of patients at the clinic with Consultant Anaesthetists Dr Roger McMorrow, Dr Nikki Higgins and their team. Pharmacy provides advice on the safety of maternal medications during pregnancy and breastfeeding with weekly attendance from Benedetta Soldati. Clinical Dietetics with Dr Sarah Louise Killeen and Laura Harrington who review women with inflammatory bowel disease and those requiring dietetics (included patients with severe hyperemesis, bariatric surgery and high BMI).

Specialist Services

Rheumatology: We hold a monthly Reproductive Rheumatology Health Service – the ROSE clinic, in conjunction with Ms Louise Moore ANP rheumatology.

Hepatology: Prof Omar El-Sherif attends on a monthly basis for a joint hepatology clinic.

Clinical Genetics: Dr Samantha Doyle and her team provide a service of our patients who may be have a genetic disorder for counselling and genetic testing as appropriate, and where requested.

Epilepsy: There is a fortnightly clinic to review pregnant women with epilepsy run by Ms Sinead Murphy, specialist epilepsy midwife funded by Brainwave. This post became vacant during the year when Sinead took up a new post at SVUH and funding for a replacement is sought from HSE.

Cardiology: Dr Carla Canniffe was jointly appointed to NMH and St Vincent's University Hospital to provide a service for women with cardiology problems, before, during and after pregnancy in 2021. She reviews patients at a monthly joint obstetric clinic at NMH and weekly at SVUH in a dedicated woman's cardiology clinic. We have established a National Maternal Cardiac database with NPEC, and are grateful to Dr Aoibhinn Smyth for assisting with database set up and data entry.

Renal Medicine: Dr Colin Lenihan attends our monthly renal clinic reviewing patients with renal disease and also with complex essential hypertension.

Obstetric Haematology Service: comprises Consultant Haematologists Dr Karen Murphy, Dr Maryse Power and Dr Joan Fitzgerald, a haematology registrar and the haematology midwife Ms AnnMarie Cruse. There is a weekly haematology clinic shared with Maternal Medicine colleagues which provides for women with thrombotic and bleeding problems. This blended team ensures provision of high quality care for this complex group of patients during pregnancy.

In addition to the numbers recorded below, AnnMarie Cruse had approximately 4,500 visits in our service comprising a weekly iron deficiency anemia clinic, reviewing women with family history of venous thromboembolism, women with thrombocytopenia, family history of haemoglobinopathy, and VTE risk assessment. She also collaborates with other services including the National Coagulation Centre.

Maternal Medicine Midwife Clinic: In 2025 Celine O'Brien and Shauna Callaghan provided care for 81 women through the maternal medicine midwife clinic which is a service for women in conjunction with the maternal medicine clinic to review women with stable medical conditions. This gives women access to midwifery care.

In 2025 there were 582 new patients seen in the maternal medical service. Some patients presented with more than one problem. The main diagnoses and indications for referral to the clinic in 2025 are recorded below (one diagnosis per patient).

In our pre-pregnancy service, we saw 51 women and their partners / family members, our collaboration with Merrion Fertility Clinic with pre-pregnancy counselling has strengthened and our joint fertility – maternal medicine service receives referrals from many fertility clinics throughout Ireland.

Prof Fionnuala McAuliffe
Consultant Obstetrician & Gynaecologist

Medical Reason	No.
Haematology	**199**
Previous venous thrombo-embolism	45
VTE current pregnancy (PE 2, DVT 8, CVST 3)	13
Superficial thrombophlebitis	7
Anti-phospholipid syndrome	24
Factor V Leiden mutation	9
Protein S or C deficiency	4
Pai-1 MTHFR	2
PT mutation	5
Von Willebrand's Disease	5
Factor VIII deficiency/carrier	7
Factor XI deficiency	1
Factor XII deficiency	2
Bleeding disorder of unknown aetiology	3
Immune thrombocytopenic purpura	9
Platelet dysfunction	2
Essential Thrombocytosis	10
VTE risk assessments in clinic	32
Severe anaemia	3
Spherocytosis	2
Neutropenia	4
CLL	1
Blood refusal consultation	5
Anaemias Sickle / Thalassaemia	3
Polycythemia Vera	1

Infection (excluding COVID)	**14**
HIV	6
Active pulmonary TB	1
Hepatitis B	5
Hepatitis C	2
Drug dependency (no hepatitis C)	**4**
Methadone in pregnancy	3
Cannibas in pregnancy	1
Cardiac	**47**
Aortic coarctation	1
Aortic stenosis repaired	1
Aortopathy dilated	2
Mitral regurgitation	1
Mitral valve prolapse with mild-mod MR	1
Holt oram	1
PFO not repaired	3
Tetralogy of Fallot repaired	1
Ebsteins repaired	1
TAPVD repaired	1
Long QT syndrome	3
Palpitations	15
SVT	6
Atrial fibrillation pre pregnancy	1
AVNRT ablated	1
Ventricular tachycardia	1
Pacemaker in situ	2
Takotsubo cardiomyopathy	1
Carotid artery dissection pre-pregnancy	1
POTS	3

GIT	**40**
Ulcerative colitis	15
Crohn's disease	20
Gastric Sleeve	5
LIVER	**18**
MASLD	3
Autoimmune hepatitis	4
Cirrhosis and varices	1
Focal Nodular dysplasia	1
Primary Sclerosing Cholangitis	1
Liver resection adenomas	1
Severe obstetric cholestasis	2
Prior acute fatty liver in pregnancy	1
Portal hypertension/Caroli syndrome	2
Liver transplant	2
CNS	**112**
Epilepsy	75
Multiple sclerosis	20
T6 Spinal cord injury	1
Neuromyelitis Optica	1
Idiopathic intracranial hypertension	2
Arnold Chiara Malformation	5
Guillian Barre	2
Myasthenia Gravis	1
Arachnoid cyst	1
Coiled cerebral aneurysm	1
Spinal nerve stimulator	1
Subarachnoid haemorrhage pre-pregnancy	1
Transverse myelitis	1
Vascular	**29**
Essential hypertension	21
TIA in early pregnancy	1
Cerebral venous malformation	1
CVA pre-pregnancy	6
Connective tissue disorders	**53**
Rheumatoid Arthritis	19
Juvenile rheumatoid arthritis	2
Inflammatory Arthritis	6
SLE	7
Systemic sclerosis	1
Sjögren's disease	4
Ankylosing Spondylitis	5
Psoriatic Arthritis	6
Undifferentiated & mixed Connective Tissue Disease	1
Ro+	2

Respiratory	**13**
Cystic fibrosis	3
Sleep Apnoea requiring night time treatment	1
Severe asthma	6
Sarcoidosis	1
COPD	2
Renal	**15**
Renal transplant	1
Lupus nephritis	1
Adult polycystic kidney disease	2
IgA nephropathy	3
New severe proteinuria in pregnancy	2
Renal Calculi	4
CKD stage 2	1
CKD stage 3	1
Oncology	**21**
Breast cancer pre-pregnancy	3
Colon cancer pre pregnancy	1
Hodgkins pre-pregnancy	5
Non Hodgkins Lymphoma pre-pregnancy	1
Astrocytoma pre-pregnancy	1
Wilms tumour pre-pregnancy	1
Phaechromocytoma pre-pregnancy	1
Thyroid cancer pre-pregnancy	2
Gastric Hodgkins pre-pregnancy	1
Colon cancer pre-pregnancy	1
Breast cancer in pregnancy	2
Rectal cancer in pregnancy	2
Endocrine	**4**
Cushing's syndrome	1
Addison's syndrome	1
Pituitary macroadenoma	1
Hyperparathyroidism	1
Miscellaneous	**13**
Silver Russell syndrome	1
Alpha 1 anti trypsin deficiency	2
Alport syndrome	1
Dopa responsive dystonia	1
Pemphigoid gestationis	1
Stickler Syndrome	1
Moya Moya syndrome	1
Hydradinitis suppuritiva	2
Histamine intolerance	1
Multiple pelvic fractures	1
Melnich Needle syndrome	1
Overall Total	**582**

Maternity Outpatient Clinic

The Public antenatal clinic 'Holles Clinic' had a busy year with 20,492 attendances in its clinics over the course of the year accounting for 60.7% of the antenatal women in the NMH. Holles Clinic continues to offer a well-rounded service for women with combined care between their GP's and The National Maternity Hospital (NMH). There are obstetric and midwifery led clinics running concurrently on a daily basis which ensures women are supported in their most appropriate pathway of care. All women are offered a first trimester scan either in the Holles Clinic or in the Fetal Assessment Unit. Follow-up appointments are in the Holles Clinic with women assigned a clinic according to their appropriate pathway of care. Approximately 700 booking visits were undertaken by Midwives in the past year with a collaborative plan with our Community colleagues to increase same in the coming month with a view of further increasing our Midwifery follow up clinics in the clinic and out in the community.

There are six obstetric led public antenatal clinics weekly staffed by a consultant and NCHD, as well as daily midwifery led clinics ensuring women can move between care pathways if required. Women meet a midwife at each visit and have the opportunity to discuss all aspects of her care and plan for labour and birth. We promote parent education classes e.g. preparation for labour, elective LSCS, VBAC, teens and attendance is actively encouraged.

The Virtual History Clinic is an integral part of our service; 60% of women booking with the main obstetric led clinics are contacted in advance by a midwife to go through their booking history over the phone.

Holles Clinic also hosts a number of specialist clinics: Preterm Birth, Maternal Medicine, Diabetes and Endocrinology. These clinics are multi-disciplinary offering specialised care for those who require it. A Clinical Midwife Specialist also offers midwifery care to the women attending the Maternal Medicine Clinic where suitable.

The Daisy clinic operates weekly offering support to younger women with multidisciplinary team input focusing on their health and well-being. Strong relationships between the midwives and the younger women evolve during their attendances at these clinics which is overseen by consultant obstetrician and gynaecologist and senior midwife with input from medical social work, dieticians, perinatal mental health and physiotherapy.

Outpatient clinic attendances

	Consultant led Clinics	Midwives Clinics	Pearse St Clinics	Specialist Clinics	Fitzwilliam Clinics	Total
(New) First Visits	2,927	303	431	976	2,500	7,137
Follow Up Visits	11,394	1,918	0	2,974	4,338	20,624
Total Attendances	**14,321**	**2,221**	**431**	**3,950**	**6,838**	**27,761**

Multiple Pregnancy

Total Mothers Delivered	7096
Total Babies Born	7218

Type	No. of Cases	No. of Births*
Twins	106	211
Triplets	7	21
Quads	1	4
Totals	**114**	**236**

**Babies born >= 23 wks and/or 400g (singleton) or 200g (multiple)*

All Twin Sets	Spontaneous Labour	Induction of Labour	Caesarean Section	Total	cPNMR^
Dichorionic Diamniotic	13/76 (17.1%)	14/76 (18.4%)	49/76 (64.5%)	76/76 (100.0%)	1/152 (6.6 per '000)
% Caesarean Section	*4/13 (30.8%)*	*4/14 (28.6%)*	*49/49 (100.0%)*	*57/76 (75.0%)*	*(0, 0, 1)**
Monochorionic Diamniotic	3/29 (10.3%)	6/29 (20.7%)	20/29 (69.0%)	29/29 (100.0%)	3/57 (52.6 per '000)
% Caesarean Section	*0/3 (0.0%)*	*2/6 (33.3%)*	*20/20 (100.0%)*	*22/29 (75.9%)*	*(1, 1, 1)**
Monochorionic Monoamniotic	0/1 (0.0%)	0/1 (0.0%)	1/1 (100.0%)	1/1 (100.0%)	0/2 (0.0 per '000)
% Caesarean Section	*0/0 (0.0%)*	*0/0 (0.0%)*	*1/1 (100.0%)*	*1/1 (100.0%)*	*(0, 0, 0)**
All Twins	16/106 (15.1%)	20/106 (18.9%)	70/106 (66%)	106/106 (100.0%)	4/211 (19.0 per '000)
% Caesarean Section	*4/16 (25.0%)*	*6/20 (30.0%)*	*70/70 (100.0%)*	*80/106 (75.5%)*	*(1, 1, 2)**

*^Excludes Congenital Anomaly (n=1), *(Antepartum Deaths, Intrapartum Deaths, Early Neonatal Deaths)*

Perinatal Deaths	Number
Antepartum Deaths	1
Intrapartum Deaths	1
Early Neonatal Deaths	2
Congenital Anomalies	1
Total	**5**

5 Year Table: TWINS	2021	2022	2023	2024	2025
Number of Cases	149	126	106	121	106
Twin Babies	298	251	212	241	211
Incidence per '00 deliveries	2.2	1.9	1.6	1.9	1.6
Perinatal Deaths*	11	4	9	9	5
Perinatal rate per '000 twin babies	36.9	15.9	42.5	37.3	23.7
Caesarean Section	100/149 (67%)	97/126 (77%)	76/106 (72%)	88/121 (73%)	80/106 (75%)

**Includes Congenital Anomaly*

Nulliparous Twin Sets

	Spontaneous Labour	Induction of Labour	Caesarean Section	Total	cPNMR
Dichorionic Diamniotic	7/39 (17.9%)	5/39 (12.8%)	27/39 (69.2%)	39/39 (100.0%)	1/78 (12.8 per '000)
% Caesarean Section	*1/7 (14.3%)*	*3/5 (60.0%)*	*27/27 (100.0%)*	*31/39 (79.5%)*	*(0, 0, 1)**
Monochorionic Diamniotic	1/16 (6.3%)	3/16 (18.8%)	12/16 (75%)	16/16 (100.0%)	2/31 (64.5 per '000)
% Caesarean Section	*0/1 (0.0%)*	*2/3 (66.7%)*	*12/12 (100.0%)*	*14/16 (87.5%)*	*(1, 1, 0)**
Monochorionic Monoamniotic	0/0 (0.0%)	0/0 (0.0%)	0/0 (0.0%)	0/0 (0.0%)	0/0 (0 per '000)
% Caesarean Section	*0/0 (0.0%)*	*0/0 (0.0%)*	*0/0 (0.0%)*	*0/0 (0.0%)*	*(0, 0, 0)**
All Twins	8/55 (14.5%)	8/55 (14.5%)	39/55 (70.9%)	55/55 (100.0%)	3/109 (27.5 per '000)
% Caesarean Section	*1/8 (12.5%)*	*5/8 (62.5%)*	*39/39 (100.0%)*	*45/55 (81.8%)*	*(1, 1, 1)**

*Excludes Congenital Anomaly (n=1), *(Antepartum Deaths, Intrapartum Deaths, Early Neonatal Deaths)*

Multiparous Twin Sets without a previous caesarean section

	Spontaneous Labour	Induction of Labour	Caesarean Section	Total	cPNMR
Dichorionic Diamniotic	5/26 (19.2%)	9/26 (34.6%)	12/26 (46.2%)	26/26 (100.0%)	0/52 (0 per '000)
% Caesarean Section	*2/5 (40.0%)*	*1/9 (11.1%)*	*12/12 (100.0%)*	*15/26 (57.7%)*	*(0, 0, 0)**
Monochorionic Diamniotic	2/9 (22.2%)	3/9 (33.3%)	4/9 (44.4%)	9/9 (100.0%)	1/18 (55.6 per '000)
% Caesarean Section	*0/2 (0.0%)*	*0/3 (0.0%)*	*4/4 (100.0%)*	*4/9 (44.4%)*	*(0, 0, 1)**
Monochorionic Monoamniotic	0/1 (0.0%)	0/1 (0.0%)	1/1 (100.0%)	1/1 (100.0%)	0/2 (0 per '000)
% Caesarean Section	*0/0 (0.0%)*	*0/0 (0.0%)*	*1/1 (100.0%)*	*1/1 (100.0%)*	*(0, 0, 0)**
All Twins	7/36 (19.4%)	12/36 (33.3%)	17/36 (47.2%)	36/36 (100.0%)	1/72 (13.9 per '000)
% Caesarean Section	*2/7 (28.6%)*	*1/12 (8.3%)*	*17/17 (100.0%)*	*20/36 (55.6%)*	*(0, 0, 1)**

**(Antepartum Deaths, Intrapartum Deaths, Early Neonatal Deaths)*

Multiparous Twin sets with at least one previous caesarean section

	Spontaneous Labour	Induction of Labour	Caesarean Section	Total	cPNMR
Dichorionic Diamniotic	1/11 (9.1%)	0/11 (0.0%)	10/11 (90.9%)	11/11 (100.0%)	0/22 (0 per '000)
% Caesarean Section	*1/1 100.0%)*	*0/0 (0.0%)*	*10/10 (100.0%)*	*11/11 (100.0%)*	*(0, 0, 0)**
Monochorionic Diamniotic	0/4 (0.0%)	0/4 (0.0%)	4/4 (100.0%)	4/4 (100.0%)	0/8 (0 per '000)
% Caesarean Section	*0/0 (0.0%)*	*0/0 (0.0%)*	*4/4 (100.0%)*	*4/4 (100.0%)*	*(0, 0, 0)**
Monochorionic Monoamniotic	0/0 (0.0%)	0/0 (0.0%)	0/0 (0.0%)	0/0 (0.0%)	0/0 (0 per '000)
% Caesarean Section	*0/0 (0.0%)*	*0/0 (0.0%)*	*0/0 (0.0%)*	*0/0 (0.0%)*	*(0, 0, 0)**
All Twins	1/15 (6.7%)	0/15 (0.0%)	14/15 (93.3%)	15/15 (100.0%)	0/30 (0 per '000)
% Caesarean Section	*1/1 (100.0%)*	*0/0 (0.0%)*	*14/14 (100.0%)*	*15/15 (100.0%)*	*(0, 0, 0)**

**(Antepartum Deaths, Intrapartum Deaths, Early Neonatal Deaths)*

Liveborn twins with congenital anomalies: n = 1

Case No.	EGA	BW	Gender	Inborn	External referral	Delivery mode	Apgars	Day of death	Place of death	Placental histology	Cause of death	PM
6	32+3	900	Female	Yes	Yes	C-Section	1, 1, 1	1	NMH NICU	Moderate chorioamnionitis.	Multiple congenital anomalies including lethal pulmonary hypoplasia, arthrogryposis, airway anomaly, polysplenia, IUGR	Yes

Liveborn deaths of normally formed inborn twins: n = 2

Case No.	EGA	BW	Gender	Inborn	External referral	Delivery mode	Apgars	Day of death	Place of death	Placental histology	Cause of death	PM
8	23+5	510	Female	Yes	Yes	Vaginal	4, 6, 8	6	NMH NICU	DCDA. No abnormal histology reported.	E.Coli sepsis, extreme prematurity	No
10	25+0	655	Female	Yes	Yes	C-Section	1, 7	1	NMH NICU	MCDA. TTTS. High grade MVM.	TTTS, pulmonary hypoplasia, extreme prematurity	No

Stillbirths of normally formed inborn twins: n = 2

Case No.	EGA	BW	Gender	External Referral	Delivery mode	IUGR	Placental Histology	Cause of death	PM
1	21+5	400	Male	Yes	Vaginal	No	MCDA. Severe acute chorioamionitis with fetal response.	Ascending infection	No
2	21+5	425	Male	Yes	Vaginal	No	MCDA. Severe acute chorioamionitis with fetal response.	Ascending infection	No

Stillbirths of inborn twins with Congenital Anomalies

No cases to report.

Comment: There is a dedicated Consultant- led Twin Clinic at the National Maternity Hospital. All monochorionic and complicated dichorionic twin pregnancies, triplets or any higher order multiple pregnancies have their antenatal care delivered through this clinic. The perinatal mortality rate in multiple pregnancies at the NMH is influenced by the complexity of the case mix where complicated cases from other hospitals are referred to our tertiary referral centre.

Excluding congenital anomalies, there was 4 perinatal deaths in 2025. The corrected perinatal mortality rate was 19.0 per 1000.

In 2025, a total of 114 sets of multiple pregnancies had their care managed though this service, comprising 106 pregnancies with a twin pregnancy, 7 sets of triplets, and 1 set of quadruplets.

A total of 29 MCDA twin pairs, and 1 MCMA twin pairs were reviewed. Of the triplet pregnancies, there was 3 Monochorionic sets, 2 Dichorionic sets and 2 Trichorionic sets. 76 sets of complicated Dichorionic twins were reviewed through this service.

***Dr Ann McHugh,* Consultant Obstetrician and Gynaecologist**

Eoin & Louise Hyland with their newborn twin sons, Bobby & Harry.

Perinatal Genetics and Genomics

The Department of Perinatal Genetics and Genomics continues with the support of a multi-disciplinary team within The National Maternity Hospital (NMH).

The Perinatal Genetics and Genomics Service is for women who:

- Receive news that their baby may have abnormalities on scan (Fetal Medicine Department referral).
- Are at risk of their baby inheriting a genetic condition.
- Have a genetic condition and are attending the Maternal Medicine Clinic at The NMH.
- Lose a baby in pregnancy which may have been caused by a genetic condition.
- Suffer recurrent pregnancy losses.

Care is delivered in a holistic and integrated way. The Perinatal Genetics and Genomics Team attends joint clinics with the Fetal Medicine Department and provides multidisciplinary team (MDT) input into:

- Recurrent miscarriage specialist cases every second week
- Fetal medicine MDTs, which occur weekly (the Perinatal Genetic and Genomics Team attend fetal medicine MDTs outside the Hospital also)
- Maternal Medicine MDTs when complex cases are being discussed
- Radiology discussions of cases likely to be genetic where close collaboration facilitates a diagnosis in some situations
- Pathology cases which are likely genetic and a collaborative approach allows for expedited testing.
- Neonatal Intensive Care Unit consultations

In addition to providing care to patients attending The NMH, the Perinatal Genetics Department receive referrals from all over the country. Women are seen in person and virtually, and the team aim to provide a service that works for patients.

The service has developed particularly strong links with the South/Southwest Hospital Group. The Department of Perinatal Genetics and Genomics receives referrals from fetal medicine colleagues in other hospital groups. The team also attends the Weekly Fetal Medicine MDT virtually with the team at Cork University Maternity Hospital along with the perinatal pathology meeting where required. This has strengthened the collaborative relationship with the teams there enhancing patient care.

Following a successful recruitment campaign to grow the team, Mr Sean Fitzpatrick joined the perinatal genetics team in September 2025 as a Genetic Counsellor. His appointment strengthens the team and his expertise has served to improve care delivered to patients. Another Genetic Counsellor will join the team in early 2026.

The excellent service delivered was acknowledged with an Irish Hospital Consultant Association President's award at the IHCA conference in 2025.

Future

The Department of Perinatal Genetics and Genomics continues to expand with increasing numbers of referrals. The development is driven by the vision of developing an equitable service that provides timely access to clinical genetics for people planning families. We await the funding of the National Perinatal Genetics and Genomics Framework and the improved collaboration with colleagues nationwide that this funding will facilitate.

Dr Sam Doyle
Consultant Clinical and Biochemical Geneticist with a special interest in Perinatal Genomics

Perineal Clinic

The Perineal Clinic is a weekly clinic, providing care to women who have sustained an anal sphincter injury following vaginal delivery. It also assesses antenatal patients and provides advice regarding future mode of delivery. Other referrals include faecal incontinence of presumed obstetric origin and cases of pudendal neuropathy, resulting in pelvic floor dysfunction. Patients undergo a thorough assessment in terms of history and examination, with every patient having an endoanal ultrasound. If deemed necessary, patients will also undergo manometry and nerve conduction studies.

The majority of our patients will have been previously assessed in the Postnatal 'Poppy' Clinic at 6 weeks if they have delivered in the NMH. Appointments for assessment in the Perineal Clinic are generally issued for 4 to 6 months postnatal, allowing time for recovery and strengthening of the anal sphincter. Persistence of symptoms of faecal incontinence at this stage and weak anal sphincter strength necessitate further intervention, which will always include physiotherapy. The importance of the physiotherapy services in managing these women cannot be overstated. In 2025 we saw less return patients than in previous years and this is a reflection of the better immediate management of OASIS resulting in better outcomes and less need for repeat visits to the Perineal Clinic.

Of the 212 new referrals seen, 158 were for assessment of an obstetric anal sphincter tear of varying grades (3a, 3b, 3c, 4th, recurrent). Only one patient sustained a recurrent third degree tear. Our experience in the clinic suggests that the recurrence risk of such tears, in women who undergo vaginal delivery, is lower than the quoted recurrence risk of 6 - 8%. This provides a degree of reassurance to doctors and patients alike when counselling regarding future mode of delivery.

Of the 158 patients assessed for OASIS, 11 sustained a 4th degree tear. This mirrors the 2024 findings. 4th degree tears are increasing and the incidence is higher than the quoted 0.1%. They require a skilled operator to ensure the optimal repair and to minimise potential complications, in particular fistula formation.

Only 24 of the 212 (11%) new referrals were seen for antenatal counselling regarding mode of delivery. It is reasonable to suggest that this low figure represents the increasing number of women opting for elective caesarean section, with the decision having been made in the antenatal clinic thereby negating a visit to the perineal clinic. We would encourage antenatal referral, nonetheless, to aid in fully counselling the woman regarding recurrence risk before a definitive decision is made.

Of the 212 new attendances, 92 (43%) were from other units, emphasising the important role the clinic has held for many years in assisting our colleagues around the country in the management and care of patients with OASIS. Reassuringly the vast majority of patients attending the Perineal Clinic for assessment are asymptomatic or have mild symptoms of faecal incontinence. This is a yearly finding and it is evidence that the quality of repairs being undertaken is good. This is reflected on endoanal ultrasound findings, which are generally good.

***Dr Myra Fitzpatrick*, Associate Specialist, Obstetrics & Gynaecology**
***Linda Kelly,* AMP Women's Health & Urodynamics**

Table 1: Perineal Clinic Activity

	2021	2022	2023	2024	2025
Appointments offered	300	330	282	272	307
Attendances	256	235	237	222	257
New referrals	175 (68%)	187 (67%)	159 (67%)	149 (67%)	212 (82%)
Follow-ups	81 (32%)	74 (31%)	78 (33%)	73 (33%)	45 (18%)
Did Not Attend	44 (15%)	67 (28%)	45/282 (16%)	50 (23%)	50 (16%)

Table 2: Indications and Sources for New Referrals

Indication for New Referrals [n=212]	No.	%
3A	51	24.1%
3B	76	35.8%
3C	19	9.0%
4TH	11	5.2%
Recurrent OASIS	1	0.5%
Antenatal Assessment	24	11.3%
Faecal Incontinence	15	7.1%
Miscellaneous	15	7.1%

Source of New Referrals [n=212]		
NMH	120	56.6%
Other units	92	43.4%

Placenta Accreta Spectrum

Placenta Accreta Spectrum (PAS) refers to a range of clinical conditions characterised by abnormal placental adherence to the uterine wall. The incidence of PAS has increased substantially from 0.8 per 1,000 deliveries in the 1980s to 3 per 1,000 deliveries in the past decade, largely attributed to a rising global caesarean section rate. The condition is associated with significant maternal morbidity.

The PAS multidisciplinary team (MDT) service was established in The National Maternity Hospital in June 2017. This service provides care to patients of the NMH and Rotunda and also accepts external referrals nationwide.

In 2025 an average of 4 cases were discussed at each monthly MDT, amounting to 51 total cases discussed by 5 units over the 12-month period.

10 women with suspected PAS were cared for in the NMH in 2025, with an additional 2 women with caesarean scar pregnancies receiving care here. There were 6 NMH referrals and 6 external referrals. The median gestational age at delivery for cases of suspected PAS was 33 weeks (Range 29-36 weeks). The median EBL in these cases was 2500mls (IQR 785-4300mls).

Three women had uterine-conserving surgery via pfannenstiel incision, 2 women had a midline laparotomy and caesarean hysterectomy, 1 woman had a pfannenstiel incision and TAH due to SAPH and 1 woman had a placenta praevia only at CS.

Table 1 provides a summary of the 8 cases that delivered under the care of the PAS team in 2025.

All women were offered input from allied healthcare professionals including social work, perinatal mental health, physiotherapy, and lactation support and provided with information about the Placenta Accreta Ireland patient advocacy group.

Caesarean Scar Pregnancy

Caesarean scar pregnancy (CSP) is a precursor to severe PAS and both conditions exist as part of a common disease spectrum. The true incidence of CSP is unknown with reported rates in literature varying from 1:800 to 1:2656. Although relatively uncommon, its incidence is also increasing in line with increasing caesarean section rates.

In 2025, two women with CSP were managed within the PAS MDT. The first case was diagnosed after 12 weeks, had opted to continue the pregnancy but sadly miscarried. An ERPC under US guidance was performed, however this patient required a return to theatre where a haematoma was evacuated and the myometrial defect resected. The second case was diagnosed at 6 weeks and had an uneventful ERPC under US guidance with no haematoma at 3 month follow up. Table 2 provides a summary of these CSP cases.

Research

The PAS service is engaged in a diverse range of research projects, collaborating with colleagues both nationally and internationally. Since 2017, a prospective database of all women cared for by the PAS MDT has been maintained, alongside a biobank consisting of tissue and serum. Research published to date has focussed on multi-disciplinary team care, exploring the lived experience of women and their partners.

Placenta Accreta Ireland

Placenta Accreta Ireland is a patient advocacy and support group founded in 2019. Placenta Accreta Ireland supports women and their families by focussing on the following key areas: advocacy, support, information, education, and research. Their website paireland.ie and podcast 'Accreta and Me' allows patients to access evidence-based information, connect with other accreta mums and learn from the lived experience of others. Placenta Accreta Ireland supports women and their families both in Ireland and across the globe, while working in close collaboration with The National Maternity Hospital.

Dr Siobhan Moran
Placenta Accreta Fellow

Table 1: Overview of PAS procedures

	Referral Source	Gestation at Delivery	Place of Delivery	Procedure	Anaesthesia	EBL	PAS on Histology
1	NMH	36+4	NMH	Pfannenstiel, myometrial wedge resection, repair of cystotomy	Regional	3800mls	Yes
2	External	35+5	NMH	Pfannenstiel, myometrial wedge resection	Regional	900mls	Yes
3	External	32+0	External SAPH	Pfannenstiel, TAH BS	General	8000mls	Yes
4	External	34+4	NMH	Midline, TAH BS	General	2500mls	Yes
5	External	29+3	NMH	Pfannenstiel, myometrial wedge resection	Regional	785mls	Yes
6	External	32+5 – patient RIP, coroner's case pending					
7	NMH	34+3	NMH	Pfannenstiel + CS	General	700mls	No
8	NMH	32+3	NMH	Midline, TAH BS	General	4300mls	Yes

Table 2: Caesarean scar pregnancy overview

	Gestation	Procedure	EBL
1	14 weeks	ERPC under US guidance. Return to theatre for evacuation of haematoma and myometrial wedge resection.	2300mls
2	6 weeks	ERPC under US guidance.	150mls

The Poppy Clinic – Postnatal Maternal Morbidity Clinic

The Postnatal Maternal Morbidity Clinic (The Poppy Clinic) is led by Consultant Obstetrician & Gynaecologist Dr Laoise O Brien and Advanced Midwife Practitioner (AMP) Ms Caroline Brophy.

The Poppy clinic is a model of care unique to The National Maternity Hospital and was established in 2014. The clinic provides a service that bridges the gap in postnatal follow up for women who experience morbidity during the antenatal, intrapartum or postnatal periods. Nearly 800 new mothers attended the service last year with a DNA rate of 7.9%. The service offers 3 clinics per week: a Consultant-led clinic on Friday, an AMP Clinic on Thursday and an urgent review AMP clinic on Monday.

The service continues to evolve with the introduction of new sub clinics during the couple of years:

- Placenta Pathology Clinic: established by Dr Ann McHugh, Consultant Obstetrician & Gynecologist, providing timely discussion on abnormal results and future pregnancy planning.
- Socially vulnerable women including those seeking international protection: postnatal review as required, including a 6-week postnatal check –up, cervical screening and administration of long acting, reversible contraception.
- The Postnatal Clinic and ward rounds are provided with advice and guidance from Dr Susan Knowles, Consultant Microbiologist.

All non-routine referrals are reviewed and triaged by the Advanced Midwife Practitioner. Timely appointments are arranged for the appropriate clinic.

Referral Source

NMH: Midwives (Midwives, CMMs, CMWs CMSs, AMPs), Obstetricians (SHOs to Consultants), MDT – Social work, Perinatal Mental Health, Physiotherapy

Community: Public health nurse, GPs, Community physiotherapists

External Hospital: The Poppy clinic accepts referrals from all hospitals within the HSE Dublin South East Hospital group. Reasons for referrals are protracted perineal pain and hyper granulation tissue.

Self-referral: as the clinic is becoming more visible women are self-referring to the clinic.

The service has a close working relationship with members of the hospitals multidisciplinary teams and external support services

- Perinatal Mental Health
- Consultant Microbiologist
- Social Work
- Physiotherapy
- Perineal Clinic
- Urogynacology Service
- General Gynae,
- Anaesthetics
- Psychosexual Counsellor

External: Public Health Nurses, Wound Clinic St Michaels Hospital, Radiology at St Vincent's Private Hospital & Colorectal Surgeon St Michaels

Education & Research

The Poppy Clinic is a dynamic model of Outpatient Postnatal Care unique to the National Maternity Hospital, providing holistic and time-sensitive care to women. Education is an integral part of the Poppy Service providing Midwives, PHNs, GPs and Obstetricians the awareness and tools to offer timely and relevant care to this vulnerable group of new mothers. Research and audit continue as the service evolves.

***Caroline Brophy,* Advanced Midwife Practitioner**

Referral Criteria

Indication	Appointment
PPH > 1.5 L	6 weeks
Hb < 8.gldl	2 weeks
OASIS (3rd & 4th degree tears)	6 weeks
Perineal Wound	As required
Protracted Perineal Pain	Up to 6 months
Dyspareunia	Up to 6 months postnatal
Previous Perineal Trauma	Antenatal Review
Caesarean Section Wounds	As required
Obstetric Complication – severe PET, Hypertension	As required
Placenta Pathology	As required
Other PN Concerns	Referral reviewed
Away from Home	Within 2 weeks
Debriefing – focused, morbidity related:	6 weeks to 1yr
Postnatal Readmission	Seen as outpatient and followed up in clinic
Postnatal Ward Rounds	Weekly on Friday, daily review as required

Table 1: Poppy clinic attendances 2021 – 2025

	2021	2022	2023	2024	2025
Attended	856	786	917	975	779
DNA	116	69	75	58	67
DNA Rate	11.9%	8.1%	8.1%	5.6%	7.9%
Total Deliveries	7694	6818	6765	6598	7096
% Attend Poppy	11.1%	11.5%	13.5%	14.7%	11.0%

Preterm Birth Clinic

Preterm Birth Team

Consultants; Dr Siobhan Corcoran, Dr Donal O'Brien
Specialist Midwife; Ms Larissa Luethe
PTB Fellow Dr Ita Shanahan

Referral Criteria & Care Pathway

Women are referred for antenatal care in the PTB clinic if they have previously had a preterm birth (<34 weeks) or have risk factors for sPTB (spontaneous Preterm Birth) such as two or more LLETZ procedures or a cone biopsy. Frequent consultations every 2-3 weeks, a dedicated specialist midwife, microbiological screening, cervical length surveillance & interventions such as vaginal progesterone and cervical cerclage where indicated are employed in this high risk group.

The numbers of patients seen in the PTB Clinic has risen since 2023 and we are increasingly now receiving referrals from many units around the country for shared obstetric care of these high risk patients. The overall Caesarean section rate in this group is higher than the background rate in the hospital. We feel this may in part at least be due to the number of women that require Caesarean Birth owing to abdominal cerclage.

We continue to offer pre-conceptual care to women at risk of preterm birth and saw 31 patients for this purpose in 2025. We also offer bereavement follow up service to those that had spontaneous mid trimester loss or experienced perinatal death due to extreme prematurity. There were 11 such consults in 2025.

Dr Siobhan Corcoran
Consultant Obstetrician & Gynaecologist

Figure 1: Number of antenatal patients

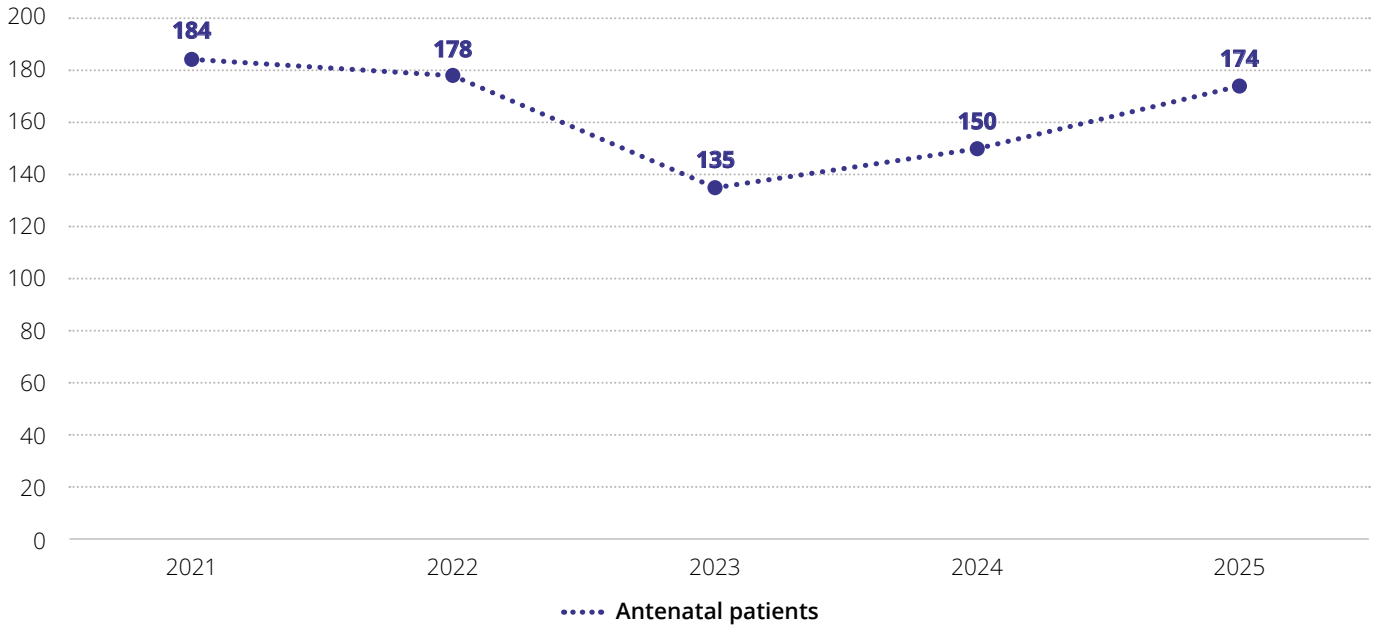


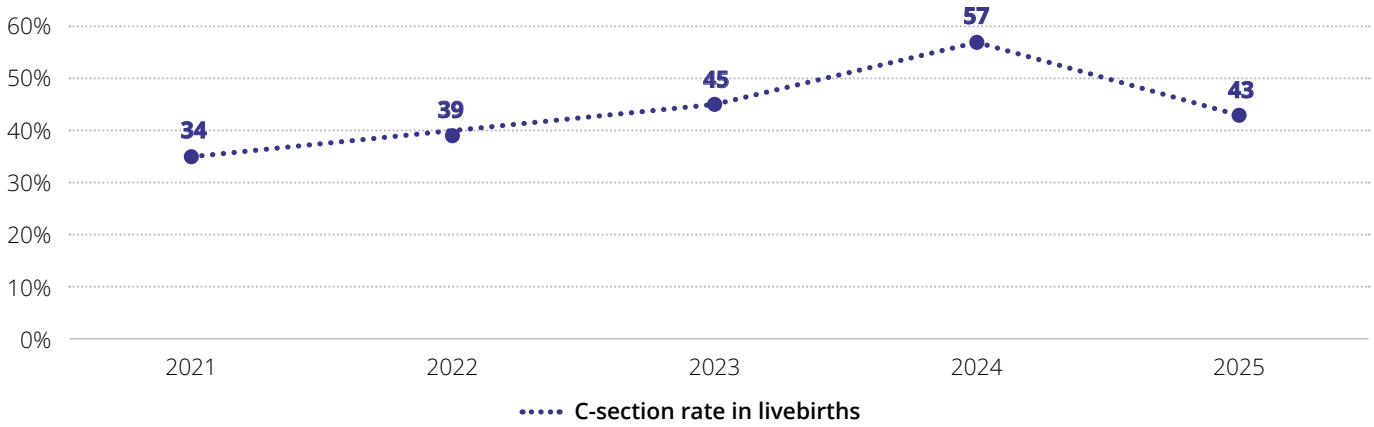
Table 1: Preterm birth clinic activity

Total	174
Livebirths >=23 wks EGA	173/174 (99.4%)
Stillbirths >=23 wks EGA	0/174 (0.0%)
Mid- trimester Losses 14 - 22+6 wks	1/174 (0.6%)
EGA at delivery of livebirths - range	25+2 - 41+6 wks
Nullip	50/174 (28.7%)
Multip	124/174 (71.3%)
CS rate	75/173 (43.4%)
Operative vaginal delivery	12/173 (6.9%)
Spontaneous vaginal delivery	86/173 (49.7%)
Livebirths delivery <=34 wks	25/173 (14.5%)
Livebirths delivery 34+1 - 36+6 wks	14/173 (8.1%)
Livebirths delivery 37+0 - 42/40	134/173 (77.5%)

Table 2: Cerclage and pessary activity

Women that delivered in 2025 with McDonald/Shirodkar Cerclage placed & removed in pregnancy	**22**
• Mid trimester losses in this group	0
• Livebirths in this group	22
• Livebirths <28 weeks	3 (1 CS due to IUGR, 2 SOL)
• Livebirths <36+6 weeks	5
• Livebirths >37 weeks	14
• Range of GA of Livebirths in this group	25+2 – 40+2
Women that delivered in 2025 with Abdominal Cerclage in situ	**6**
• Mid trimester losses in this group	0
• Livebirths in this group	6
• Range of GA of Livebirths in this group	29+4* – 38+0 *Abruption
Women that had a pre-pregnancy abdominal cerclage placed for PTB prevention in 2025	**9**
Arabin pessary	3
• Midtrimester losses in this group	0
• Livebirths in this group	3
• PPROM in this group	0
• Range of GA of Livebirths in this group	34-39

Figure 2: C-section rate in livebirths



Reproductive Medicine & Surgery

The National Maternity Hospital Fertility Hub

The National Maternity Hospital Fertility Hub is one of six Regional Fertility Hubs in Ireland and provides advice, investigation and treatment for eligible couples with infertility. The Fertility Hub caters for couples seeking fertility investigations and treatment. The Hub can also refer eligible couples for publicly funded Assisted Human Reproduction (AHR) treatments including Intrauterine Insemination (IUI), In Vitro Fertilisation (IVF), or Intracytoplasmic Sperm Injection (ICSI). There were 1,306 referrals to the NMH Fertility Hub in 2025 (figure 1), a 4% increase in numbers compared with 2024 data (n=1,256 referrals).

Of the referrals shown in Figure 1, there were 737 eligible couples referred to the hub in 2025. Table 1 gives a breakdown of the hub clinical activity in 2025.

Publicly funded Assisted Human Reproduction (AHR)
There were 284 eligible couples who were referred to private providers for AHR treatment in 2025. This figure continues to grow year on year and outcome data is reported nationally.

Reproductive Surgery

The number of reproductive surgery procedures performed is outlined in table 2.

The National Maternity Hospital and Merrion Fertility Clinic is the only service in Ireland who together perform laparoscopic oocyte retrievals. For a small subset of women, it can be the only approach to allow access to the ovary to retrieve eggs, for example in the presence of cervical cancers, a laparoscopic approach can be safer for the patient. There were three laparoscopic oocyte retrievals carried out in 2025.

Merrion Fertility Clinic

The number of referrals to the Merrion Fertility Clinic increased by 6%. The number of female fertility preservation cycles, which had increased significantly in 2024, remained high in 2025. The demand for diagnostic semen analyses grew a further 10% on 2024 figures, while sperm freezing services grew by 20%.

Assisted reproduction outcomes

Fresh embryo transfer cycles
Patients under 37 years having a fresh transfer of a good quality, untested blastocyst had a clinical pregnancy rate (as defined by the European Society for Human Reproduction and Embryology (ESHRE)) of 46% in 2025. As expected, increasing female age at time of embryo creation saw a decrease in clinical pregnancy rates. The overall rate for patients having a good quality fresh embryo (GQE) transferred was 38.4% (figure 2). Unfortunately, not all patients achieve a good quality embryo, considering all fresh embryos transferred in 2025, the clinical pregnancy rate was 31%.

Frozen embryo transfer (FET) cycles

The clinical pregnancy rate for patients who underwent a frozen embryo transfer (FET) of an untested embryo in 2025 was 44.6% (figure 2), with a multiple pregnancy rate of less than 1%. When stratified by patients aged 37 years when their embryo was frozen, this rate increases to 50%. An excellent cryopreservation programme allows for the safe preservation and storage of blastocysts if a fresh transfer is not possible or desirable. The Pre-Implantation Genetic Testing (PGT) service at Merrion Fertility Clinic is now well established, accounting for 17% of cycles performed in 2025. The clinical pregnancy rate for patients of all ages having a PGT embryo transfer for 2025 was 70% (figure 2).

Single embryo transfer

The percentage of patients at Merrion Fertility Clinic have a single embryo transfer continue to grow and now stand at 87%, an increase of 6% from 2024.The has been achieved without any decrease in clinic pregnancy rates for the same period.

Child, Adolescent and Young Adult (CAYA) Fertility Preservation Services

Twenty-three adolescent males and nine adolescent females (<18 years of age) and were for cryopreservation services before undergoing gonadotoxic treatment or surgery for cancer or autoimmune disease. Twelve female survivors of CAYA cancer attended in 2025 for an initial fertility consultation, while 25 women attended for a follow-up fertility consultation and ovarian reserve testing. This very important programme is kindly supported by the Irish Cancer Society.

Research

We maintain an active and productive research portfolio, collaborating with scientists in Irish academic institutions and other teaching hospitals, and is a member of the UCD Perinatal Research Centre. Merrion Fertility Clinic employs a full-time head of research, and clinical research fellow posts exist for higher training in reproductive medicine and surgery, with fellows undertaking higher degrees. Merrion Fertility Clinic also hosts and/or mentors several MSc and PhD students. Our studies span a range of topics, from basic mechanistic biology to clinical translational research. In 2025, our researchers also worked closely with collaborators at several of Ireland's leading academic research institutions, including University College Dublin, Trinity College Dublin and Maynooth University on the following research projects:

- Endometrial microbiome and infertility
- Endometriosis and uterine immune cells
- Healthcare providers' knowledge and perceptions towards anti-obesity medication in fertility patients
- Follicular microenvironment in low ovarian reserve (Funding: Ferring)
- Ovarian reserve in childhood cancer survivors (Funding: Irish Cancer Society)
- Employer/workplace supports for employees pursuing fertility treatment (Funding: Research Ireland)

Assisted Human Reproduction Legislation

In June 2024, the Health AHR (Assisted Human Reproduction) Act was signed into law by the President of Ireland. For the act to function, the AHR Act 2024 required the establishment of the Assisted Human Reproduction Regulatory Authority (AHRRA). Dr David Crosby and seven other experts in the field of AHR and surrogacy were appointed by the Minister of Health to the Assisted Human Reproduction Regulatory Authority in 2025.

***Dr David Crosby*, Head of Department of Reproductive Medicine, The National Maternity Hospital and Clinical Director, Merrion Fertility Clinic**

Figure 1: NMH fertility hub referrals

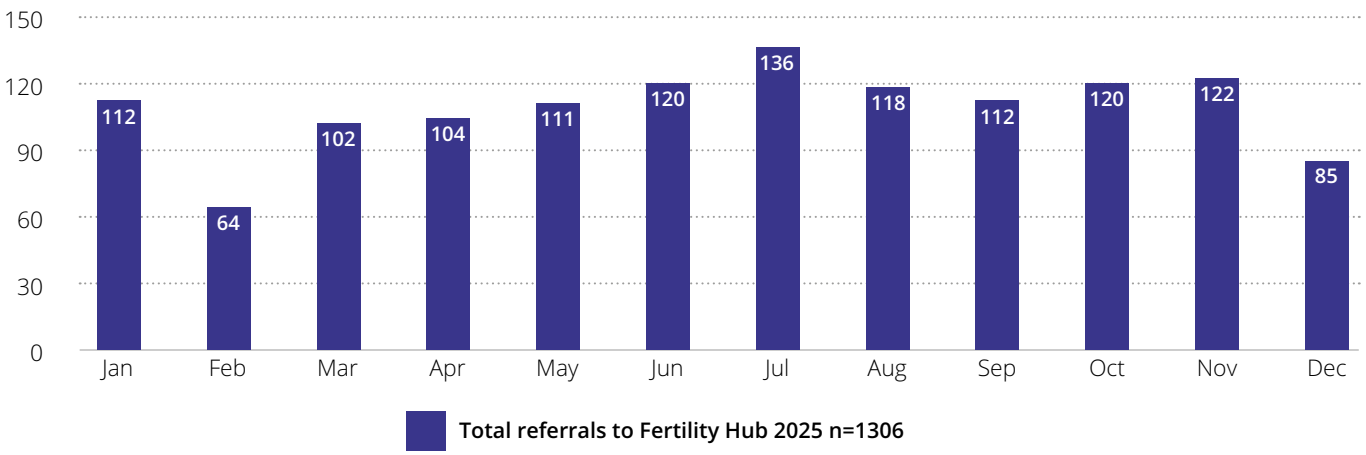


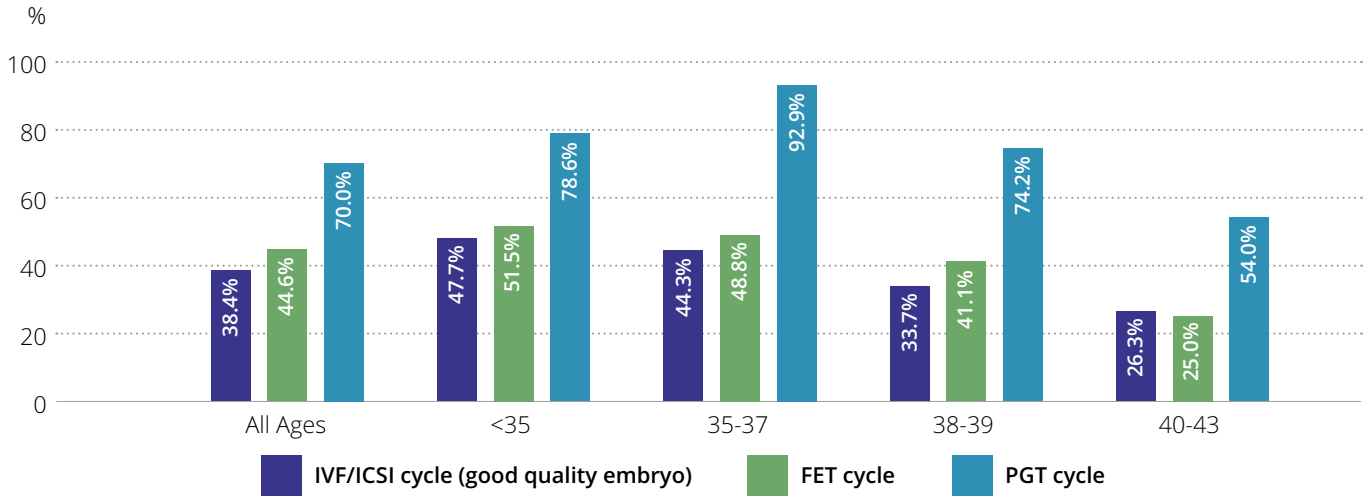
Table 1: Clinical activity in fertility hub

Total referrals meeting referral criteria	737
Total Consultant led clinics	82
Consultant appointments completed	528
Nurse led clinics	449
Ovulation induction clinics	97
Semen analyses analysed	545
Number of onward AHR Referrals	284
Reported spontaneous conceptions	125
Total	**1306**

Table 2: Reproductive surgery under general anaesthesia

	2024	2025
Hysteroscopy – operative and diagnostic	210	330
Operative laparoscopy	124	75
Diagnostic laparoscopy	65	62
Myomectomy	9	23

Figure 2: Clinical pregnancy rates per embryo transfer by maternal age



Severe Maternal Morbidity

Severe Maternal Morbidity

Data is compiled from a number of sources including the High Dependency Unit Record, Pathology Department, Accreta Group, Haematology team, Maternal Medicine Clinic, Microbiology Department as well as referral Intensive Care Units and Interventional Radiology teams.

The NMH reports all SMM to the National Perinatal Epidemiology Centre for inclusion in the National SMM report.

Prof Mary Higgins
Consultant Obstetrician & Gynaecologist

Table 1: Morbidity

	Number of women where this was the primary SMM	Number of women who had this SMM
Major Obstetric Haemorrhage	19	19
Uterine Rupture	0	0
Peripartum Hysterectomy	2	2
Eclampsia	4	4
Renal / Liver Dysfunction	8	8
Pulmonary Oedema	0	0
Acute Respiratory Dysfunction	0	0
Pulmonary Embolism	3	3
Cardiac Arrest	0	0
Coma	0	0
Cerebral Vascular Accident	3	3
Status Epilepticus	0	0
Septic Shock	2	2
Anaesthetic Problems	0	0
ICU/CCU admission	2**	4
Interventional Radiology	3	4
TOTAL	**46**	**49**

** Data from January 1st 2025 to December 31st 2025; some women had more than one SMM*
***One patient was admitted to the Intensive Care Unit in St Vincent's University Hospital, she was not reported in this table, as she was a patient from another maternity unit, but did receive care from NMH staff. This one person has been reported to the National Perinatal Epidemiology Centre for the Severe Maternal Morbidity report.*

Shoulder Dystocia

Including all brachial plexus injuries and all fractures in the baby

Definition: Shoulder dystocia is diagnosed in the NMH at vaginal delivery when the anterior shoulder fails to deliver on the first attempt with routine axial traction. Included also are the deliveries that proceed to either internal manoeuvres or delivery of the posterior arm without an attempt at routine axial traction.

Shoulder Dystocia

Shoulder Dystocia	Nullips	Multips	Total
No. of Cases	**24**	**20**	**44**
Incidence in Spontaneous and Operative vaginal deliveries	24/2083 1.2%	20/2309 0.9%	44/4392 1.0%
Spontaneous labour	7	12	19
Induction of labour	17	8	25
Spontaneous vaginal delivery	7	15	22
Operative vaginal delivery	17	5	22
Birthweight >= 4Kg	10	11	21

Single Cephalic Vaginal Deliveries Birthweight >= 4Kg	Nullips	Multips	Total
Spontaneous Vaginal	131	360	491
Operative Vaginal	82	33	115
C-Section	187	210	397
	400	603	1003
Incidence in Single Cephalic Vaginal Deliveries Birthweight >= 4Kg	10/213 4.7%	11/393 2.8%	21/606 3.5%

Procedures to Assist Delivery of Shoulders	Nullips	Multips	Total
McRoberts	2	4	6
Suprapubic Pressure	1	1	2
McRoberts & Suprapubic Pressure	8	9	17
McRoberts & Suprapubic Pressure & Internal Rotation	0	0	0
McRoberts & Suprapubic Pressure & Delivery of Posterior Arm	4	3	7
McRoberts & Suprapubic Pressure & Internal Rotation & Delivery of Posterior Arm	5	1	6
McRoberts & Internal Rotation	0	0	0
McRoberts & Posterior Arm	4	0	4
McRoberts & Internal Rotation & Delivery of Posterior Arm	0	0	0
Internal Manoeuvre Only	0	0	0
Suprapubic Pressure & Delivery of Posterior Arm	0	1	1
Not Recorded	0	1	1
Total	**24**	**20**	**44**

Position of Head at Delivery	Nullips	Multips	Total
ROT	14	6	20
LOT	10	14	24
Total	**24**	**20**	**44**

Maternal Complications	Nullips	Multips	Total
PPH >= 1000ml	4	1	5
Third or fourth degree tear	2	0	2

Neonate Complications	Nullips	Multips	Total
Apgars < 7 @ 5 mins	5	1	6
Encephalopathy	1	0	1
Brachial Plexus Injury	8	5	13
Right Clavicular Fracture	2	0	2

Comment:
The incidence of shoulder dystocia overall is 1.0% (1.2% in nulliparous women and 0.9% in multiparous women).
The incidence of shoulder dystocia in babies delivered vaginally weighing ≥ 4.0kg is 3.5% (4.7% in nulliparous women and 2.8% in multiparous women).

All Brachial Plexus Injuries in the Baby

BPI	Nullips	Multips	Total
No. of Cases	**13**	**10**	**23**
Incidence Per Overall Deliveries	13/3471 0.4%	10/3625 0.3%	23/7096 0.3%
Associated with Shoulder Dystocia	8	5	13
Birthweight >= 4Kg	1	3	4

Pathway to Delivery	Nullips	Multips	Total
Spontaneous labour	2	6	8
Induction of labour	11	3	14
Pre labour c-section	0	1	1

Method of Delivery	Nullips	Multips	Total
Spontaneous vaginal	2	6	8
Operative vaginal	10	3	13
C-Section	0	0	0

Incidence in Single Cephalic Vaginal Deliveries	Nullips	Multips	Total
All vaginal deliveries	13/2083 0.6%	10/2309 0.4%	23/4392 0.5%
Vaginal deliveries birthweight >= 4Kg	1/213 0.5%	3/393 0.8%	4/606 0.7%

Outcomes	Nullips	Multips	Total
Cases Resolved at 2 weeks	9	4	13
Cases Associated with Shoulder Dystocia Resolved at 2 weeks	6	1	7

Comment:
Brachial plexus injuries (BPI) are reported as any case identified prior to discharge. Reporting systems for the presence of BPIs at or after 6 months are not always easy to identify to verify the continual presence of a BPI. The reporting of BPIs should be standardised as most of them resolve. Of the 23 BPIs recorded in 2025, 13 cases had resolved by 2 weeks.

All Fractures in the Baby

Fractures	Nullips	Multips	Total
No. of Cases	**7**	**4**	**11**
Incidence Per Overall Deliveries	7/3471 0.20%	4/3625 0.11%	11/7096 0.16%
Associated with Shoulder Dystocia	2	0	2
Birthweight >= 4Kg	3	2	5

Location of Fracture	Nullips	Multips	Total
Fractured Right Clavicle	2	2	4
Fractured Left Clavicle	4	1	5
Fractured Right Humerus	0	0	0
Fractured Left Humerus	1	1	2

Pathway to Delivery	Nullips	Multips	Total
Spontaneous labour	3	2	5
Induction of labour	4	1	5
Pre labour c-section	0	1	1

Method of Delivery	Nullips	Multips	Total
Spontaneous vaginal	1	3	4
Operative vaginal	6	0	6
C-Section	0	0	0

Incidence in Single Cephalic Vaginal Deliveries	Nullips	Multips	Total
All vaginal deliveries	7/2083 0.34%	4/2309 0.17%	11/4392 0.25%
Vaginal deliveries birthweight >= 4Kg	3/213 1.41%	2/393 0.51%	5/606 0.83%

Smoking Cessation Service

The Smoking Cessation Service was established in 2020 with the 'Smoke Free Start' project. This pilot project sought to introduce a midwifery-led, intensive smoking cessation service to routinely treat tobacco addiction as a care issue in pregnancy and promote the health and wellbeing of the unborn child.

The aim of the service is to effectively support smoking cessation and improve pregnancy and birth outcomes, physical and psychological health and quality of life for women and their families and reduce health inequalities.

The service provides education to staff and awareness of the HSE's health promotion programme 'Making Every Contact Count', as well as delivering student midwife education in collaboration with UCD.

Supporting pregnant women to stop smoking and addressing second-hand smoke exposure are two of the most significant interventions that can be employed by healthcare professionals in order to lower the risk of adverse birth outcomes and promote the health and wellbeing of society. Stopping smoking is the single most important thing pregnant women can do to protect their health and the health of their baby and families1.

Breath Carbon Monoxide Testing

Breath Carbon Monoxide (BCO) testing has been introduced at booking visits for all women. There is an opt-out referral to the service for women who smoke, use e-cigarettes, have recently quit or have a BCO reading of ≥4ppm. This ensures that pregnant tobacco users are routinely identified, offered interventions and referred to the smoking cessation service; 64% of women referred through this pathway entered the support programme in 2025.

E-cigarette use in Pregnancy and The ECHO Study

In 2025, 17% of referrals to the service were related to e-cigarette use. The NMH is participating in The ECHO Study which is a national study to evaluate the impact of using e-cigarettes during pregnancy and on childhood health outcomes. The results from this research are due in 2027 and will help inform practice and provide much needed evidence-based information for women.

Table 1: HSE KPI data

Target	275
Actual Count	327 (119%)

Table 2: Number of Referrals by Specialty

Specialty	No.
Obstetric	425
Gynaecology	53
Staff	3
Total	**480**

References: [1]Chamberlain, C., et al. (2017) 'Psychosocial interventions for supporting women to stop smoking in pregnancy', Cochrane Database of Systematic Reviews, 2017(2), pp. 1-55.

The World Conference on Tobacco Control 2025

The World Conference on Tobacco Control took place in Ireland during the year. The NMH 'Smoke Free Start' project was presented at the conference as part of the Tobacco Free Ireland's engaging workshop, which explored the intersection of health inequalities and the goal of a tobacco-free society in Ireland. It was an exciting opportunity to share our learnings on establishing our midwifery led service on the world stage.

Orla Bowe
Smoking Cessation Midwife CMM2

Termination of Pregnancy

The Hospital provides care under each of the four legal provisions for Termination of Pregnancy (TOP) care (<12 weeks, Maternal, Maternal Emergency and Fetal). Options for surgical and medical TOP care is given to all women <12 weeks and, gestation dependent, to those with maternal or fetal issues.

The majority of people attending for TOP care are for those less than 12 week's gestation (78%), followed by fetal indication (18%) and maternal (1%). These rates have remained consistent since 2019.

Over one third (38%, mostly <12 weeks) underwent a surgical TOP and the remainder (63%, including the most people having a TOP under Section 9 and 10 indications) were medical. For both, extensive multidisciplinary input is required to provide safe, respectful, compassionate care to the women and their families. Teams involved include obstetrics, maternal fetal medicine, midwifery, nursing, anaesthesiology, bereavement, chaplaincy and perinatal mental health (psychology and psychiatry).

First trimester service: <12 weeks gestation

In 2025, as in previous years, most women had only one visit to clinic. Of these, some women chose to continue in their pregnancy following attendance in the clinic, often requiring many hours of discussion with clinic staff members. Some women attended whom, on examination and ultrasound investigation, were over 12 week's gestation and unable to avail of a TOP under Section 12 of the Act.

Women under the age of legal consent are also seen by the medical social work team and mandatory referrals are made to Tusla. Some women have also required the input of the Sexual Assault Unit, the Gardai (if allegations of assault, or need for forensic examination of products of conception) or the Genito-urinary medicine teams (if positive for sexually transmitted infections).

Women attending for first trimester TOP are given the option between medical (MTOP) and surgical (STOP) based on woman's preference and medical need. Over half will complete the TOP within six hours but the remainder require an overnight stay. Most women are discharged post procedure within six hours of admission.

Over half of the clinic attendances were following 'unsuccessful' community TOP – meaning they had a persistent positive pregnancy test after the community TOP. Many these women had a positive pregnancy test due to retained products of conception and required an ERPC. A small minority had an ongoing pregnancy and attended for consideration of repeat TOP (usually choosing surgical).

TOP for maternal medical conditions

Two women underwent TOP due to a maternal medical condition that met the criteria for the Act. They were seen by consultants in maternal medicine and all were seen by consultants in maternal fetal medicine. Planning for TOP due to maternal medical conditions involves the input of multiple specialities to provide safe and respectful care. We continue to be grateful to our general medical and speciality colleagues in St Vincent's University Hospital for their input into the care of this complex group.

TOP for fetal abnormalities

Seventeen women underwent TOP in NMH in 2025 where Section 11 criteria were met. Please see the Fetal Medicine chapter for further details.

Prof Mary Higgins
Consultant Obstetrician & Gynaecologist

Ultrasound

The National Maternity Hospital Fetal Medicine Department receives referrals from all over Ireland and provides a comprehensive service for early pregnancy assessment, ultrasound scans throughout pregnancy, fetal medicine consultations, genetics consultations and gynaecology ultrasound examinations.

Fetal Assessment Unit

The National Maternity Hospital Ultrasound Department provides a comprehensive service for early pregnancy assessment, obstetric ultrasound scans, fetal medicine consultations, expert fetal medicine procedures, and gynaecology ultrasound examinations. We deliver care for the patients of The National Maternity Hospital, with referrals from all over Ireland.

We provide an early pregnancy assessment service for patients referred with pain or bleeding in the first trimester, and for those with a history of pregnancy loss. All antenatal patients are offered both a 12 week dating scan and a fetal anatomy scan at 20-22 weeks.

Heather Hughes.

The scheduled obstetric ultrasound workload, including scans across all trimesters of pregnancy, the postnatal period and for consultation with our midwives, accounted for >16,000 ultrasound examinations in 2025 (see Table 1).

In addition to the scheduled workload, we provide a same day scan service for inpatients admitted to antenatal, postnatal and gynaecology wards and those attending outpatient and, satellite clinics as well as the emergency room, as required. This accounts for an average of 90 additional scans per week.

The outpatient gynaecology services are expanding with an associated increase in demand for ultrasound imaging. We have restructured our gynaecology ultrasound service to meet this increasing demand.

Other services provided in the fetal assessment unit include CTG monitoring, breech clinic, phlebotomy, assistance at invasive procedures, patient counselling, bereavement counselling, and liaising with external services. The team includes midwife sonographers, radiographers, health care assistants and administrative staff.

Teaching and education is an integral part of our work. The FAU continues to play an active role in teaching for UCD and RSCI undergraduates. We contribute to the clinical and theoretical components of the MSc and Professional Certificate Ultrasound Programmes in association with UCD. We sponsor one candidate on UCDs MSc Ultrasound Programme every year.

NCHDs, midwives and nurses were supervised undertaking early pregnancy, fetal biometry and ambulatory gynaecology professional certificates with 11 staff commencing training this year. We also coordinate a successful NMH Point-of-care Ultrasound Course for midwives working in the outpatient and community midwifery teams.

Heather Hughes
Ultrasound & Outpatient Services CMM3

Table 1: Unit workload in 2025 (n= 28,440 attendances)

Fetal Assessment Unit: Midwife & Radiographer-led Services attended	Description	Total 28,440
Obstetric Ultrasound Examinations appointments	Reassurance scans in the first trimester for previous history, dating, fetal anatomy, growth and fetal wellbeing scans, Doppler's, placental location, fetal presentation and post-dates.	**16,660**
Early Pregnancy Assessment appointments	Ultrasound scans, serial HCG monitoring, virtual telemed appointments.	**4,928**
Fetal medicine unit appointments	Consultant fetal medicine led scans including fetal echo, fetal medicine procedures and joint fetal med/neonatal consultations.	**4,612**
Gynaecology Ultrasound Examinations appointments	Diagnostic workup for gynaecology outpatients and inpatients, recurrent miscarriage clinic patients, pre-conceptual counselling for high-risk obstetric patients, and patients with postnatal morbidity.	**1,136**
Fetal Medicine Midwives Clinic appointments	Care of women with a diagnosis of a fetal abnormality/complex pregnancy, memory making, counselling, coordinating care for high-risk fetal medicine patients, follow-up post termination of pregnancy and supportive care in a subsequent pregnancy. Screening ultrasound appointments for previous history and medical conditions.	**661**
Counselling for Fetal medicine patients appointments	Therapeutic care for women with recent diagnosis of fetal anomaly and those who have termination of pregnancy for fetal anomalies.	**443**

Fetal Medicine

The Fetal Medicine Department at the NMH provides care for those pregnancies at high risk for fetal complications. This includes diagnosis, counselling and management of pregnancies complicated by fetal abnormalities, disorders of intrauterine growth, and pregnancies affected by fetal infection or maternal antibodies. It also includes the screening and management of pregnancies at risk for fetal disorders due to a background history, such as prior pregnancy complications, or known or suspected genetic predispositions.

The service is provided by 8 sub-specialists in Maternal and Fetal Medicine and 3 Clinical Midwife Specialists in Fetal Medicine. In 2025 there were 12 dedicated Fetal Medicine sessions attended by a fetal medicine specialist weekly; as a result, patients can be seen within 1-2 working days of referral as required and we are delighted to receive referrals from every obstetric department in the country.

Our specialised fetal medicine midwives are a key part of the multidisciplinary team (MDT) involved in the patient pathway, and work in partnership with the fetal medicine consultants to co-ordinate care for the patients. They are often the direct contact provided to the patients with complex pregnancies where the fetus has a confirmed or suspected disorder. They are involved in pre and post assessment counselling, assist at fetal procedures, and are key co-ordinators of the patient pathway, particularly where liaison with bereavement and loss services or termination of pregnancy for fetal anomaly options are appropriate.

Services provided by the Fetal Medicine MDT in 2025 included:

- High Risk Early Pregnancy Assessment
- Prenatal Screening
- Prenatal diagnosis including Amniocentesis, Chorion Villus Sampling, Cordocentesis
- Fetal echocardiography
- Paediatric Cardiology
- Fetal MRI
- Fetal Neurosurgery Service
- Antenatal Neonatology Consultations
- Perinatal Genetic and Genomics Service
- Fetal Therapy: Chest shunts / Fetal blood transfusion
- Management of complicated multiple pregnancy, including laser ablation for TTTS
- Placental insufficiency assessment
- Assessment of Placenta Accreta Spectrum disorders
- Fetal Medicine Therapy for psychological support for couples

In total in 2025, there were 385 fetal medicine clinics, with 3,009 appointments attended. In addition, there were 257 specialised fetal medicine midwifery clinics where a further 662 scans were performed. There were also 196 neonatology counselling appointments, and 35 paediatric cardiology clinics with 353 appointments.

The number of prenatal diagnostic procedures carried out was 169, with 55 CVS's and 114 amniocentesis performed. The majority of prenatal diagnostic testing was carried out when there was an ultrasound suspicion of an abnormality. Table 2 outlines the indications for amniocentesis/CVS over the past ten years and Table 3 outlines the various abnormalities detected by these procedures. In total 52 out of 169 (31%) of those undergoing diagnostic yielded abnormal results.

Table 4 outlines the ultrasound anomalies diagnosed using the RCOG/RCR classification for the last 10 years. There were a total of 364 abnormalities detected by ultrasound. In addition, there were 416 anomalies diagnosed on prenatal testing, many of whom had additional structural anomalies, giving a total of 419 congenital abnormalities for the year. The majority of diagnoses within the hospital population are made by midwife sonographers or radiographers and are usually seen within 24 hrs by a fetal medicine consultant where appropriate. We continue to see an increase in the number of external referrals and if these are deemed urgent they can usually be seen within 24 – 48 hours. There is a daily high risk clinic which is staffed by a consultant in which these patients can be seen. Where appropriate genetic testing, surgical, neonatal and genetic counselling is arranged pre-delivery and the patient usually attends the fetal medicine unit for the remainder of the pregnancy.

2025 was the seventh year since the Health (Regulation of Termination of Pregnancy) Act 2018 was passed into law and permitted access to abortion in Ireland. There were 17 patients seen at The National Maternity Hospital who met the criteria for FFA/LLC under Section 11 of the Act and underwent termination of pregnancy.

Whilst the absolute numbers are not large, the time and workload that each of these sensitive cases entails is considerable. There are often multiple visits involving screening, ultrasound diagnosis, discussion of diagnostic procedures, interpreting results, genetic or other specialist consultation, informing patient of results, neonatal input and consideration of options before further visits and their admission. Information is given in a clear balanced manner about their options and that they will be fully supported in whatever path they choose. Not all couples with FFA/LLC choose termination of pregnancy and these couples are followed up in the Fetal Medicine Unit with a care pathway outlined for the remainder of the pregnancy and delivery with appropriate psychological, bereavement and chaplaincy support. We also continue to care for at least as many women who receive a diagnosis of a condition that is likely to result in severe disability who choose to travel outside of the jurisdiction for termination of pregnancy. We are indebted to our Fetal Medicine Midwives, Barbara Cathcart, Lisa Hyland and Ella Connaughton, who coordinate all of the above in a very calm, sensitive and efficient manner. Dr Claire Flahavan, Perinatal Therapist, continues to offer a much needed and valuable support service for couples who find themselves in these very distressing situations with excellent patient feedback.

Our Perinatal Genetics team with Dr Sam Doyle, Consultant Clinical and Biochemical Geneticist are an integral part of the fetal medicine MDT. They provide pre and post pregnancy counselling in cases of confirmed or suspected hereditary genetic disorders and develop future pregnancy testing pathways.

Our weekly Perinatal Meeting co-ordinated by our Fetal Medicine Subspecialty training fellow continues to be an excellent forum for MDT discussion of fetal and neonatal cases.

This year our monthly Rhesus meeting continued in collaboration with Dr Joan Fitzgerald, Consultant Haematologist, and our colleagues at the Irish Blood Transfusion Service, to discuss all cases of red cell or platelet antibodies with the potential to cause fetal or neonatal anaemia or thrombocytopenia.

Fetal Cardiology Service

(Dr Siobhan Corcoran)

This service is delivered by Prof Colin McMahon, Paediatric/ Fetal Cardiology and Ms Cecelia Mulcahy, Fetal Medicine Midwife & Sonographer.

The diagnoses (table 6) pertain to any patient that was seen in the Fetal Cardiology Clinic that had a suspicion of congenital heart disease and delivered in 2025. There were 343 appointments with the service in total including many other cases that were scanned and reassured and discharged to local follow up. In 2025 we noted an increase in referrals for aortic arch anomalies and subtle ventricular disproportion, reflecting the increasingly detailed interrogation of the fetal cardiac anatomy at the anomaly scan on a national level.

- 55/79 cases were external referrals from peripheral units.
- 58/79 of the cases listed in this table were delivered in the NMH.
- 31/58 of these originated as external referrals from peripheral units.
- 4 patients underwent termination of pregnancy and the remainder mostly delivering by planned local delivery in their local maternity unit having had antenatal paediatric consultation in the NMH.

Table 6: Fetal cardiology diagnoses

Lesion	Cases
Atrial Ventricular Septal Defect AVSD	4
Aortic Stenosis (Critical)	2
Aortic stenosis (Mild)	1
Biventricular hypertrophy	2
Coarctation of the Aorta	1
Complex Heart Defect	3
Congenital Heart Block	2
Double Outlet Right Ventricle	5
Hypoplastic Left Heart Syndrome	5
Hypoplastic Right Heart Syndrome	1
Premature Atrial Contractions	5
Right Aortic arch/Double aortic arch/Vascular Ring	7
RV/LV disproportion	16
Supraventricular Tachycardia	1
Tetralogy of Fallot	5
Transposition of the Great Arteries	1
Tricuspid atresia/dysplasia/regurgitation or stenosis	4
Truncus Arteriosus	4
Ventricular Septal Defect	14
Total	**79**

Fetal Therapy Programme

(Prof Fionnuala McAuliffe)

Since 2010, the fetal therapy teams at the National Maternity Hospital, Dublin, and the Rotunda Hospital Dublin have jointly collaborated for the management of all cases of TTTS referred to either centre. This has resulted in a single team approach to cases, regardless of which of the two hospital locations such patients are seen. During 2025, a total of 15 cases of severe TTTS were managed by the Dublin Fetal Therapy Group by means of fetoscopic laser ablation of placental vessels. By the end of 2024, the group have treated 352 fetuses with laser surgery for severe TTTS, with at least one survivor occurring in 81% of pregnancies (144/176). These results are consistent with the results at the major international centres providing this advanced fetal therapy.

In 2025 NMH treated 6 cases with survival in 6/12 neonatal survivors. This approach to a complex but relatively rare fetal problem is an excellent example of a joint collaborative management strategy that successfully optimises care for these patients.

National Fetal Neurosurgery Programme

(Prof Fionnuala McAuliffe, Dr Clare O'Connor)

This unique national service receives referrals from all maternity hospitals.

There are weekly fetal neurosurgical clinics with Mr. Darach Crimmins, Mr John Caird, Ms Tafadzwa Mandiwanza, the Neurosurgery specialist nurses from Children's University Hospital, Temple St and our fetal medicine midwives. Cases are presented to a multidisciplinary team at our weekly perinatal meeting, with ultrasound and fetal MRI images presented and discussed. Following MDT the patients are seen and jointly counselled by the neurosurgery and fetal medicine teams. Women with pregnancies with fetal spina bifida are offered referral to Leuven Belgium to explore the option of fetal NTD repair, where appropriate.

Mr Crimmins, Mr Caird and Ms Tafadzwa request that all fetal cases in Ireland being referred to Leuven, Belgium for consideration for fetal spina bifida repair be referred to this clinic to facilitate appropriate counselling the postnatal care.

Dr Gabrielle Colleran and Dr Niamh Adams review the fetal MRI images and provide an excellent service.

In 2025, 33 individual cases were seen and assessed at the clinic, though a number of other cases were discussed at the fetal neurosurgery multidisciplinary meeting, without the patient being seen in clinic.

Details of cases seen in the joint clinic with one diagnosis per patient are: thirteen fetal spina bifida, two occipital encephalocele, eight ventriculomegaly, two cases of cerebral haemorrhage (cerebellar haemorrhage with NAIT and one intraventricular haemorrhage), one dandy walker spectrum, one dilated cisterna magna, one arachnoid cyst, one polymicrogyria, one rhomboencephalosynapsis, one semi lobar holosprosencephaly, one vein of Galen aneurysm.

This service is coordinated by Heather Hughes, Barbra Cathcart, Lisa Hyland and Ella Connaughton and Cecelia Mulcahy. The programme receives referrals from all over Ireland and is the only clinic of its kind in Ireland.

The workload of the unit remains busy in terms of both volume and complexity. The tables below summarise the level of activity over recent years. We continue to be recognised for full sub-specialty training in Maternal Fetal Medicine by the RCOG making this the only centre in Ireland for full training and this year Dr Fiona O'Toole completed her subspecialty training and was awarded her M.D.

In 2025 Valerie Spillane, CMM3 Ultrasound and Outpatient Services left NMH after 19 years. I would like to acknowledge the remarkable contribution Valerie made to our specialised fetal medicine service. Her expertise, and above all her calm, kind and thoughtful approach to patient care made a real difference to the families we support, often during very challenging times. Her mentorship built and strengthened our wonderful team. We wish her every success and happiness in her new role, mentoring our future midwife specialists. Congratulations to Heather Hughes, CMS in Fetal Medicine who was promoted to CMM 3 Ultrasound and Outpatient Services, and who has hit the ground running with clear vision and a deep commitment to patient care.

Finally Dr Siobhan Corcoran was appointed as the new Director of Fetal Medicine and will commence in the role from January 2026; I wish her every success in the role.

Publications from the Department are listed in the publications section in the NMH Annual Research Report 2025.

Prof Jennifer Walsh
Consultant Obstetrician & Gynaecologist
and Fetal Medicine Department Director

Laura & Mark Brennan with Heather Hughes.

Table 1: Prenatal Screening and invasive diagnostic procedures

	2021	2022	2023	2024	2025
Amniocentesis	126	93	127	115	114
Chorionic Villus Sampling	53	54	64	67	55

Table 2: Indication for Prenatal Diagnosis (Amniocentesis and CVS)

	2021	2022	2023	2024	2025
Maternal age	0	0	2	1	1
Abnormal fetal ultrasound	108	100	121	125	104
Positive screening test	37	21	35	31	23
Previous chromosomal abnormality/carrier of translocation	13	2	15	10	13
Previous non-chromosomal genetic syndrome	7	13	12	13	15
Miscellaneous	10	11	6	2	13
Total	**175**	**147**	**191**	**182**	**169**

Table 3: Abnormalities Detected by Prenatal Testing

	2021	2022	2023	2024	2025
Trisomy 21	31	22	36	26	25
Trisomy 18	16	25	20	17	15
Trisomy 13	8	2	5	6	3
Other aneuploidies	12	19	14	10	5
Non chromosomal genetic abnormality	1	8	4	2	4
Total	**68**	**76**	**79**	**61**	**52**

**not all genetic diagnoses complete at time of report additional results awaited*

Table 4: Abnormalities Detected based on RCOG/RCR classification

	2021	2022	2023	2024	2025
CNS (excluding choroids plexus cyst)	62	58	55	57	53
Head and Neck (including hygromata)	58	58	53	61	26
Cardiovascular system (excluding echogenic foci and untreated arrythmias)	79	66	66	67	91
Renal (excluding pelvic dilatation of <10mms)	46	45	61	61	60
Abdominal contents (including anterior abdominal wall defects and excluding echogenic bowel)	30	34	33	30	17
Skeletal	23	34	30	31	37
Thoracic (excluding cardiac abnormalities)	11	12	13	15	13
Others	34	15	34	32	67
Total	**343**	**322**	**345**	**358**	**364**

Table 5: Intrauterine Transfusions (IUT)

	2021	2022	2023	2024	2025
No. of patients requiring IUTs	2	4	2	4	3
No. of IUTs	2	9	3	6	5

Our Babies

This collage captures 22 of the 7,218 babies born in The National Maternity Hospital during 2025. Each photograph represents a unique family story, and we were privileged to support parents and babies during these important first moments together.

Georgie Deevy

Rian Maloney

Paidi Bergin

Celia Segura

Theo Roche with his big brother Rian (NMH baby 2021) and big sister Ava (NMH baby 2023)

Lucy Cox born in the NMH in 2014 holding her baby brother Taigen

Teidi O'Sullivan

Baby Mulcahy

Boston Baller

Remi Rigley

Henry Murphy

Bea O'Dywer

Theodore Kelly

Noah O'Connor

Noah Quill

Caroline Doyle

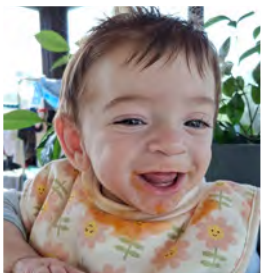
Beth Heavey

Thomas Byrne

Tadhg Toner

Tommy Walker

TJ Ryan



Ruairi Moran

Michael McGuinness with his baby sister Éireann

Gynaecology and Colposcopy

Ambulatory Gynaecology

The Ambulatory Gynaecology (AG) service at NMH continued to develop in 2025. Patients undergo assessment, investigations and treatment in 1-2 visits.

The service is led by Dr Venita Broderick. The clinical team includes Dr Zara Fonseca Kelly, Dr Nita Adnan, Dr Laoise O' Brien, Dr Helen Ryan, and Dr Mohammed El Sheik. Prof David Crosby and Dr Fiona Martyn run an AG service for those undergoing fertility investigations. Ms Niamh Murray is our candidate Advanced Nurse Practitioner (cANP). The AG service is supported by our gynaecology nursing team, healthcare assistants, administration team, ultrasonographers, radiologists and pathologists.

We provide a rapid access pathway for women presenting with postmenopausal bleeding. Key performance indicators are returned to the HSE on a quarterly basis. We treat women presenting with abnormal uterine bleeding, intrauterine polyps and fibroids. Other indications for referral include retrieval and insertion of intrauterine devices and fertility and miscarriage investigations and evacuation of retained products of conception.

We received an average of 150 referrals per month. 91% of patients seen were new patients. Over 50% of referrals were for postmenopausal bleeding. In addition to diagnostic and operative hysteroscopy, 860 biopsies were sent to the laboratory and almost 300 intrauterine contraceptive devices were inserted. 770 pelvic ultrasound examinations were performed by our ultrasonographer and radiology colleagues. Our DNA (Did Not Attend) rate was extremely low at 3% and 14% of women required a procedure under general anaesthetic.

As the ambulatory model of care represents a significant change in the traditional care pathway, we identified a need for a more dynamic way of informing women about their clinic visit. cANP Niamh Murray and I worked with the National Women and Infant's Health programme (NWHIP) to develop an animated patient video resource depicting the patient journey. This video resource was launched in May 2025. It is accessible through the NMH website. It is in use across all AG services in Ireland and is available in 12 languages. We received the Declan Meagher Medal for best innovation project at the 2025 RISE symposium at NMH.

The AG service at NMH received very positive feedback in the National Patient Experience Survery carried out during 2025. 98% of the patients surveyed said they would be happy to have their hysteroscopy performed as an outpatient again if needed. The AG video resource also received positive feedback.

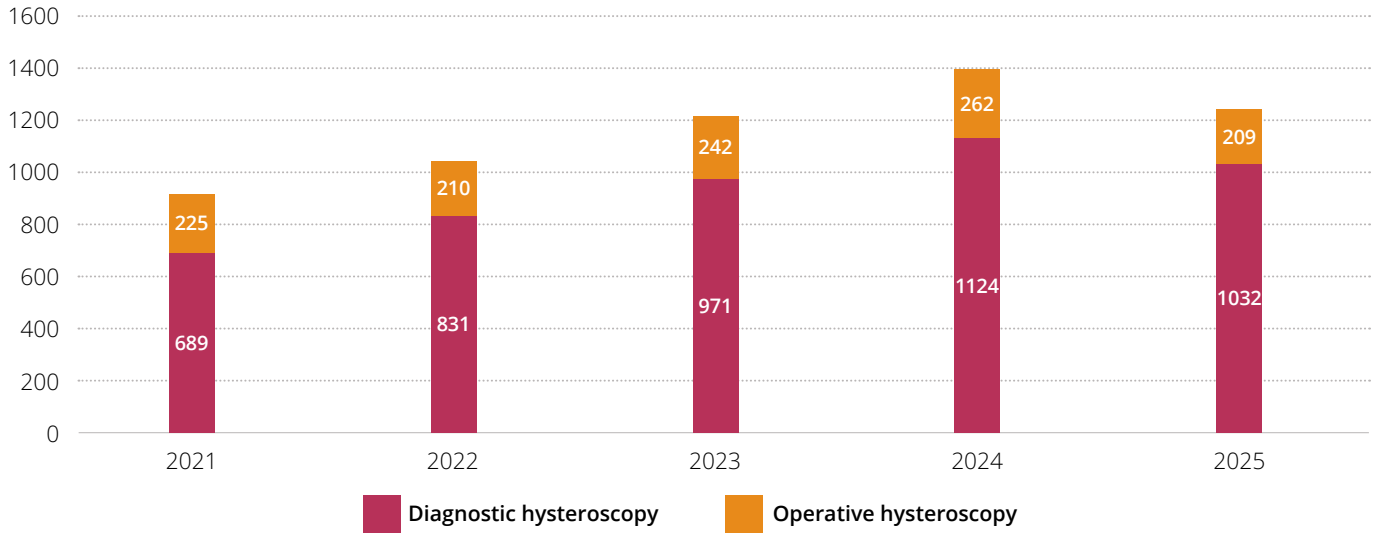
Work on the development of a purpose-built Ambulatory Gynaecology suite within the Hospital continued in 2025 and we anticipate this will be open in the first quarter of 2026. This will provide our patients with more modern and comfortable facilities including an accessible bathroom, changing facilities and a recovery area. This will lead to an enhanced patient experience and enable us to expand the service to include nurse-led clinics.

Dr Venita Broderick
Consultant Obstetrician & Gynaecologist

Table 1: Ambulatory Gynaecology Activity

	2021	2022	2023	2024	2025
Total no of referrals to ambulatory gynae	1134	1369	1752	1857	1823
Total no of patients attending hysteroscopy clinic	1007	1119	1346	1515	1406
Total outpatient hysteroscopy procedures	914	1041	1213	1386	1241
Diagnostic hysteroscopy	689	831	971	1124	1032
Operative hysteroscopy	225	210	242	262	209
Cases requiring general anaesthetic	9.5%	13%	12%	13%	14%

Figure 1: Ambulatory Gynaecology Activity



Dr Venita Broderick, Consultant Obstetrician and Gynaecologist, Niamh Murray Advanced Nurse Practitioner who were recipients of the Declan Meagher Innovation Medal for their presentation, "Development of a Video Animated Patient Information Resource for Ambulatory Gynaecology", pictured at Charter Day with William Johnson, Honorary Secretary.

Colposcopy

The Colposcopy Department at The National Maternity Hospital is recognised as one of the largest and highest-performing services in Ireland. Activity remained high in 2025, with a total of 6,821 patients seen or treated including 2,885 new referrals and 3,935 follow-up attendances.

The service is delivered by a multidisciplinary team comprising highly trained and accredited nurses and medical staff certified by the British Society for Colposcopy and Cervical Pathology (BSCCP), supported by healthcare assistants and administrative personnel. There are 13 colposcopy clinics weekly.

The number of referrals received and processed during the year was 3,103. Of the 2,885 new attendances, 786 were referred with low grade or normal cytology and HPV positivity. 281 were referred with high grade cytology and 255 were referred for clinical reasons (46 urgent clinical concern). The Suspicious Cervical Review Clinic has continued to facilitate the reduction in the number of women with clinical symptoms being referred to colposcopy, thus freeing up clinic slots for abnormal cytology.

Appointments are prioritised according to the severity of cytological abnormality, in line with the timeframes recommended by Cervical Check quality standards. In 2025, 100% of women with high-grade cytology were offered an appointment within the recommended four-week timeframe following receipt of referral. All women with low-grade or normal cytology with positive HPV were offered appointments within the recommended eight-week period. This represents a significant achievement and reflects the sustained efforts of the administrative team, supported by the introduction of three additional evening clinics delivered by Nurse Colposcopists.

The unit continues to maintain a low 'Did Not Attend' (DNA) rate, attributable to the proactive approach of the administrative team, including appointment reminders via letter and telephone contact prior to clinic attendance. This process requires considerable administrative input and remains essential in optimising clinic utilisation. The overall DNA rate for 2025 was 5.4%, representing an improvement from 6.9% in 2024, and remains well within the Cervical Check target of <10%. The DNA rate for new appointments was 3.5%, while for return appointments it was 6.5%.

Clinical activity within the unit remains high, as reflected by the 2,107 punch biopsies performed during the year. However, consistent with trends observed in recent years, the number of treatments undertaken continues to decline, with a total of 504 excision and 162 ablation treatments performed in 2025. This reduction likely reflects the positive impact of the HPV vaccination programme, with a corresponding decrease in the prevalence of significant cervical pathology among vaccinated cohorts.

This trend aligns with the World Health Organization's strategic objective of the elimination of cervical cancer.

In recent years, the introduction of more sensitive HPV testing within the Cervical Check programme has led to an increase in referrals of women aged over 50 years. This cohort presents particular diagnostic challenges. Cervical assessment in this population is frequently limited by anatomical and physiological changes. It is also increasingly recognised that a proportion of these women demonstrate persistent HPV positivity in the absence of identifiable cervical intraepithelial neoplasia. At present, there is no clearly defined exit pathway for this group, either from colposcopy follow-up or from enhanced screening protocols. Ongoing research aims to improve risk stratification in this population to better distinguish between low and high risk individuals. However, a definitive, evidence-based clinical management algorithm has yet to be established.

A dedicated multi-zonal HPV clinic was established to provide a comprehensive and integrated assessment of patients with complex HPV-related disease. This service enables systematic evaluation of the lower genital tract, including the cervix, vagina, and vulva, within a single clinical setting. The adoption of a standardised multi-zonal approach aligns with the recommendations of the British Society for Colposcopy and Cervical Pathology (BSCCP) and supports adherence to Cervical Check quality standards. This approach promotes

consistency in clinical examination, enhances diagnostic accuracy, and facilitates the detection of multifocal HPV-related disease. Furthermore, it supports improved clinical decision-making, streamlines patient pathways, and reduces the need for multiple attendances, thereby enhancing both service efficiency and patient experience.

Our histopathology team are vital to the efficient running of the service. Each punch biopsy and excision must be examined and reported. In addition, the histopathology department play an active and vital role within the multidisciplinary team (MDT) discussion of complex cases.

We also work closely with our colleagues in the Gynaecology Oncology Unit in St Vincent's hospital, where the cancer patients are referred for MDT discussion and treatment.

Clinico-pathological review meetings are held on a monthly basis, incorporating multidisciplinary review of cytology, colposcopy, and histology findings. These meetings continue to represent a valuable component of clinical governance and quality assurance within the service. In addition, quarterly quality assurance meetings are convened to evaluate operational performance and ensure compliance with Cervical Check standards.

Structured training remained a key focus throughout 2025. A new fellowship position was established during the year, delivered as a joint programme between the Sexual Assault Treatment Unit at the Rotunda Hospital and the Colposcopy Department at the Hospital. The fellow has made a significant contribution to the service, while also gaining valuable specialist training experience within the department.

Dr Kate Glennon
Consultant Obstetrician & Gynaecologist

Table 1: Colposcopy attendances

	2021	2022	2023	2024	2025
New attendances	2506	2864	3108	2916	2885
Return attendances	3842	4395	4384	4357	3936
Total attendances	**6348**	**7259**	**7492**	**7273**	**6821**

Table 2: Administrative standards cervical check

	NMH	Target
Proportion of patients referred with high grade smear seen within four weeks	100%	>90%
Proportion of patients referred with a low-grade smear seen within eight weeks	100%	>90%

Table 3: Treatments

	2021	2022	2023	2024	2025
LLETZ	654	754	700	627	504
Ablation	264	269	166	130	162
Knife Cone	17	15	5	7	4
Total	**941**	**1138**	**871**	**764**	**670**

Gynaecology Oncology

The gynaecological oncology service is based between St Vincent's University Hospital (SVUH) and The National Maternity Hospital (NMH) and is part of the UCD Gynaecological Oncology Group (UCD-GOG). This group, incorporating UCD, the Mater Misericordiae University Hospital (MMUH) and St Vincent's University Hospital is the largest Gynaecological Oncology Group in the country serving over two million people.

There were 182 new cancers diagnosed in 2025. This is an increase from 2024 (160 new cancers).The complexity of the cases remained high. The bed crisis continued to affect the health service in general and the use of the private hospital to provide much needed elective beds to public patients unfortunately came to an end. This means that unfortunately theatre lists are not fully utilised due to the lack of elective beds.

The Gynae Oncology team includes Sarah Belton, Advanced Nurse Practitioner and Sharon Glynn, Clinical Nurse Specialist. The nursing team deliver nurse led survivorship programmes at NMH and SVUH which is important in helping patients manage treatment induced side effects of their cancer care, as well as delivering high quality care from diagnosis to surgery or other treatment modality.

The Gynae Oncology nursing team are involved in several projects to improve patient information and nursing education, nationally and internationally. The National Cancer Control Programme recently launched a 'Patient Passport' for ovarian cancer, with input from specialist nurses from around Ireland, and are currently developing a similar document for cervical cancer. As co-chair of the Nursing Education Board of the IGCS, Sarah was involved in the first online Nursing Symposium, held in September, which covered topics such as Menopause, Fertility Preservation and different nursing roles globally.

Treatment Services

Almost all major surgery is now carried out at SVUH and diagnostic surgeries are carried out at NMH. Radiotherapy is provided mainly at St Luke's Hospital as well as SVUH. Medical oncology services are provided at SVUH. A limited number of patients who are suitable for peritonectomy and HIPEC (heated intraperitoneal chemotherapy) are treated in the Mater Hospital. The UCD-GO group delivers the largest publicly funded robotic surgery program in Ireland.

Multidisciplinary Structure

Every woman with a new diagnosis of gynaecological cancer is discussed at a multidisciplinary team (MDT) meeting. There were 26 MDT meetings in 2025 at which 570 women were discussed. This is an increase from 2024, reflecting the increasing complexity of the cases.

Results

Endometrial cancer remains our most common cancer and 89 (increase from 70 in 2024) patients were treated during the year. The vast majority by minimally invasive surgery. The DaVinci robot system and the expertise of Mr Ruaidhri McVey and Dr Michael Wilkinson have really helped treat the patients with higher BMIs.

Unfortunately, ovarian cancer continues to be the biggest challenge for the unit. The numbers continue to rise with 55 people diagnosed this year. Patients need a MDT approach and we get great support from Dr McSorley and Dr Fennelly and the medical oncology team in SVUH.

Cervical cancer was diagnosed in 25 women and 13 cases of new primary malignant vulval cancer were diagnosed in 2023.

There were 20 cancer recurrences detected and treated during 2025 and their sites are listed below.

***Dr Donal O'Brien,* Consultant Obstetrician & Gynaecologist and *Sarah Belton,* ANP Gynae Oncology**

Table 1: New Cancer Diagnosis by Cancer Specialty

	Borderline	Primary	Synchronous	Total
Endometrium	0	87	2	89
Ovary	19	36	0	55
Cervix	0	25	0	25
Vulva/Vagina	0	13	0	13
Total	**19**	**161**	**2**	**182**

Table 2: Recurrent Cancer Diagnosis by Cancer Specialty

	Recurrence	Second Recurrence	Total
Endometrium	6	1	7
Ovary	7	2	9
Cervix	1	0	1
Vulva/Vagina	3	0	3
Total	**17**	**3**	**20**

Some Gynaecology Ward Staff.

Gynaecology Outpatient Clinics

The Gynaecology Outpatient Department provides an extensive range of general and specialised gynaecology services including benign gynaecology care, urogynaecology, fertility, complex menopause, premature ovarian insufficiency, adolescent care, oncology, rapid access menorrhagia, perineal, transgender services, colposcopy, hysteroscopy, recurrent miscarriage and pessary clinic.

The National Maternity Hospital as the Central Referral Office (CRO) for all benign gynaecology referrals in the Dublin and the South East region, currently oversees the initial management and coordination of all benign gynaecology referrals across The National Maternity Hospital, St. Vincent's University Hospital and St. Michael's Hospital. The benefits include a more streamlined pathway for patients, reduction in referral duplication, equity in appointment scheduling and reduced DNA rates. The primary aim is to ensure right care, right place, and right time – first time.

With our key objectives in 2025 focusing on improving access to care, the CRO has played an integral role. This CRO has resulted in an increase in the number of new gynaecological referrals received in 2025. To meet this demand a total of 11,099 patients were scheduled to attend the gynaecology clinic in 2025, this included 4,641 new patient appointments. The number of scheduled virtual appointments equated to 23% of all Gynaecology Outpatient Clinic Appointments, continuing an upward trend of offering greater convenience to patients' while enhancing operational efficiency. A total of 971 outpatient appointments were lost to those who 'Did Not Attend' (DNA) in 2025, 198 less than that lost in 2024. The number of new patient DNAs equated to 4.3% which is well below the National Outpatient Protocol KPI set at 10%.

Two new rapid access clinics were established in 2025 to increase capacity for new patients requiring urgent gynaecological assessment. Funding was also secured via the HSE Access and Integration programme to run additional weekend clinics aimed at further reducing patient waiting times.

Funding was also secured via the HSE Access and Integration programme to run additional Ambulatory Gynaecology - Hysteroscopy sessions in the form of 'Sunday Blitz' to improve KPIs for Post-menopausal Bleeding. Work continues on the new Ambulatory Gynaecology Suite with completion planned in 2026. This new suite should further increase access to service and also provide an enhanced patient environment.

An additional Urogynaecology clinic commenced in September 2025 and as a result of this, towards the end of the year, waiting time for Urogynae appointments had decreased from 18 to 13 months.

The Fertility Hub continues to provide investigations and specialist care for couples seeking fertility support. Nurse led virtual history clinics have resulted in a reduction in time needed for in person appointments thereby increasing capacity.

Key Performance Indicators in line with Slainte Care Waiting Time Action Plan (29/12/2025)

- 90% waiting < 12 months for first appointment: NMH 96.5%
- 50% waiting < 10 weeks for first appointment: NMH 38.7%
- Average weighted wait time < 5.5 months: NMH 4.7 months

Helen Thompson CMM3
Gynaecology Outpatient Services & Emergency Room

Paediatric & Adolescent Gynaecology

At the Paediatric and Adolescent Gynaecology (PAG) service at The National Maternity Hospital we see young women aged 12-18. The service represents one of a few specialist PAG clinics in Ireland.

Referrals are accepted from general practitioners and hospital consultants throughout our health region and beyond and from Children's Health Ireland (CHI).The majority of referrals are for menstrual problems. Other common reasons for referral include pelvic pain and ovarian cysts. We have noticed a significant increase in referrals for suspected endometriosis.

Many of the young girls attending the Adolescent Gynaecology clinics, and especially those with congenital anomalies, have complex needs. The impact of these diagnoses both on the adolescent and their families is significant. These patients require frequent appointments and multidisciplinary care. Virtual appointments are offered where appropriate. The DNA rate for the clinic was low at 7.5% thanks to the dedication of the admin team.

We work closely with paediatric and adult medicine colleagues in radiology, endocrinology, haematology, genetics and other specialties.

We provide continuity of specialist care for women diagnosed with complex congenital conditions e.g. Müllerian anomalies and premature ovarian insufficiency.

A nutrition and dietetics clinic for adolescents runs alongside our PAG clinic where a one stop service is provided.

We work closely with The Merrion Fertility Clinic in relation to fertility preservation for young people at risk of premature ovarian insufficiency, who are assessed in the clinic and offered fertility preservation where appropriate.

Dr Venita Broderick
Consultant Obstetrician & Gynaecologist

Table 1: Clinic Attendances Aged <18 yrs

Clinic attendances	New Patients	Return Patients	Virtual Appointments	Total
2025	176	155	85	416
2024	223	95	111	429
2023	119	87	114	330
2022	196	130	112	438
2021	171	89	95	309

Table 2: Total Clinic Numbers

Clinic attendances	New Patients	Return Patients	Virtual Appointments	Total
2025	244	315	189	748
2024	344	312	251	916
2023	320	295	246	861
2022	358	299	198	855
2021	427	316	236	979

Urogynaecology

Demand for urogynaecology appointments and procedures continued to grow during 2025. This trend is likely to continue for a number of reasons; the ageing demographic of our population, the increased participation in exercise and the increased awareness among women that effective treatment is available. Thankfully, women are less reluctant to present with these symptoms than previous generations and they are also sharing their experiences among their social circles and through online platforms.

The ongoing 'Pause' in the use of the mid urethral sling procedure for the treatment of stress urinary incontinence in Ireland continues to pose a major challenge to service delivery. This procedure has very robust evidence, accumulated over many years, to support its role as a highly effective treatment with low levels of complications. The employment of mesh in other areas of vaginal surgery, specifically prolapse surgery, was found to result in higher levels of complications in these patients. As these findings emerged, caution was advised regarding the use of vaginal mesh for prolapse surgery. However, UK and Irish authorities took the decision to 'Pause' the use of all vaginal mesh products, including the highly effective and extensively studied Mid Urethral Slings for Stress Urinary Incontinence.

This 'Pause' has impacted our service in several ways; firstly, new service development was required. We established two national centres to manage patients suspected of having a complication related to vaginal mesh surgery. One at The National Maternity Hospital and the other in Cork University Maternity Hospital. Understandably, the announcement of the 'Pause' caused a great deal of anxiety for patients who had undergone these procedures. The priority was, and is, to review and manage these patients as promptly and as thoroughly as possible. This led to the founding of the two national centres, the establishment of multidisciplinary teams and additional services such as translabial scanning. These services have taken years to evolve as we worked to develop the necessary expertise through forging new cross hospital links and in house recruitment. The addition of Professor Kirk Levins, Consultant Pain Specialist, to The National Maternity Hospital team being a case in point.

Secondly, in addition to new service development, patients affected by complications or concerns regarding mesh procedures required considerable input from our existing services. Time had to be provided for multiple lengthy consultations with one of the lead consultants in the clinic. Women's Health Physiotherapy, Urodynamic investigations and Surgical Theatre sessions had to be allocated to this patient group. While an extremely worthwhile and necessary undertaking, this very significant commitment of limited resources has impacted on our ability to see other 'non-mesh' patients with pressing urogynaecological problems.

Thirdly, the mid urethral sling is a highly effective treatment with subjective cure rates reported at 92%. Having to rely on alternative treatments with lower subjective cure rates means that each patient with stress urinary incontinence requires a significantly increased number of consultations and treatments in an effort to achieve what the patient perceives as a satisfactory result. This all inevitably has a knock-on effect for those waiting to access care. Many women are frustrated that they are being denied the right to choose a mid-urethral sling procedure. This is especially frustrating for those who have observed family members successfully and safely treated with this procedure in the past.

We are seeing increasing numbers of women travelling outside the jurisdiction to access care. This is being done either through the Government's Treatment Abroad Scheme or through their private insurers.

While women are travelling overseas to access the surgical procedure, we are still supporting them with pre and post-operative care and investigations in our unit.

Moving forward, the Urogynaecology service has seen increased efficiency in scheduling appointments and we look to improve this further by pooling urogynaecology appointments and procedures among the specialist team. Improvements to the service saw the number of in person consultations increase again this year while also adding 230 virtual consultations, despite the challenges mentioned earlier.

A locum Consultant Urogynaecologist (locum) has expanded his role in the Pelvic Floor Centre at St. Michael's Hospital and we have been fortunate to have a Urogynaecology fellow for the last two years who has been crucial in developing our expertise in translabial scanning, organising the multidisciplinary team meetings and establishing new clinical relationships with our colleagues in Northern Ireland.

Looking forward to 2026, we hope to expand our capacity in outpatient cystoscopic procedures, to appoint a third permanent Consultant Urogynaecologist and welcome a new Urogynaecology fellow.

Since the Urogynaecology mesh complications service commenced in 2018, a total of 219 patients have been seen and by the end of 2025, 120 were discharged from the service.

Dr Gerry Agnew
Consultant Urogynaecologist

Table 1:Clinic Activity

	2021	2022	2023	2024	2025
Consultant Led					
New	700	656	444	555	452
Return	817	896	1001	947	1075
Total Attendances (in-person)	**1517**	**1552**	**1445**	**1502**	**1527**
DNA Rate	*12%*	*11%*	*11%*	*14%*	*10%*
Virtual	-	-	-	-	230
Advanced Midwifery Practitioner (AMP) Led					
Total Attendances	**161**	**159**	**152**	**181**	**218**
DNA Rate	*14%*	*9%*	*13%*	*6%*	*6%*
Urodynamics Performed	143	207	166	160	165
Flow Studies	36	22	26	35	25
Self-Catheterisation	10	12	9	11	11
Nurse Led Urogynaecology Referrals Source					
Consultant NMH	142	205	204	203	218
Consultant Elsewhere	1	2	0	3	-
Total Referrals	**143**	**207**	**204**	**206**	**218**
Nurse Led Urodynamics Diagnosis					
Normal Urodynamic Studies	27	19	37	34	34
Urodynamic Stress Incontinence	43	88	65	51	67
Mixed Incontinence	16	36	36	48	33
Hypersensitive Bladder	1	1	0	0	0
Overactive Bladder	0	50	23	15	23
Voiding Disorder	0	2	0	2	1
UTI No UDS – MSU Taken	0	1	5	7	2
Other	8	10	0	3	5
Total Diagnosis	**95**	**207**	**166**	**160**	**165**

Table 2: Mesh Outpatient Clinic Activity

New	25
Follow Up/Post Op/Telemed	73

Table 3: Suspected Mesh Complication Procedures 2025

Translabial Scan	15
EUA/ Cystoscopy/ Mesh Excision/Revision	15
EUA/ Cystoscopy	9
Cystoscopy/ Botox	4
EUA/ Cystoscopy/ Urethral Dilation	1
Anterior / Posterior Repair	1
Total	**45**

Table 4: Surgical Procedures

Procedure	No.
Anterior repair	46
Posterior repair	53
Combined anterior and posterior vaginal repair	27
Vaginal hysterectomy	33
Vault prolapse repair-vaginal	8
Sacrocolpopexy	1
Manchester repair	1
Colpocleisis	1
Fenton's procedure	6
Laparoscopic anterior paravaginal repair	1
Burch colposuspension-laparoscopy	1
Pubovaginal fascia sling	8
Injection of urethral bulking agent	60
Cystoscopy and Botox injection therapy	62
Cystoscopy	122
Labial reduction	3
Removal of Mesh exposure	15
Removal of pessary from vagina	2
Total	**450**

Dr Eve Gaughan, SHO and Dr Barbara Guerrini, Registrar, in Theatre.

Other Clinical Services

Anaesthesia, Pain Medicine and High Dependency Care

The Anaesthetics Department provides comprehensive anaesthetic and pain management services for obstetric and gynaecological patients. The department strives to ensure that every patient receives safe, compassionate, and evidence-based anaesthetic care—ranging from pain relief during labour, to anaesthesia for theatre births, fertility treatment and gynaecological procedures in theatre. The team also supports emergency resuscitation and critical care for women who require it.

Our philosophy centres around three core principles: safety, individualized care, and continuous improvement. We strive to enhance maternal satisfaction while minimizing anaesthetic-related morbidity through rigorous standards, continuous education, and innovation in clinical practice.

Key Outcomes and Performance

In 2025, the department adapted to an increased procedural workload driven by a higher birth rate, a growing number of high-risk patients, higher caesarean section rate and expanding surgical services.

Theatre Activity

There were 6,240 procedures carried out in theatre in 2025. This is a 5% increase on the figure of 5,939 for 2024. 2,704 of these procedures were Caesarean sections. This is 6.28% increase on the figure of 2,544 from 2024.

We provide anaesthesia for large numbers of patients undergoing major and minor gynaecological procedures. In 2025 approximately 3,000 of our theatre patients were gynaecology patients. The most common procedures performed under general anaesthesia include hysteroscopy with dilatation and curettage, laparoscopic hysterectomy and laparoscopic ovarian cystectomy.

Analgesia for Labour and Delivery

A wide range of multi-modal labour analgesic options were utilised by women including both non-pharmacologic (relaxation therapy, aromatherapy, TENS, birthing pool) and pharmacologic methods (nitrous oxide inhalation, intramuscular opioids and neuraxial techniques). Intravenous remifentanil patient controlled analgesia (PCA) during labour was also offered for patients with contraindications to neuraxial blockade, and those who preferred it over an invasive procedure such as an epidural; 11 women used this analgesic option in 2025 which is an increase on the number of 8 from 2024.

Jyothis Thomas and Lenna Dsouza Staff Nurses Gynaecology Ward, Margaret Keane and Deirdre Roche Administrators, with Anne Lopez, CNM2 Gynaecology Ward.

Epidural Rate

There was a total of 3,818 epidurals which represents an 8% increase on the 2024 figure (see Table 2). Subtracting the number of mothers who had a 'pre-labour' caesarean section (1,763) from total delivered (7,096), gives us the closest approximation of mothers who had intention of labour and thus potentially had an opportunity to request epidural analgesia.

Table 3 below shows epidural rates according to Robson Ten Groups Classification of Caesarean Section. While the overall epidural rate for total births was 53.8%, this includes many women who had a pre-labour caesarean section as discussed above. Unsurprisingly, rates of epidural utilisation are highest amongst nulliparous women, especially those who require labour induction (84.6%). Rates of epidural utilisation are similarly high amongst multiparous women who require labour induction (74.6%). Overall epidural rates according to onset of labour are shown in Table 4.

Post Dural Puncture Headaches (PDPH) and Epidural Blood Patches

There were 23 patients requiring epidural blood patches in 2025. Five of these were following spinal anaesthesia and 18 were following epidural placement, 6 of which were related to intrathecal catheters. Three patients required a repeat epidural blood patch. Not all patients who had accidental dural puncture developed PDPH. Not all patients who had PDPH required an epidural blood patch. All patients who developed a PDPH were followed up postpartum.

Anaesthesia for Caesarean Section

1,277 caesarean sections (approximately 47% of total) were elective, which is a similar breakdown compared to 2024. The most common anaesthetic administered for caesarean section is spinal anaesthesia (accounts for 72.8% of all anaesthetics), followed by anaesthesia by epidural top-up/ extension (23.3%). A minority of patients require a general anaesthetic at some time-point during their caesarean section.

General Anaesthesia for Caesarean Section

An annual audit of our general anaesthesia (GA) for caesarean section cases revealed that 77 women required a GA at some point during their caesarean section, giving an overall rate of 2.8%. This is within international recommendations and is a reduction compared to 2024 data (3.8%). Breakdown by elective and emergency cases is shown below.

Pain during Caesarean Section Audit

A total of 77 women reported pain during their caesarean section, representing an overall incidence of 2.8%. This incidence is similar to previous years. It is important to note that more than 1/3 of this reported pain was pain not related to the incision/anatomy directly involved in surgery e.g. shoulder-tip pain. Reported pain according to elective and emergency cases is shown below. Overall, 26% (20/77) of patients reporting pain required a general anaesthetic.

Summary of Achievements

- In June our department collaborated with the antenatal education department to ensure an anaesthetist is now supporting and answering questions at each caesarean section preparation class for women attending the Hospital. This initiative has been warmly received, with 100% of polled women saying the talk aided in psychologically preparing them for caesarean section and understanding what sensations they are likely to experience during surgery.
- A new post-partum neuropathy guideline, led by Dr Ingrid Browne, and in conjunction with the departments of physiotherapy, obstetrics and neurology at St Vincent's university hospital, has been introduced.
- Sustainability Advances:
  - In 2025 the department of anaesthesia led the charge to decommission piped N2O into theatres. We transitioned to a cylinder based N2O delivery system. This will drastically decrease N2O leakages, and the amount of N2O that needs to be discharged due to going out of date.
  - We stripped back our custom epidural packs to the minimum equipment required, in an effort to minimise production costs, and eradicate unused components being wasted.
- The cell saver was employed for 191 theatre cases in 2025. 48 successful autologous blood transfusions resulted. This service is predominantly nurse/midwife led and has benefits for both patients and the Hospital.
- The anaesthesia section of the NMH website has been reviewed to ensure it is more user-friendly and easier to navigate. Social media posts with patient centred anaesthesia information have also been uploaded.

Staff Highlights and Achievements

Professional Achievements and Personal Highlights

Dr Larry Crowley continues as honorary secretary of the Irish Society of Obstetric Anaesthesia (ISOA)

Postpartum Anaesthesia Review

We perform the postpartum anaesthesia ward round daily, with the intention to review every single postnatal patient who had an anaesthetic intervention. We use this opportunity to ensure each woman experienced high quality anaesthesia care and to arrange appropriate follow up, should it be required. In 2025 we reviewed 5,442 women on the postnatal wards after having an anaesthetic intervention to facilitate their deliveries.

High Dependency Unit (HDU)

There were 160 instances of patients requiring admission to the HDU in 2025. This is an 8% decrease compared to 2024. The most common reasons for HDU admission were haemorrhage, hypertensive disease of pregnancy and sepsis.

There were 5 patients transferred from our unit to a tertiary referral general hospital for further specialist care. This figure included 3 patients for level 2 or 3 care and two patients for specialist medical/surgical team consultation. In addition, there were a number of patients transferred for radiological imaging.

Outpatient Clinics

The anaesthesia high risk clinic is held bi-weekly; in this clinic we see antenatal patients with complex medical issues, or previous anaesthesia complications referred to us by our obstetric or midwifery colleagues. We also see postnatal patients who have had unanticipated general anaesthesia to facilitate delivery, failed neuraxial techniques, or complications such a dural puncture headaches. In 2025 a total of 495 women attended these clinics. A further 38 women who required multi-disciplinary (MDT) input were reviewed in one of our MDT clinics. Some of these patients were also presented for discussion at one of our weekly maternal medicine MDT meetings.

Pre-Assessment Clinic

The pre-assessment clinic (PAC) endeavours to pre-operatively assess all gynaecological patients requiring general or regional anaesthesia. It is a nurse-led clinic with strong anaesthesia support. The team consists of CNM2 Niamh Carney, CNM2 Carmel Breen, administration support person Ciara Luckie, and anaesthesia lead Dr Nikki Higgins. See the dedicated summary of the clinic's activity for 2025 in a further section of this report.

Pain Medicine Service

The pain medicine service continued to welcome multidisciplinary referrals from within house, from consultant obstetric and anaesthetic colleagues, physiotherapists, midwives and from primary care physicians in the community. 83 invasive interventions in the form of local anaesthetic, local anaesthetic and steroid injection and radiofrequency neuromodulation were provided by Dr Kirk Levins in the operating theatre. This figure is up 18.5% on the 2024 figure.

2026

We will introduce an Enhanced Recovery After Caesarean (ERAC) programme. Full integration of ERAC pathways into the routine recovery plans for women delivering by caesarean section will improve maternal satisfaction and comfort and reduce fasting times.

Data collated from MN-CMS, Theatre Database & Audit Projects.

Dr Nikki Higgins
Consultant Anaesthesiologist
With special thanks to
Dr Rob Ffrench O'Carroll

Table 1: Key Performance Indicators (KPIs) – 2025

Indicator	2024 Results	2025 Results	Change
Total births	6598	7096	+7.5%
Regional analgesia for labour	3533	3818	+8.1%
General anaesthesia for caesarean section	100	77	-23.0%
Dural punctures requiring epidural blood patch*	14	23*	+64.3%
Patients requiring transfer to another hospital for specialist care	8	5	-37-5%
High dependency unit admissions	174	160	-8.0%

**3 of these patients required a repeat blood patch*

Table 2: Total Epidural Rates

	Total Delivered	Epidural	Pre-labour C-Section	Rate %
Total	7096	3818	1763	71.6% (3818/5333)

Table 3: Robson Ten Groups Classification Epidural Rates

	Epidural No.	Number of Delivery / Births	Size of Group %	Epidural rate in grp %	Contr of each grp %
1. Nulliparous, single cephalic, >=37 weeks, in spontaneous labour	750	962	13.6%	78.0%	10.6%
2. Nulliparous, single cephalic, >=37 weeks, induced and CS before labour	1494	2059	29.0%	72.6%	21.1%
2a. Induced labour	*1490*	*1762*	*24.8%*	*84.6%*	*21.0%*
2b. Pre-labour C-Section	*4*	*297*	*4.2%*	*1.3%*	*0.1%*
3. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, in spontaneous labour	488	1079	15.2%	45.2%	6.9%
4. Multiparous (excluding prev. CS), single cephalic, >=37 weeks, induced and CS before labour *	791	1153	16.2%	68.6%	11.1%
4a. Induced labour	*790*	*1059*	*14.9%*	*74.6%*	*11.1%*
4b. Pre-labour C-Section	*1*	*94*	*1.3%*	*1.1%*	*0.0%*
5. Previous CS, single cephalic, >= 37 weeks	128	1027	14.5%	12.5%	1.8%
6. All nulliparous breeches	5	175	2.5%	2.9%	0.1%
7. All multiparous breeches (including prev. CS)	5	117	1.6%	4.3%	0.1%
8. All multiple pregnancies (including prev. CS)	24	108	1.5%	22.2%	0.3%
9. All abnormal lies (including prev. CS)	0	37	0.5%	0.0%	0.0%
10. All single cephalic,<=36 weeks (including prev. CS)	133	379	5.3%	35.1%	1.9%
Total	**3818**	**7096**		**53.8%**	**53.8%**

Table 4: Epidural Rate by Onset to Delivery

	Epidural No.	Number of Delivery /Births	Epidural rate
Induced labour	2372	2950	80.4%
Pre labour c-section	26	1763	1.5%
Spontaneous labour	1420	2383	59.6%
Total	**3818**	**7096**	**53.8%**

Table 5: Mode of Delivery after Epidural Analgesia

	Nullip (%)	Multip (%)	Total (%)
Spontaneous Vaginal Delivery	1052 (44.9%)	1276 (86.6%)	2328 (61.0%)
Vaginal Operative Delivery	669 (28.5%)	100 (6.8%)	769 (20.1%)
Caesarean Section	623 (26.6%)	98 (6.6%)	721 (18.9%)
Total	**2344**	**1474**	**3818**

Table 6: Specific Epidural Rates

Total Rate of Epidural Blood Patches for Epidurals	0.57% or 1 in 177 patients
Total Rate of Epidural Blood Patches for Spinals	0.25% or 1 in 397 patients

Table 7: Mode of Anaesthesia for Caesarean Section on MN-CMS

	All C-Sections	Elective	Emergency
Spinal	1969 (72.8%)	1245 (97.5%)	724 (50.7%)
Epidural	631 (23.3%)	4 (0.3%)	627 (44.0%)
General	77 (2.8%)	13 (1.02%)	64 (4.5%)
Combined Spinal/Epidural	14 (0.5%)	10 (0.8%)	4 (0.3%)
Not recorded	13 (0.5%)	5 (0.4%)	8 (0.6%)
Total	**2704**	**1277**	**1427**

Table 8: Caesarean Section cases requiring General Anaesthesia

	All C-Sections	Elective	Emergency
Overall	77 (2.8%)	13 (1.0%)	64 (4.5%)
Primary GA	34 (1.3%)	3 (0.2%)	31 (2.2%)
Neuraxial to GA Conversion	43 (1.6%)	10 (0.8%)	33 (2.3%)

Table 9: Pain During Caesarean Section: Elective vs. Emergency

	All C-Sections	Elective	Emergency
Overall	77 (2.8%)	25 (2.0%)	52 (3.6%)

Jerome Tanega, Staff Nurse Theatre.

Emergency Room

The Emergency Room (ER) provides a dedicated in person and telephone triage service 24 hrs a day for women requiring urgent pregnancy and gynaecological care. Patients present with a range of conditions during pregnancy including early pregnancy bleeding, pain, hyperemesis, reduced fetal movements, hypertension, and postnatal complications such as suspected infection.

Gynaecological presentations include pelvic pain, abnormal vaginal bleeding, vaginal discharge, ovarian cysts and prolapse. The ER also accepts benign gynaecological transfers from St. Vincent's University Hospital and St Michaels Hospital.

The ER experienced an unprecedented increase in demand during 2025. A total of 14,167 patients attended the ER in 2025 ranging from 12 to 99 years of age. This represents a 13% increase from the previous year; 10,810 antenatal, 2,125 postnatal and 1,232 gynaecological patients attended. This increase is attributed in part to the rising number of postnatal attendances, a 28% increase from 2024.

It is hoped the establishment of the new postnatal hubs in 2026 may help reduce this number. In addition to patient attendances there are a large number of telephone calls that are triaged on a daily basis.

The Emergency Room also supports the Early Pregnancy Assessment Unit at weekends and bank holidays, providing HCG blood tests and follow up, to determine outcomes for patients with potential complications in early pregnancy.

Staff continue to deliver dedicated care for patients in a timely and supportive manner with 81% of patients having a length of stay in the ER of under 4 hours.

Patient care is provided by experienced Clinical Midwife Managers, Midwives, Healthcare Assistants and NCHDs and the service is overseen by a Consultant Obstetrician and Gynaecologist. A number of midwifery staff are qualified in ultrasound scanning and registered as midwife prescribers.

Helen Thompson CMM3
Gynaecology Outpatient Services/Emergency Room

Amanda Murphy, Healthcare Assistant.

Pathology and Laboratory Medicine

The laboratory service covers the scope of Pathology and Laboratory Medicine with Biochemistry, Blood Transfusion, Haematology, Histology and Microbiology laboratories. The service is provided 24/7 in line with clinical need. A microbiology service is provided for the Royal Victoria Eye and Ear Hospital. Alongside in-house testing, the Department manages specimens referred to external reference laboratories. There was significant recruitment activity across the Department during the year.

2025 was the busiest year on record in the laboratory. There were 214,791 sample requests, a 7% increase on 2024, across 34,967 individual patients, See Figure 1: Laboratory Requests Summary 2021 to 2025

The laboratory retained its ISO 15189 accreditation in 2025. The project to design, build, implement and test the new upgraded WinPath Laboratory Information System began in January 2025.

Laboratory activity continues to increase each year, placing greater pressure on staffing, laboratory space and systems. Recruitment remains challenging due to the national shortage of Medical Scientists. Maintaining competency for the multidisciplinary on-call service, staffed by two Medical Scientists each day, also requires ongoing training, particularly with flexible work rosters. The existing LIS has required a disproportionate level of staff time to maintain; while the planned upgrade is a necessary long-term improvement, its implementation will place additional operational pressure on the Department during 2026. Infrastructure and space constraints remain ongoing concerns. A business case has been submitted to the HSE for a second Consultant Microbiologist to serve both the NMH and the Royal Victoria Eye and Ear Hospital.

Plans for 2026

- Finalise the design and commence User Acceptance Testing of the new Laboratory Information System, with a planned cut-over to the new system in July 2026.
- Advance plans for improved infrastructure in Anatomic Pathology
- Support the proposed co-location of NMH on the St. Vincent's University Hospital campus at Elm Park.

BIOCHEMISTRY

The Biochemistry laboratory provides a wide range of Biochemistry, Endocrinology and specialised fetal monitoring testing for the NMH and other hospitals.

Successes and Achievements

- Reconfiguration of the Biochemistry Laboratory in preparation for new analyser installations.
- Verification and introduction of the Roche cobas e402 analyser for endocrinology testing.
- Allocation of a Senior Medical Scientist from Biochemistry to point of care testing (POCT) to progress accreditation in line with the new ISO 15189:2022 standard.
- Ongoing training and re-training of scientists for the on-call service.

Plans for 2026

- Verification and introduction of two Roche cobas c303 analysers for routine biochemistry testing.
- Verification and introduction of an additional Roche cobas e402 analyser.
- Expand the in-house biochemistry and endocrinology test repertoire.
- Achieve ISO 15189:2022 accreditation for POCT.

Sarah Brady, Senior Medical Scientist Point of Care Coordinator in the NICU. Point of care testing facilitates swift analysis, quick result turnaround times and smaller sample volumes aiding patient care.

BLOOD TRANSFUSION

The service includes the investigation of blood group and antibodies, provision of blood and blood products, supporting the prevention and management of Haemolytic Disease of Foetus and Newborn through detection and monitoring of antibodies and the provision of routine antenatal Anti-D prophylaxis. Review of fetal RhD screening results analysed by the Irish Blood Transfusion Service (IBTS).

Successes and Achievements

- Implementation of automated antibody titrations on the IH500 blood grouping analyser
- Implementation of new backup plasma defroster
- Introduction of the NHSBT Sp-ICE reporting system to allow laboratory access to NHSBT referral reports for Fetal genotyping
- Review and enhancement of the Electronic Crossmatching procedure
- Investigation into the feasibility of providing Rh+K matched RCCs for all c-negative antenatal and women of childbearing potential at the NMH
- Ongoing training and retraining of scientists for the on-call service.
- Reconfiguration of the Blood Transfusion lab to improve workflow and utilisation of space

Plans for 2026

- Extension of Neonatal Emergency O Negative Red Cell validity in theatre from 5 to 8 days.
- Review of the laboratory procedure for issuing Anti-D out of hours.
- Introduction of Electronic Issue on Demand for Caesarean Section patients.
- Implementation of a new plasma freezer.
- Continued participation in multidisciplinary Massive Haemorrhage skills and drills training.
- Ongoing training of scientists for the on-call service.

HAEMATOLOGY

The haematology laboratory investigates blood disorders and plays a key role in the detection and management of anaemias, sepsis and coagulation disorders. Kleihauer tests are also performed to estimate fetomaternal haemorrhage.

Successes and Achievements

- Implementation of Haemoglobinopathy testing on cord blood samples of neonates.
- Ongoing training and retraining of scientists for the on-call service.
- Engagement with Green Lab initiative.

Plans for 2026

- Procure, interface, and verify a dedicated analyser to support an enhanced haemoglobinopathy screening service.
- Introduce in-house haemoglobinopathy screening for adult patients and expand antenatal screening to meet current guideline requirements.
- Establish in-house HbA1c testing in collaboration with the Biochemistry laboratory.
- Continue training and retraining of scientists for the on-call service.

Alison Nolan, Biochemistry Medical Scientist.

HISTOLOGY

The histology laboratory provides a diagnostic service in gynaecological and perinatal pathology, examining patient tissue from surgical procedures, outpatients, placentas and post-mortems. The laboratory also offers ancillary testing, including immunohistochemistry and special stains to provide further diagnostic evaluation.

Successes and Achievements

- Development of the in-house immunohistochemistry repertoire, now transitioning to a fully automated service.
- Improved process flow through revision of placental examination triaging criteria.
- Continued renovation of the storage area for patient tissue archives.
- Engagement with the Green Lab initiative.
- Continued participation in the NQAIS quality programme and external EQA schemes, including NordiQC, NEQAS, and the NEQAS Tissue Diagnostics Scheme.
- Participation in the training of TUD Biomedical Science students.
- Expansion of the Medical Scientist role to include histodissection and assistance with the perinatal post-mortem service.

Plans for 2026

- Expand voice recognition services to cover both macroscopic and microscopic reporting.
- Continue liaising with the Executive Management Team and the HSE Dublin & South East group to secure appropriate facilities.
- Continue planning for the Regional Perinatal Pathology service to be based at the NMH.
- Complete the introduction of the in-situ hybridisation assay for HPV detection.

MICROBIOLOGY

The Microbiology laboratory provides a routine bacteriology and fungal testing and molecular microbiology service for both The National Maternity and Royal Victoria Eye and Ear Hospitals. Surveillance reporting is provided for both hospitals.

Successes and Achievements

- A safe service was maintained with reduced staffing levels throughout 2025, with changes in practice introduced in 2024 continuing. Several new staff joined during the year, with training completed or ongoing.
- Accreditation was successfully achieved for VRE screening and ESβL testing.
- New swabs were introduced for GBS screening for antenatal women.
- A number of internal quality improvements were also completed.

Plans for 2026

- Apply for accreditation of new swabs for GBS screening, streamlining the processing of specimens in the laboratory.
- Introduction of new susceptibility cards for Gram-negative organisms.
- Evaluation of Candida specific agar as part of undergraduate project.
- Verification of in-house testing for Chlamydia trachomatis, Neisseria gonorrhoeae, Trichomonas vaginalis, Mycoplasma genitalium testing on the Aus Diagnostics platform (currently performed in NVRL).
- Progress the configuration, implementation, and go-live of the regional ICNet clinical surveillance infection control system for NMH and RVEEH.
- Progress the appointment of a second Consultant Microbiologist for NMH and RVEEH.

Mariela Zalduendo, Specimen Reception Supervisor.

QUALITY MANAGEMENT

The Department of Pathology and Laboratory Medicine is committed to delivering the highest quality diagnostic and consultative services for all its users and to the implementation of The National Maternity Hospital mission statement. These commitments are defined within the Laboratory Quality Policy. The Department defines and audits the quality management system to ensure compliance with the ISO 15189:2022 standard.

Successes and Achievements

The Department of Pathology and Laboratory Medicine maintained ISO 15189:2022 accreditation across all disciplines and received an extension of scope for additional tests. Retaining the flexible scope allowed the laboratory to continue providing accredited services while introducing quality improvement initiatives. The department also submits an annual Blood Transfusion report to the Health Products Regulatory Agency (HPRA), covering activity, blood usage, wastage, and planned changes.

Plans for 2026

The laboratory aims to maintain ISO 15189:2022 accreditation across all disciplines. Additional tests will continue to be introduced under the flexible scope, and an extension of scope is planned to cover Point of Care Testing and the new Laboratory Information System.

SUSTAINABILITY

Successes and Achievements

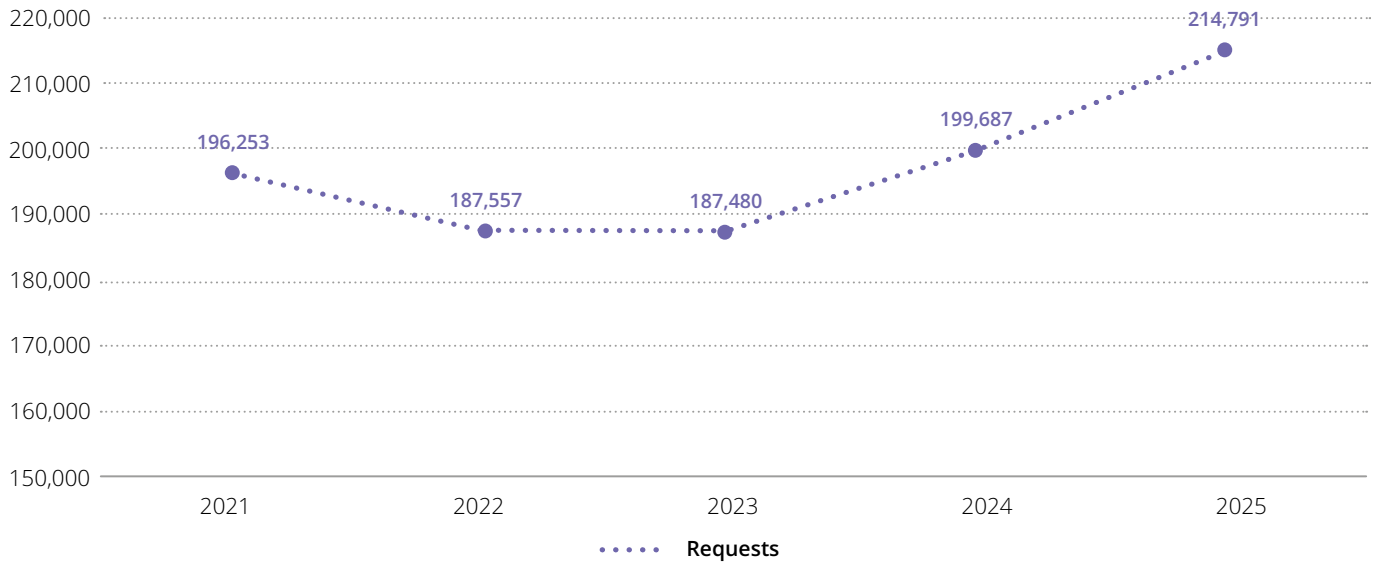
- The laboratory achieved My Green Lab certification in 2025 and presented its sustainability work at the RISE Symposium.

Plans for 2026

- Continue to improve recycling practices and reduce packaging.
- Continue the Freezer Challenge programme.
- Introduce a sustainability policy and include sustainability training in the induction of all new staff.

***Damian Lally,* Laboratory Manager**

Figure 1: Laboratory Requests 2021 – 2025



Specialist Perinatal Mental Health Service

This year has seen the streamlining of the Perinatal Mental Health Service in order to manage the demands on the SPMHS. We have prioritised the specialist care and treatment of women suffering with moderate to severe perinatal mental illness and support our colleagues in the community who manage women at the milder end of the spectrum. This has allowed us to offer a responsive, nuanced service for those most in need. We offer a range of interventions, both in group format and individually, for mother, baby and partner. The multidisciplinary approach allows for a patient-centred approach, meeting the biopsychosocial needs of our women and families.

In 2025, groups facilitated by the SPMHS, including the postnatal café and baby massage, were embedded within patients' treatment plans and became an integral component of the care provided. These interventions complement individual therapeutic work and promote structured peer support, thereby contributing positively to patient engagement and clinical outcomes.

Spotlight on Video Interactive Guidance (VIG)

This year the SPMHS has extended the Video Interactive Guidance (VIG) service as a therapeutic intervention within the Hospital. We have 1 fully accredited VIG Practitioner with 2 more SPMHS team members undergoing accreditation.

VIG aims to improve infant mental health and promote healthy bonding and attachment among women suffering with perinatal mental illness. It is a strengths-based, evidence-informed approach that uses short video recordings of everyday parent–infant interactions to support parental sensitivity, confidence, and reflective capacity. Through guided review of selected video clips, parents are supported to recognise moments of attuned interaction, emotional connection, and effective communication with their infants. This process promotes parental self-efficacy, strengthens early relationships, and supports infant emotional development during a critical period.

Video Interactive Guidance (VIG) can be particularly helpful when parents experience difficulties bonding with their baby. By focusing on short, positive moments of interaction, VIG helps parents notice signs of connection, responsiveness, and enjoyment that they may otherwise miss. This strengths-based approach can reduce anxiety and self-criticism, support emotional attunement, and gradually build confidence and closeness in the parent–infant relationship.

Feedback from parents highlights increased confidence in reading their baby's cues, greater enjoyment in interactions, and a strengthened sense of connection. Clinicians report that VIG enhances engagement, particularly for parents who found verbal therapies challenging, and complements existing perinatal mental health interventions.

Given the success this year, the SPMHS plans to expand the use of Video Interactive Guidance (VIG) by increasing the number of trained practitioners within the team. This will improve access for parents experiencing bonding difficulties, perinatal mood and anxiety disorders, and trauma-related presentations.

Dr Catherine Hinds
Consultant Perinatal Psychiatrist

Yvonne Fallon, CMS Bereavement, Dr Aoife Menton Principal Specialist Clinical Psychologist and Brenda Casey, CMS Bereavement / Psychotherapist, with Bereavement Affirmation Cards which were launched this year. These cards were developed by Yvonne for women who are pregnant again after a previous pregnancy loss; they were printed with thanks to The NMH Foundation.

Pre-Assessment Clinic

The objective of this clinic is to enhance the clinical care of patients by conducting timely assessments, identifying health issues and arranging prompt treatment prior to their scheduled surgery. This leads to a reduction of cancellations, efficient use of time and resources on day of surgery and an enhanced patient experience. The nurse led clinic is run by two clinical nurse/midwife managers with support from a consultant anaesthesiologist and an anaesthesiology registrar. The clinic runs daily and also facilitates a consultant led obstetric high risk anaesthetic clinic bi-weekly.

Appointments are arranged by theatre administrative staff after electronic referral is received and date for surgery is confirmed. Administration staff book a virtual appointment for all patients, ideally 4-6 weeks pre-operatively.

Virtual telephone appointments with a nurse/midwife to a patient obtains medical, surgical, social, and physical health information as well as a medication review. This appointment facilitates a general discussion about their procedure and peri-operative journey. Patient information leaflets regarding surgery and general health information in preparation for surgery is sent to patient to support this education. An assessment is made by the nurse/midwife at this appointment as to whether the patient needs medical follow-up in the clinic or any additional investigations.

At the in person follow up appointments, the patient is reviewed by an anaesthesiologist. The telephone assessment and pre-operative advice is revised, and any additional patient concerns are addressed.

Niamh Carney and Carmel Breen
Pre-assessment Clinic CMM2

Figure 1: Activity vs 2024

Clinic Name	Attendances	Follow up Attendances	Total Attended	DNA	DNA Rate
Anaesthetic Clinic	+3.0%	+1.4%	+2.6%	+0.8%	-0.1%
Theatre Pre-Assessment Clinic					
Pre-Theatre Telephone Clinic					

Karthika Mohan, Staff Nurse with Margaret Daly in the Gynaecology Ward.

Quality and Safety Services

Central Decontamination Unit

The Central Decontamination Unit (CDU) re-processes all Reusable Invasive Medical Devices (RIMD). Patient equipment is carefully cleaned, disinfected and sterilized. Sterility assured re-processing of RIMD is achieved through adherence with HSE Decontamination Standards and Guidelines as well as hospital policies, procedures and guidelines.

Aidan Gilbert Mannion, CDU Technician.

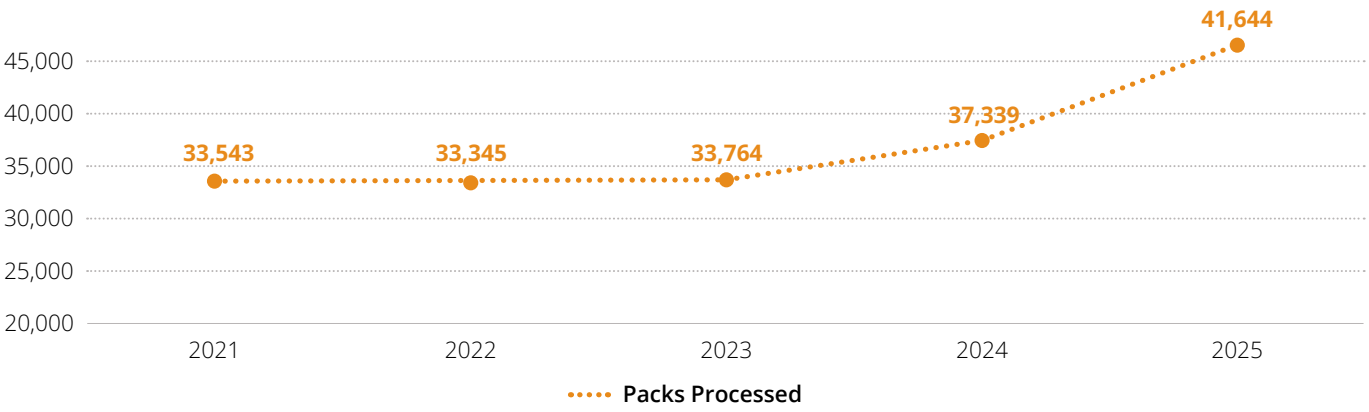
Infection Control

Four Environmental Monitoring audits took place in 2025; this is when air and surfaces are sampled and tested in the laboratory to ensure they comply with infection control standards. Water sampling from the reverse osmosis water treatment unit is also conducted quarterly and tested in an external laboratory to ensure compliance.

In total 41,644 packs were inspected, packed and sterilised in 2025. This is an increase on 2024 and is mainly due to the rollout of sterilising breastfeeding kits throughout the postnatal wards of the Hospital. The total number of surgical packs processed over the last 5 years can be seen in Figure 1 below.

Pam Hutchings
CDU Manager/Decontamination Lead

Figure 1: Packs processed over 5 years



Baby Cora with her Mother Aisling MacIntyre.

Haemovigilance

The main aim of Haemovigilance is to promote safe and effective transfusion practice in our hospital. Compliance with Blood Transfusion quality standards is a key performance indicator of transfusion safety for patients. The haemovigilance service participates within the overall Laboratory Quality Management system.

Successes / Achievements / Reports

- INAB (ISO 15189) Accreditation achieved for 2025 *(Audits/ Quality/Guidelines/Education/Reporting/CPD)*
- 100% Traceability of blood components and products as required by European Blood Directive 2002/98/EC
- 16 reports were submitted to the National Haemovigilance Office (NHO) in 2025 *(1 Mandatory under EU Directive, 7 non-mandatory and 8 wrong blood in tube (WBIT))*
- Completion of root cause analysis of adverse events and implementation of preventative action contributes to safety within the blood transfusion process.
- Continued participation in multidisciplinary clinical team in the implementation of the National Post-Partum haemorrhage and Life threatening Intraoperative haemorrhage guidelines
- Attendance and participation at Blood Transfusion (BTC & PPH/Anti-D) and Quality (QMT & QA) committees
- The HVO and Consultant Haematologist participated in education events as part of CPD

Clinical Audit Transfusion

- Participated in the UK 2025 National Comparative Audit of Blood Transfusion In Major Haemorrhage

Mandatory Haemovigilance Education Programme

- On line system 'Totara' for NCHD Induction was successfully continued in 2025
- Use of 'NMH guide to Haemovigilance' in Totara and 'Essential Transfusion Practice' in HSE Land was continued for Midwifery/Nursing staff and Midwifery Students.
- Consultant Haematologist provided teaching sessions on Major Haemorrhage, Antenatal Blood Grouping, Anti-D Ig prophylaxis and Anaemia Management at NCHD changeovers
- Delivery of targeted haemovigilance education to other staff groups (MCA & Portering staff) involved in the transfusion chain process

Specific Blood track training for blood track users (L1) is continued by local L2 Trainers (CSF/Senior Midwifery staff) (train the trainer- L2 trained by HVO). Staff are enabled on the database by HVO which allows access to the controlled blood fridges.

Bridget Carew
Haemovigilance Officer

Health and Safety

The Health and Safety Department is dedicated to ensuring the safety, health and wellbeing of all patients, staff, visitors and contractors. This is achieved by promoting a positive and pro-active safety conscious culture to ensure a safe environment and place of work in line with best practice.

Three hundred and twenty-three individuals attended twenty-three Health and Safety Training sessions during the year which were favourably received by all. The induction program for staff is further complemented by the mandatory study day which is open to both clinical and non-clinical staff. This runs online regularly throughout the year and ensures all staff have an opportunity to refresh their health, safety and emergency procedures awareness. In addition, online training is also available for staff, through Totara and HSELand.

Our Fire Safety Consultants provided training for fifty-four of our fire wardens in Oct 2025. The Hospital liaises closely with the Dublin Fire Brigade and the Emergency Services during trial evacuations. Staff were involved in the main mock evacuation with over eight hundred and forty-seven participants taking part including patients and staff. Ski sled and patient hoist awareness training is also provided during manual handling sessions.

There were thirty-eight Manual Handling training sessions conducted by the multi-disciplinary manual handling teams and three hundred and forty-three staff attended. Twenty-six of the sessions were scheduled and twelve additional sessions were organised to facilitate individual key departments/cohorts of staff. The upgrading of the current bed stock was completed to enhance the ergonomic environment for nursing staff and is in line with the Manual Handling Policy of the Hospital.

Contractor Management remains a key focus area especially in light of recent developments. Additional minor capital projects undertaken improve site facilities and patient safety in the long term. These additional construction projects require the effective implementation of contractor management controls. Managers in control of the workplace and our contractors work together to ensure safe systems of work are in place and are working effectively.

The Annual Accident Review was conducted and there were a number of initiatives during the year to raise staff awareness of these hazards. All staff are engaged in working proactively with managing these risks to ensure a safe working environment for all our patients, visitors and staff.

Martin Creagh
Health & Safety Officer

Dr Max Waterstone, Obstetrics & Gynaecology Senior House Officer.

Infection Surveillance, Stewardship, Prevention and Control

The Infection Prevention and Control (IPC) team work alongside staff to ensure measures are taken to reduce and prevent healthcare associated infection (HCAI) through education, audit, surveillance, consultation, posters, leaflets and the development of policies/guidelines. Antimicrobial stewardship and minimising development of antimicrobial resistance is a key goal of the IPC team.

The team contributes to multi-disciplinary committees including IPC, Drug & Therapeutics, Quality Risk & Patient Safety, Decontamination Steering, Hygiene, Sepsis & IMEWS, Audit Steering and Clinical Governance Executive.

Clinical Outcomes

Sepsis and Septic Shock (Maternity and Gynaecology)

- Twelve women developed maternal sepsis in 2025 (1.69 per 1000 mothers delivered compared to 1.21 in 2024, 0.89 in 2023, 1.03 in 2022 and 0.52 in 2021). There was also one gynaecology patient with sepsis. Two women developed septic shock and 11 had sepsis (13 cases in total).
- Five of the maternity cases occurred during the antenatal period at 26, 26, 34, 35 and 37 weeks gestation. Seven followed deliveries at 28, 36, 37, 39 (4 cases) weeks.
- The organisms identified were E. coli (8), Staphylococcus aureus (2), 1 each Citrobacter, polymicrobial infection and no organism identified.

Blood Stream Infection (BSI) and Meningitis (Neonates)

- The rate of neonatal early onset group B streptococcus (GBS) disease was 0.14 per 1000 births in 2025 compared to zero in 2024, 0.87 in 2023, zero in 2022 and 0.38 in 2021.
- The rate of all laboratory confirmed early-onset sepsis was 0.14 per 1000 births in 2025, compared to 0.44 in 2024, 1.45 in 2023, 0.57 in 2022 and 0.64 in 2021.
- There were 12 HCAI late-onset blood stream infections: 7 gram negative bacilli, 2 S.aureus, two coagulase negative Staphylococcus and 1 GBS.
- Three infants were diagnosed with late-onset meningitis: 2 Enterovirus and 1 no organism identified.

(Adults)

- There were 30 BSI in 2025; 6 antenatal, 11 intrapartum, 12 postnatal and 1 gynaecology. Causative organisms were E.coli (12), Streptococcus species (5), E.faecalis (3), group B Streptococcus (3), S.aureus (2), anaerobe (2) and one each Citrobacter, Proteus and polymicrobial. Thirteen (43%) were HCAI.

Bronwyn Redmond, Clinical Midwife Manager 2; Edgars Daukulis, Administrator; Dr Meadhbh Collison, Clinical Microbiology Specialist Registrar; Carol O'Connor, Surveillance Scientist; Shideh Kiafar, Assistant Director of Midwifery and Nursing; Louise Delany, Antimicrobial Pharmacist, Dr Susan Knowles, Consultant Microbiologist.

Device Associated Infection, Surgical Site Infection (SSI) and Clostridioides difficile

- Central line associated BSI rate in NICU was 2.55 per 1000 catheter days compared to 1.04 in 2024, 2.02 in 2023, 2.14 in 2022 and 5.37 in 2021.
- Ventilator associated pneumonia rate in NICU was 3.81 per 1000 ventilator days compared to 4.65 in 2024, 1.5 in 2023, 1.93 in 2022 and 3.45 in 2021.
- The caesarean section (CS) surgical site infection rate was 6.21% in 2025; 4.55% pre-labour / no induction of labour (IOL) and 7.7% in labour / IOL. This compares to 6.09% in 2024; 5.15% pre-labour / no IOL and 6.93% in labour / IOL.
- There was no case of C. difficile infection.

Audits and Education

- Hand Hygiene
  - 86% of clinical staff were certified for hand hygiene training. 72% of clinical staff were certified for infection control training for nurses and midwives module.
  - Hand hygiene audit: Compliance rate for hand hygiene audit was 95%. Compliance rate for barrier to hand hygiene was 94% for Midwives/Nurses and 74% for Doctors. Barriers refers to rings, watches, fitbits etc.
- Peripheral Vascular Catheter care bundle = 94% and Urinary Catheter care bundle = 100%.
- Audits:
  - GBS flagging: 1,081 patients were GBS positive. 66% were flagged as 'infection risk' in chart. 39% of not-flagged were categorised as 'medical risk' which does not trigger a flag in subsequent pregnancy.
  - GBS Risk Factor audit: 235 patients audited. Compliance with asking history of GBS was 95%. 21% were GBS positive in their previous pregnancy.
  - GBS Screening if Penicillin Allergy: 137/314 patients with penicillin allergy have delivered. 75% were compliant. GBS positivity rate = 17% and 35% were clindamycin resistant.
  - MRSA Audit: 582 pregnant patients who are a healthcare worker were audited. 92% were screened for MRSA and 4.5% were positive.
  - Chlamydia trachomatis screening audit in antenatal women <25 years' old: 320 women were eligible, 96% were tested and 7% positive.
  - CPE risk factor audit: 385 charts were randomly audited. 99% were assessed for CPE risk. 3.9% were eligible for CPE test, 47% were tested and negative for CPE.
  - Negative pressure wound therapy (PICO) usage: 264 CS were audited. 32 patients had PICO dressing, 20 (62.5%) met NMH criteria for application.
  - CS dressing removal audit Sept '25: 220 patients had caesarean; excluding PICO, 196 were audited. 13% had no documentation of dressing removal. 56% were removed within 30hrs. Feedback was provided to postnatal areas.
  - Timing of dressing removal post CS audit Jan 2024-June 2025: 2895 were audited following exclusion for PICO and no documentation. 41% remove dressings at 24-30hrs, 35.74% at >30-48hrs. Compliance with dressing removal at 24hrs±6hrs is 56.7%. 85.4% documented removal of dressing. Superficial CS-SSI rates increased with time interval of dressing removal (≤30hrs-3.98% V's >30hrs-4.52%) especially elective CS (≥30hrs-2.63% V's >30hrs-4.28%).

Antimicrobial Stewardship

- 2496 inpatient charts were reviewed in 2025
- 4 patients had outpatient antimicrobial therapy (OPAT) saving 40 days of inpatient IV therapy
- 8 audits / reviews
- 7 polices reviewed
- 15 newsletters/ drug focus communications to support education amongst staff
- All reserve antimicrobials were monitored and NMH achieved >90% of reserve agents being approved by microbiology / in line with antimicrobial guidelines
- Antimicrobial Awareness Week was marked in November
- A pharmacist has been involved in conjunction with AMRIC in reviewing the National Obstetric Antimicrobial Guidelines
- Antimicrobial consumption for 2024 was 35.08/100BDU which was up from 34.03DDD/100BDU in 2023 (note 2024 data was not available for 2024 report)

Table 1: Multi-Drug Resistant Organisms (MDRO)

MRSA Paediatric			
NICU acquired	12		
Positive on admission	7		
Acquired from mother	2		
Bloodstream Infection	0		
Total	**21**		

MRSA Adult			
Bloodstream infection	0		
Colonisation	CA-MRSA	NMH-HCAI	HCAI-Other Hospital
	80	0	0
Infection	CA-MRSA	NMH-HCAI	Undetermined Source
	11	4	0
Total	**95**		

CPE	
Paediatric	3
Adult	2

VRE	
Paediatric	0
Adult	1

Paediatric Rectal Screening	
ESBL	48*
Gentamicin Resistant GNB	32*

*MRSA = methicillin resistant S. aureus; CA = community-acquired; CPE = carbapenemase-producing Enterobacterales; VRE = vancomycin resistant Enterococcus; ESBL = extended spectrum beta-lactamase; *24 isolates ESBL and Gentamicin Resistant*

Table 2: Respiratory viruses

	SARS-CoV-2	Influenza A	Influenza B	RSV
Adult	19**	78	21	11†
Paediatric	4***	0	0	0
Total	**23**	**78**	**21**	**11**

*RSV = respiratory syncytial virus; **1 co-infection with RSV ***Outbreak in NICU †1 co-infection with SARS-CoV-2*

Service Development Plans

- Second consultant microbiologist for NMH/RVEEH to be appointed
- Introduction of ICNet.
- Upgrade of laboratory information system.
- Introduction of routine vaginal disinfection before caesarean section.
- Review of notifiable infectious disease surveillance.
- Implementation of HSE AMRIC guideline for monitoring and measurement for antimicrobial.
- Stewardship programmes in acute hospitals by January 2027.
- Participate in national PPS on antimicrobial use.
- Maintain surveillance, audits, education, training, policies, guidelines, leaflet & newsletters.

Dr Susan Knowles
Consultant Microbiologist

Aoife Sammon and James Doyle with their 4 daughters all of whom were born in The NMH: Sophie (2016), Freya (2019), Isabelle (2022) and Caroline (2025). Caroline's middle name, Mela, was given to her in remembrance of James great-aunt, Mela Woods, who was a midwife in The NMH from 1970 - 1990, and died in February 2025 at the age of 99.

The Maternal and Newborn Clinical Management System

The Maternal and Newborn Clinical Management System (MN-CMS) is the Electronic Health Record (EHR) in use in The National Maternity Hospital. It is a national EHR covering maternity, newborn and neonatology, gynaecology and colposcopy services thereby providing a paperless EHR for the whole Hospital and, when fully rolled out nationally, will provide an EHR for these services. The ethos of MN-CMS is 'patient centred, clinically led' and the team work closely with the HSE National MN-CMS Team, HSE Technology and Transformation and the other participating maternity hospitals to support, manage and upgrade the system.

Apart from patient documentation, MN-CMS enables medication prescribing and administration, ordering and viewing of laboratory investigations and electronic communication with general practitioners. It also interfaces with other specialist systems such as fetal cardiotochograms (Fetalink), theatre (Periop Doc) and anaesthetic records (SN Anesthesia), ultrasound (Viewpoint), colposcopy (Mediscan) and the Patient Management System (IPMS).

The MN-CMS Department, along with Oracle Health Application Managed Services (AMS), supports the 24-hour availability and usage of the system and ensures the most efficient use of the electronic chart so both the patient and healthcare providers get the maximum benefit from the system.

Creating and maintaining user access as well as user training are essential functions of the local back office. MN-CMS training is provided in our state-of-the-art computer training facility. All new and returning users require training and in 2025 the team has trained 388 staff across all disciplines to use MN-CMS. The system uses role based access, providing users with access only to parts of the chart that are required to fulfil their role. The majority of staff receive in person training on-site and attend in person for between 2 and 6 hours, depending on their role. Users who are given read-only access for the purposes of research are required to complete an MN-CMS module on HSELand.

We provide support by phone, email and in person which are all essential requirements. We also provide cover outside core working hours for any planned downtime or upgrade to the system. Out of hours phone support is provided by Oracle Health AMS.

Improvement of documentation is a primary focus of the Department. We undertake detailed daily and monthly data quality monitoring in order to set and maintain good quality standards of documentation.

In 2025, we continued to release MN-CMS dashboards in collaboration with the Information Department. The main NMH MN-CMS Dashboard is released monthly and shows information about births in the Hospital for the previous month, including total births, mode of delivery and patient category. Dashboards are emailed to all relevant staff and the main dashboard is displayed on information screens in the Hospital. Other dashboards include NICU, Emergency Department, Antenatal Education and DOMINO. Along with these, a new comparison dashboard was also released comparing activity in 2024 vs 2025.

In 2025, two additional hospital sites started using MN-CMS: University Maternity Hospital Limerick and The Coombe Hospital. The MN-CMS Department, along with experienced NMH users provided on-site assistance on both occasions. With these additional sites, 70% of all births in Ireland are now recorded on MN-CMS. Plans are already underway to add the next four hospitals in the near future.

Our Electronic Health Record is constantly being upgraded and improved and in 2025 we began planning for the next upgrade, due in Q1 2026. Numerous other updates to MN-CMS took place in 2025 to enhance function and usability in the EHR. Plans for 2026 include incorporating the Individual Health Identifier (IHI) into MN-CMS, adding digital dictation facilities and progressing the integration of POC (Point of Care) results with the EHR.

Sive Cassidy
CMM3 MN-CMS

Occupational Health

The Occupational Health Department contributes to a safe and healthy environment for both staff and patients at The National Maternity Hospital by providing a proactive service to all staff. The Department is comprised of one full-time occupational health nurse, one consultant occupational health physician that has one session per week with administrative support.

The key services provided include pre-employment health assessment, sickness absences review, vaccinations, management of occupational bodily fluid exposure (OBE's), pregnancy risk assessment, skin surveillance, occupation injuries, ergonomics assessment and staff support and counselling.

There was a total of 2064 interactions with the Occupational health department including 191 appointments with the Occupational Health Physician. Referrals came from all categories within the hospital. See table below. Many staff have challenges both professionally and personally. We provide a confidential service where staff can talk if they need support or help to guide them in the right direction.

Staff were offered Flu and Covid-19 vaccinations on a two day roll out in October and weekly flu vaccination clinics and occasional Covid-19 vaccination clinics thereafter. 34% of staff at The NMH availed of the Covid-19 vaccination, the highest uptake in the Dublin and South East hospital region. Flu vaccination uptake reached 76%, the second highest in the region. 90 staff tested positive for Covid-19 seeing a significant drop from the previous year of 197 staff.

Jennifer Fitz-Gerald
Occupational Health CMM2

Table 1: Staff interaction with occupational health

Reason	Total
Consultations	266
Misc Vacc	241
Eye test	194
NCHD's	189
Pre-employment	184
Bloods	182
Occ Physicans. Follow up	121
Counselling	90
Covid-19 +ves	90
Flu vaccines	85
Blood requests	74
Occ Physicans. New Referrals	68
Occ Physicans Discharge	53
OBEs	45
Pertusis	45
Needlestick	42
Pregnancy Assess	29
Bone Density Scan	28
Ergonomic Assess	18
First Aid incidents	9
MRSA Swabs	4
Eye splash	3
Night Workers Health Assessment	3
Allergies	1
Self-referrals	1
Total	**2064**

Table 2: Occupational health referral appointments

Reason	Total
Midwifery / Nursing	100
General Support Staff	53
Management / Admin	14
Health & Social Care Professionals	12
Medical	6
Students	6
Total	**191**

Quality, Risk and Patient Safety

The Quality, Risk and Patient Safety (QRPS) Department continues to strive to promote the highest standards of care throughout the Hospital. 2025 saw several changes and developments.

Clinical Incident Management

The first full year of records was completed on the new Clinical Incident Management System, CIMS3 console, using the Zoho platform. This has brought more efficient incident reporting and recording and allows us to share our data clearly and graphically with both the Hospital staff and regulatory agencies.

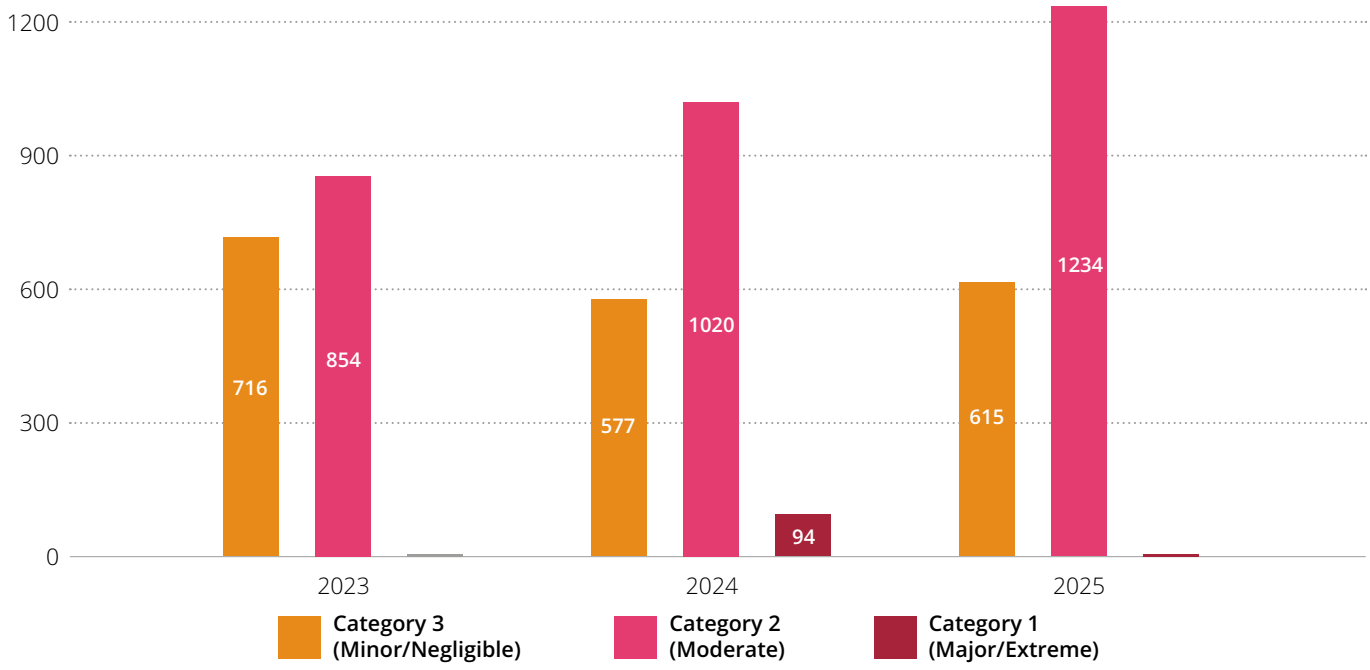
Clinical incidents are categorised and reviewed both locally and at various internal multidisciplinary review meetings including the Clinical Incident Review Group (CIRG) and the NMH Women and Neonates Serious Incident Management Forum (SIMF), depending on their category. The most significant incidents, Serious Reportable Events (SREs), are also reviewed externally at the HSE Dublin and South East Women and Neonates SIMF. This forum is also attended by the HSE Obstetric Event Support Team (OEST). Actions and learnings from these incidents are shared within the Hospital and also with regional and national authorities.

In 2025, 1,914 incidents were reported which is an increase of 13.2%; this may be explained by the encouragement of staff to report incidents. While there was some re-categorisation, it is important to note the lower number of Category 1 incidents (-30.9%) and this can be seen in Figure 1 below. We foster a strong culture of incident reporting by all staff. They are encouraged to report in a safe environment without fear of blame. The State Claims Agency (SCA) has commended the Hospital for its high level of reporting, again achieving a Grade A target.

The Hospital is compliant with the HSE Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. This requires mandatory reporting of, and Open Disclosure meetings for notifiable incidents as outlined in the legislation. This process is coordinated and recorded by the Department. It is a significant workload requiring resources which the EMT has also supported.

The Hospital also engages with the State Claims Agency for its claims review process. We work closely with the Hospital Claims Coordinator who liaises with the SCA and follows each clinical claim from notification to resolution. There are currently 91 active claims. In 2025, 16 claims were resolved and 25 new claims notified.

Figure 1: Incidents 2023–2025



Risk Registers

In line with HSE Enterprise Risk Management Policy, the risk registers are regularly reviewed. Each department records its own register and updates it as appropriate. Ownership remains with the head of each Department. Where necessary, the more significant risks are escalated to the EMT and Hospital's corporate risk register. The operational risk registers are divided into clinical and non-clinical with number of risks shown in Figure 2. Review of both risk registers continue throughout the year. The current numbers are a significant reduction from January 2024 (857). Risk register reporting is to the Clinical Governance Executive Committee, EMT and various committees of the NMH Board.

In July we were audited by Crowe and achieved a rating of 'Satisfactory Assurance'. This indicates that overall, there is adequate and effective governance, risk management and control.

Quality

The Quality team is responsible for many different work streams, including patient liaison, patient surveys (local and national), quality improvement projects, quality and safety walk rounds, q-pulse administration and support and audits (internal and external). They engage with our community partners and coordinate the GP liaison committee and the patient voice advisory group.

In July HIQA attended on an unannounced two day visit; they examined 11 standards of care. The report confirmed the Hospital was compliant in 7, substantially compliant in 3 and partially compliant in 1. The partial compliance has been addressed. We have convened a HIQA Focus Group to ensure readiness in all departments for future visits.

The hospital continues to receive significant positive feedback with a Net Promoter Score (NPS) of 83, which is a measure of patient satisfaction. A score of >/= 70 is graded excellent. Of note is 769 compliments were received.

The National Maternity Experience survey took place in 2025. We are delighted to report that the NMH performed very well, above the national average in many areas.

Negative feedback is considered seriously with actions taken to prevent recurrence. Close liaison with complainants is vital. While 2025 showed some increase in both written complaints and review requests, the Department had 99% compliance in dealing with complaints in the designated timeframe (Table 1).

Q-pulse activity remained high with a total of 1,589 requests which is an increase from 1,073 in 2023. These include document updates, formatting, passwords, and individual training and HR requests for starters and leavers.

Table 1: Patient Feedback 2023–2025

	2023	2024	2025
Compliments received	911	624	769
Complaints received	**93**	**135**	**147**
Written Complaints			
• Stage 2	73	114	118
• Stage 1	20	21	29
General Feedback	22	18	27
Information Requests	11	14	11
Debriefs	9	9	4
Complaints closed			
% closed within 30 days	97%	99%	99%
Complaints locally resolved at Unit/Department/Service level	**43**	**33**	**48**
Patient Meetings held	**15**	**19**	**4**
Requests to IEHG for further review incl. Stage 3 Internal Review (since Oct 2024)	5	8	5
Requests to Ombudsman for further review	2	0	1

Quality Improvement Projects (QIPs)

There were 22 QIPs logged in 2025 including:

- National Breastfeeding Dashboard – Pilot at NMH (Lactation Team)
- 'Pocketalk' Translation Device (Patient Services/Project Office)
- Caesarean Section Wound Care Advice Leaflet (Postnatal Team)
- Outpatient Hysteroscopy Patient Resource Video (NMH/NWIHP).

Sharing the Learning through staff education, liaison and support

We engaged in many initiatives throughout the year to promote understanding and engagement in quality, risk and patient safety practises throughout the Hospital (example shown in Figure 3).

Dr Orla Sheil
Director QRPS Department

Figure 2: NMH operational risk 2025

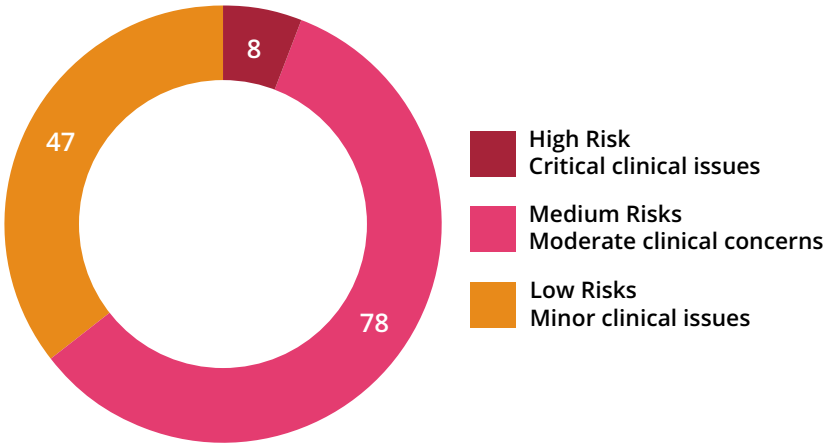


Figure 3: QRPS initiative

Health and Social Care Professionals

Clinical Engineering

The Clinical Engineering Department continues to play a critical role in ensuring the safe, reliable, and cost-effective operation of all medical technology across the Hospital. Throughout 2025, the Department maintained its commitment to clinical excellence, patient safety, and technology-driven innovation. By aligning its operational goals with the Hospital's broader vision to continuously advance the health of women and babies through excellence in healthcare, Clinical Engineering has contributed significantly to improving clinical outcomes, optimizing resources, and enhancing the overall patient experience.

Equipment Management and Maintenance

In 2025, we managed an extensive inventory of over 3,000 medical devices spanning patient monitoring, imaging, surgical systems and infusion technologies. Key achievements include:

- Preventive Maintenance Program: 90% completion rate of scheduled preventive maintenance ensuring medical equipment uptime was maximised.
- Corrective Maintenance Response: Average equipment repair turnaround reduced by 10% through streamlined work order management and enhanced spare parts availability.
- Lifecycle Management: Enhanced use of the centralized asset tracking system facilitating better forecasting for equipment replacement and budget planning, extending the useful life of key devices while maintaining regulatory compliance.

Significant investments were also made in training clinical engineers on emerging device technologies and diagnostic software to meet evolving clinical demands.

Safety, Compliance, and Quality Assurance

Ensuring continuous regulatory compliance with national and European requirements, including oversight by the Health Products Regulatory Authority (HPRA) and adherence to EU Medical Device Regulations, remains a top departmental priority. Key safety initiatives in 2025 included:

- Comprehensive device risk inclusion factors assigned to all medical devices informing preventative maintenance program
- A new Electrical Safety Monitoring Program facilitating trend data analysis of equipment related incidents.
- Attend Clinical Incident Review Group to analyse root causes and implement corrective actions in collaboration with nursing and risk management.

Digital Integration and Innovation

The Department continued its transformation into a more technology enabled operation, focusing on integration of medical devices into Hospital IT systems and the electronic health record. Major accomplishments included the continuous expansion of device connectivity including respiratory devices, transcutaneous monitoring and infusion pumps (on-going) into the centralized patient data interface, ensuring real-time clinical data visibility.

These advancements not only improved operational efficiency but also strengthened the hospital's data-driven decision-making capabilities.

Looking ahead, 2026 will focus on expanding the use of artificial intelligence for predictive maintenance, improving device utilization analytics, developing standardized Key Performance Indicators (KPIs) for hospital-wide technology governance and to align with ISO 14971 in the application of risk management to medical devices.

The Clinical Engineering Department's dedication to safety, innovation, and operational excellence ensures that medical equipment supports the highest standards of patient care and clinical performance.

Eoghan Hayden, **Head of Clinical Engineering**

The Clinical Nutrition and Dietetics Team.

Clinical Nutrition and Dietetics

We provide a dietetic service for patients under the care of maternity, neonatal and gynecology services. This service is delivered via one-to-one consultations and classes, using telehealth (phone and video) and in person, and incorporates relevant technology to support a range of nutritional interventions for women and babies. We facilitate UCD BSc Human Nutrition and MSc Dietetics students for practice placements. We co-ordinate the Healthy Ireland and Nutrition and Hydration committees and contribute to the Infant Feeding committee.

Maternity, Diabetes, Gynaecology (Adults and Adolescents)

In 2025, teams prioritised weight and haemoglobin across dietetic assessment, intervention, audit and policy. Referral numbers remained consistent with previous years, reflecting ongoing high demand for dietetic support in pregnancy. Most outpatient contacts were virtual, improving accessibility.

Diagnoses of GDM increased compared with the previous two years (Table 1). The Tús Maith programme for women with high BMI was expanded to include automatic virtual follow up, weekly emailed tips and goals, and self referral options. This streamlined dietetic contact while maintaining extended nutritional support. A quality improvement plan is underway to further develop the service.

With fewer staff than in 2024, group interventions were expanded and reviews for lower risk referrals reduced by necessity, resulting in fewer overall contacts in 2025* (Table 2).

Audits and Evaluations

- Audit of weights and measures: Measured weights for women with high BMI were not always accurately recorded.
- Iron intake and anaemia in pregnant women with IBD evaluated every two years (2023–2024): Anaemia incidence was 42%; iron supplementation type and adherence varied.
- Outcomes for women who had GDM in 2024: More women required pharmacological treatment alongside dietary changes, with increased need for dietetic support. High BMI (>30) is a likely factor. The 2025 audit is ongoing; service review due 2026.
- Pregestational diabetes outcomes: Most women with type 1 diabetes used insulin pumps and continuous glucose monitoring at booking, requiring specialist dietetic input. Further data analysis is ongoing.

Prioritise inclusion and sustainability across all areas of service in 2026

- Extend Tús Maith / Good Start lifestyle intervention for pregnant women with overweight/obesity to target risk of gestational diabetes and gestational hypertension.
- Restructure service for women with GDM and Diabetes in Pregnancy.
- Scope and plan new service to women with endometriosis.
- Evaluate service for pregnancies with high nutritional risk: hyperemesis, low BMI, post bariatric surgery, eating disorders.
- Use @Hollestic page on Instagram to promote antenatal nutrition and breastfeeding and maintain Hollestic meal planning and recipe app.
- Trial AI tools in existing software packages for nutrition analysis to support remote access and telehealth.

Neonatology

The focus remains babies with increased nutritional needs in the Neonatal Intensive Care Unit (NICU), the majority of whom are born very preterm (≤31 weeks gestational age) or with a very low birth (VLBW, ≤1.5 kg), n=135 in 2025 (12% increase from 2024 (n=120). The number of NICU admissions was 1,337 (1,271 unique babies), an increase from 1,242 in 2024 (1,167 unique babies).

We contribute to two multidisciplinary online parent classes: 'Introducing solid foods and textures for babies after the neonatal unit' and 'Feeding at home the early days'; the latter was extended in January from being offered for NICU parents only to being offered to all parents of babies born at NMH*.

We also contribute to a new multidisciplinary 'NICU Parents' Lab' launched in November to support parents*. We continue to be involved in multidisciplinary initiatives including PRIME (PReterm Infants need Milk Early) and PRIME-B (-Breastfeeding) to support maternal milk (MM) provision and breastfeeding (BF) and the ACORN (Allied Care of at Risk Newborns) programme to support neurodevelopment among high-risk infants*.

Our audit of nutrition and growth amongst babies born very preterm or VLBW showed that amongst the inborn cohort (n=123) who received feeds (n=117), the number who received MM remained high at 98% (n=115); and for those who received oral feeds in NICU (n=78), the number who breastfed was 68% (n=53).

We completed an audit examining feeding and growth among babies born moderate preterm (32-33+6 weeks GA) and late preterm (34-36+6 weeks GA) in 2023. This showed lower MM and BF rates generally amongst babies born moderate and late preterm compared with babies born very preterm; as well as a rate of growth faltering among infants born moderate preterm that more closely resembles those born very preterm than late preterm. Our findings suggest that efforts to promote MM, BF and growth amongst infants born very preterm are effective, but babies born moderate to late preterm warrant additional attention.

The use of parenteral nutrition (PN) increased, with 804 orders (29% increase from 2024), of which 59 (7%) was individualised PN (IPN) and 745 (93%) was standardised PN (SPN).

Our goal for 2026 is to continue to improve MM and BF rates and to extend our focus to include babies born moderate to late preterm and others considered at higher nutritional risk, according to resources available. We are also considering the findings of the National Maternity Experience Survey (HSE, 2025) in relation to the need for support around infant feeding, including post-discharge, and how dietetics can best contribute.

***Roberta McCarthy,* Manager (Neonatology)**
Head of Department 2025
***Sinéad Curran,* Manager (Maternity)**

Figure 1: Adult and neonatal unique patients 2021 – 2025

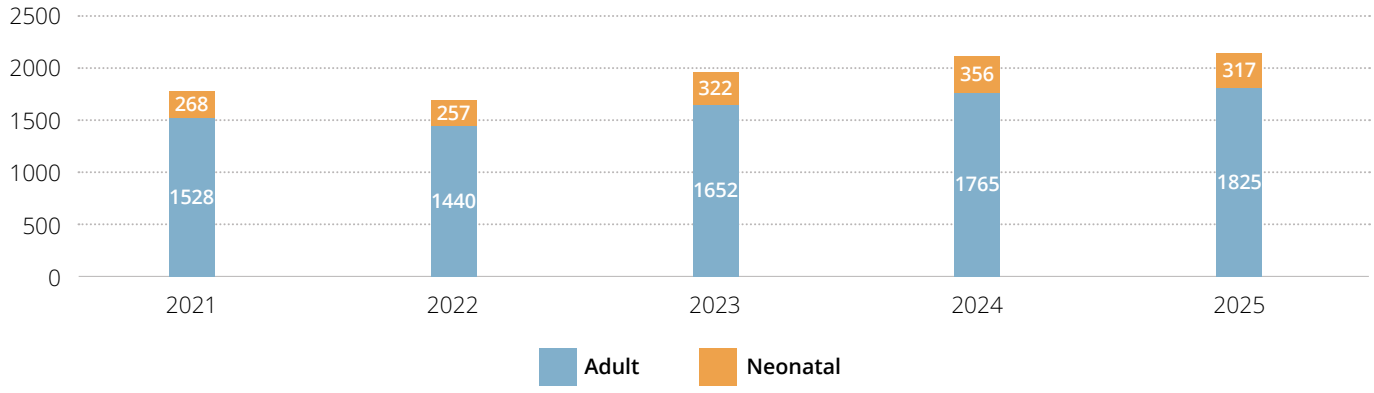


Table 1: Primary reason for adult consult

	2023	2024	2025
Gestational Diabetes (GDM)	525	505	615
Obesity / excessive weight gain	317	437	309
Hyperemesis gravidarum / nausea & vomiting	375	304	231
Low BMI / poor weight gain / weight loss	84	105	97
DM Type 1 or 2	58	69	77
Bariatric surgery	47	47	46
Therapeutic diet e.g. IBD, PKU etc.	26	22	22
Eating disorder	15	33	18
Other Indications	191	111	205
Total	**1649**	**1622**	**1620**

Table 2: Maternity, diabetes, and gynaecology dietitian activity location

	2022	2023	2024	2025
Outpatient contacts	4134	4771	5615	4227
Inpatient contacts	665	567	639	421
Antenatal Nutrition in Pregnancy Class	N/A	407	417	333
Total	**4799***	**5745**	**6671**	**4981**

Table 3: Neonatal dietitian activity

	2021	2022	2023	2024	2025
Babies with birth weight ≤1.5 kg or ≤31/40 weeks gestation - based on year of birth	149	136	124	120	135
Patient contacts					
Inpatients[a]	1532	2108	1606	1494	1560
Outpatients	410[b]	390[b]	456[a]	654[a]	556[a]
Total patient contacts	**1942**	**2498**	**2062**	**2148**	**2116**
Unique patients seen[a]					
Inpatients	218	214	243	228	231
Outpatients	95	92	133	220	164
Total unique patients seen	**268**	**257**	**322**	**356**	**317**

Data source: [a]MNCMS; [b] iPMS.
Note, the total number of unique patients does not equal the combined number of unique inpatients plus outpatients; this is because patients may appear as both a unique inpatient and a unique outpatient, but will only be counted as a single unique patient for that year.
**Details included in Neonatology chapter.*

Medical Social Work

The Medical Social Work (MSW) Department provides support to patients attending the Hospital. The service's main role is to support women and their families with any psychological, emotional, social or practical difficulties that may arise during their time as a patient of the Hospital. The MSW Department began 2025 with 481 active social work cases and received a further 960 new referrals throughout the year. Medical Social Workers had 4122 direct patient contacts throughout 2025.

Breakdown of Referrals for Specialist Areas

The breakdown of referrals for specialist areas is detailed in the table below. Outside of these specialist areas of casework our department receives referrals for a variety of areas including crisis pregnancy, relationship difficulties, poor attendance for antenatal care, limited supports, mental health, bereavement and information and tracing in relation to historic adoptions. Our Department operates twelve hours a day, six days a week.

Table 1: Breakdown of workload

	2023	2024	2025
Inclusion Health	199	231	236
Neonatal Unit Admission	158	198	207
Fetal Anomaly Diagnosis	109	102	131
Domestic Violence	92	106	117
Substance Use	99	114	116
Teen Pregnancy	-	49	36
Gynaecology	-	48	33
Other	539	-	-

Support to Maternity Units of the Dublin South East Hospital Group (IEHG)

A MSW service was offered to 85 families who attended from maternity units within our Dublin South East Hospital Group (DSE): Wexford (28), Kilkenny (41), Waterford (14) and Tipperary (2). This service enables continuity of care for families whose care is transferred to the NMH. The DSE referrals are mainly for parents whose babies are admitted to the Neonatal Unit or to families who receive an antenatal diagnosis of a fetal anomaly. They often require not only intensive emotional support, but also significant practical support when travelling from a long distance for hospital care.

High Risk Caseloads

We offer a specialist service to women experiencing domestic violence in pregnancy. In 2025, 117 women and their children were supported by this service. The Department made 41 new referrals to Tusla due to child protection concerns. Of the 117 families: 8 were already known to Tusla due to the level of risk to their children, 21 experienced homelessness as a direct result of their experience of domestic violence and Gardaí were actively involved in supporting 45 of these families in relation to their experiences of violence. The MSW supported 10 families in accessing refuge accommodation.

The MSW Department offered a specialist service to 116 women with substance use issues and in 2025. Due to the level of risk 26 families were referred to Tusla. Children from 8 families were listed on the Child Protection Notification System. Women received intensive support and as a result most babies were discharged home with their parents with a robust safety plan in place however 4 babies were placed in alternative care.

Overall in 2025 six babies were discharged to alternative care. Five babies were placed in alternative care due to child protection concerns. One baby was discharged to pre-adoptive foster care.

Inclusion Health

In 2025 we offered a specialist service to 236 women who met the criteria for support in relation to 'Inclusion Health'. Of the 236 women, 86 were homeless, 30 were at risk of homelessness, 16 were Ukrainian families, 75 were seeking International Protection from other countries and 22 were Traveller women.

Achievements

- Third place for Innovation at The National Maternity Hospital RISE 2025 in Oral Presentation for Implementation of the Extended Working Week.
- Finalist for Best HSCP Led Project (2025) for Implementation of the Extended Working Week.
- Article publication in the Irish Social Worker Journal 2025 *'Domestic Violence in Pregnancy: Developing a Domestic Violence Specialism within the Medical Social Work Department in the National Maternity Hospital'*, Gillian McMurray & Karen McCormack.

***Laura Harrington,* Principal Medical Social Worker**

Pharmacy

The Pharmacy Department provides a comprehensive clinical, governance and medicines management service across maternity, neonatal and gynaecology care. We play a central role in ensuring the safe, effective and cost-effective use of medicines, while supporting education, audit, digital transformation and national service development.

Core functions of the department include the purchase, supply and dispensing of medicines for inpatient and outpatient use, and the provision of targeted clinical pharmacy services to high-risk and specialist areas including the Neonatal Intensive Care Unit (NICU), Maternal Medicines Clinic (MMC), Antimicrobial Stewardship (AMS) Programme and Pre-assessment Clinic (PAC). Where resources allow, clinical pharmacy input is also provided to gynaecology, antenatal and postnatal inpatient wards.

The department leads the development, implementation and oversight of medication-related policies, procedures, protocols, patient information and guidelines (PPPPG), ensuring alignment with national standards and best practice. Pharmacy also has responsibility for the development, optimisation and data analytics of medication functionality within the MN-CMS electronic healthcare record.

Pharmacy provides leadership of the Drugs and Therapeutics Committee and the Medication Safety Committee, which together deliver governance for the safe, effective and economical use of medicines within a budget, monitor medication use against evidence-based guidance, and oversee the hospital's medication safety strategy and workplan.

Key Outcomes

Overall activity within the Pharmacy Department increased significantly in 2025, reflecting rising clinical activity across the Hospital.

A total of 28,770 medications were dispensed, representing the highest annual dispensing volume in over ten years (figure 1). Clinical pharmacy activity also reached its highest level in five years, with 15,567 documented clinical pharmacy reviews undertaken.

During the year, 96 medication incident reports were received and reviewed from all clinical areas of the Hospital, supporting organisational learning and system improvement (figure 2). The majority of incidents occurred at the administration stage, consistent with national reporting trends (table 2). Five new medication-related PPPPG were developed, with a further 23 updated to reflect evolving evidence and practice. Twelve medication-related audits were completed to support quality improvement and assurance.

Antimicrobial stewardship remained a key focus. Antimicrobial consumption for 2024, the most recent data available from the Health Protection Surveillance Centre, was 35.08 defined daily doses per 100 bed days used, a modest increase from 34.03 in 2023. The antimicrobial point prevalence survey demonstrated 100% compliance with AMRIC criteria for intravenous-to-oral switch and surgical antimicrobial prophylaxis, reflecting strong multidisciplinary engagement and governance.

RSV Immunisation

At the end of the first season using nirsevimab, national uptake was 83%, while NMH achieved an uptake rate of 87.5%, ranking us third nationally and the highest among tertiary referral maternity units. Informatics pharmacists in NMH and the Rotunda collaborated on an in-depth analysis of determinants of uptake, which informed national communications for the subsequent immunisation season.

Rosie Kirwan, Senior Pharmaceutical Technician.

Staff Highlights and Achievements

Following decades of collective engagement, the Hospital pharmacist career structure was revised in 2025 to include a new grade of Advanced Specialist Pharmacist. All three senior pharmacists in NMH were successful in being appointed to this grade, representing a significant milestone for professional development, workforce sustainability and specialist service delivery.

We joined the European Network of Teratology Information Services (ENTIS) during the year; teratology is the scientific study of congenital abnormalities. This has strengthened collaboration with national and international medicines information and teratology services.

We also provided on-site support for MN-CMS go-lives in The Coombe Hospital and University Maternity Hospital Limerick, supporting staff transition to the electronic healthcare record.

Throughout the year, greater than 90% of prescriptions for reserve antimicrobials were appropriately authorised or compliant with hospital policy, demonstrating robust antimicrobial governance.

Goals for 2026

Key priorities include further strengthening medicines safety, workforce capability, digital innovation and patient education.

The department will assist in the implementation of a streamlined medicines management process for intravenous iron infusions, addressing risks associated with skin staining, ensuring appropriate written consent and strengthening prescriber–pharmacist dispensing checks. Pharmacy will also seek to expand pharmacy technician staffing levels to enable technician-led medication top-ups across all inpatient clinical areas.

Funding secured through the HSE Spark Innovation Programme will be used to develop a short patient-facing educational animation on nausea and vomiting in pregnancy and hyperemesis gravidarum, supporting early symptom recognition and self-management. In parallel, the department will develop in-house online medication safety learning modules targeted at clinical staff.

We will lead a collaborative project across the six MN-CMS sites to collate and analyse data on determinants of nirsevimab uptake following the second RSV immunisation season. Additional priorities include expanding the use of upgraded smart infusion pumps with integrated drug libraries across adult clinical areas, streamlining medication incident and good-catch reporting processes, and progressing implementation of HSE AMRIC guidelines for monitoring and measurement of antimicrobial stewardship programmes in acute hospitals.

***David Fitzgerald,* Pharmacist Executive Manager**

Figure 1: Number of medications dispensed

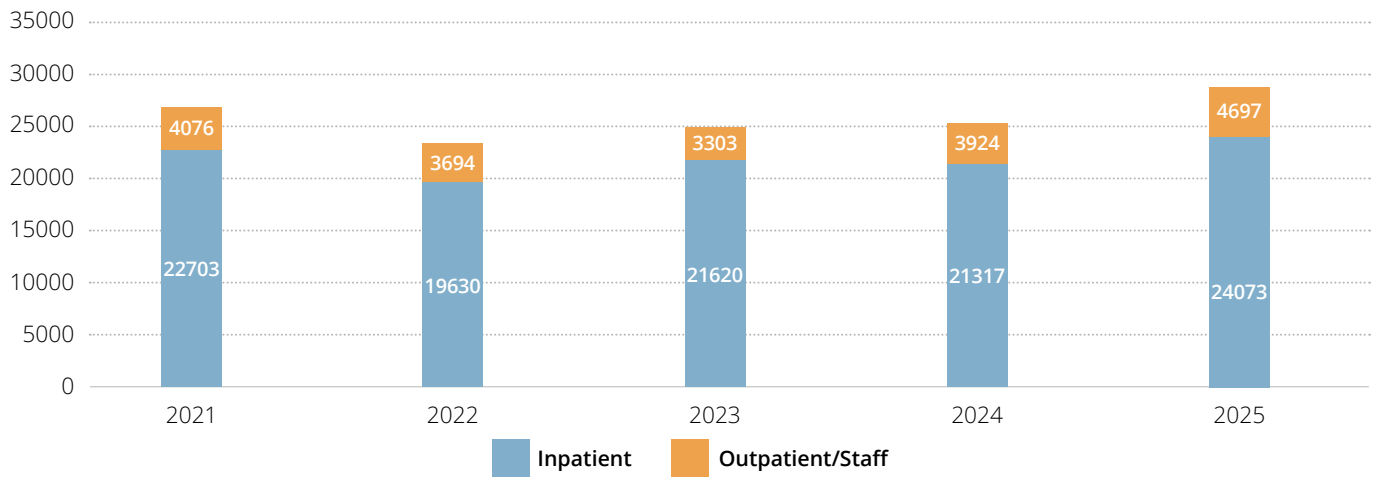


Table 1: Clinical pharmacy reviews

	2021	2022	2023	2024	2025
Number of Reviews	15134	15227	14641	14214	15567

Figure 2: Number of dedication incident reports

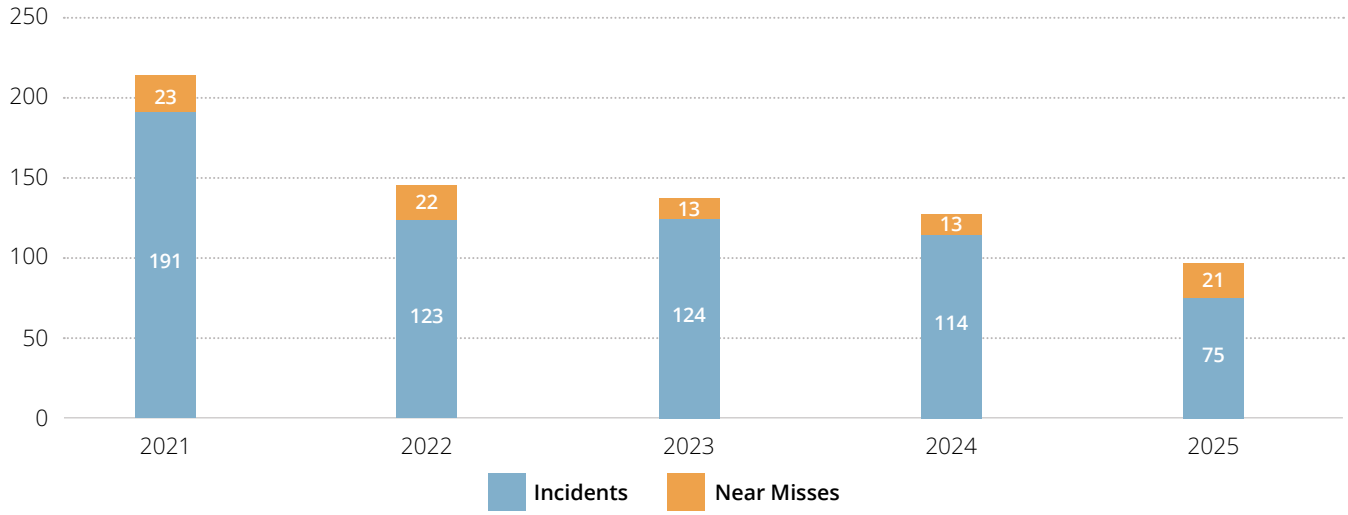


Table 2: Medication incident report parameters (n=96)

Reporter roles	Number	% of incidents
Nursing/midwifery	56	58%
Pharmacy	32	33%
Medical	8	8%

Stage of error occurrence	Number	%
Prescribing	33	34%
Administration	54	56%
Storage	8	8%
Medication reconciliation	1	1%

Top 3 Primary contributory factors	Number	%
Dose incorrect	19	16%
Administration not documented	16	13%
Duplicate dose administered	13	11%

Drug / class involved: top contributors	Number	%
Antimicrobials	17	17%
Tinzaparin	14	14%
Prostaglandins (Propess & Prostin)	9	9%
NSAIDs	8	8%
Paracetamol	7	7%

Montserrat Corderroura, Senior Pharmacist Neonatal Intensive Care Unit (NICU) and Liadh Timmons, Neonatal Dietetian in the NICU.

Physiotherapy

The Physiotherapy Department offers an inpatient and outpatient service across Maternity, Women's Heath and Neonatology. We also offer a service to the multidisciplinary Pelvic Floor Centre team based in St Michael's Hospital, undergraduate placements for UCD Physiotherapy Students as well as the following classes:

Maternity	Women's Health	Neonatal
Pregnancy Wellbeing Class	Pelvic Floor Care Class	Little feet, big steps
Pelvic Girdle & Back Pain Class	Preparation for Surgery	Thrive (in person class)
Healthy Bodies after Birth Class		

It was a particularly busy year with over 4,550 new patient referrals. The increasing demand shapes how we deliver our service with increased group classes taking place to accommodate everyone. We provide a telehealth assessment for all adult referrals initially to gather all information and give first line advice and guidance with a library of The NMH resources at our disposal.

Department activity is reviewed under Maternity, Women's Health and Neonatology. Patients are seen either as inpatients, on all maternity and gynaecology wards as well as the neonatal units, or as outpatients in the Physiotherapy Department. Some patients may require just one visit but most will require a number of treatment sessions. During the year, we commenced a monthly remote clinic in Arklow Primary Care Centre to facilitate patients living in Wicklow South.

Physiotherapy in Maternity

We offer outpatient and inpatient physiotherapy to all maternity patients. We treat a range of musculoskeletal and pelvic floor conditions during pregnancy and postnatally. Table 2 shows that the bulk of our maternity patients are referred with back and pelvic pain. In order to facilitate these patients as efficiently as possible, we run a virtual back and pelvic care information session weekly and a monthly virtual pregnancy wellbeing class focusing on physical care during pregnancy. We also run a weekly virtual postnatal class entitled Healthy Bodies After Birth class. The attendances at these classes surpasses the numbers we reached when they were held in person.

Physiotherapy in Women's Health

We run an outpatient women's health physiotherapy clinic treating patients with pelvic floor dysfunction. We also review inpatients admitted for major gynaecology surgery. We present a virtual Pelvic Health Class initially for all triaged referrals to the urogynaecology clinic to improve efficiency.

Physiotherapy in Neonates

Neonatal Physios continue their involvement in the Early Cerebral Palsy detection project alongside the delivery of physiotherapy care to the remaining neonatal caseload.

Physiotherapy in Education:

We lecture RCSI medical students, UCD Physiotherapy BSc students, postgraduate diploma neonatal nurses and hold teaching sessions with NCHD's.

***Judith Nalty*, Physiotherapy Manager**

Table 1: All physiotherapy referrals

Year	2021	2022	2023	2024	2025
Total	4148	4010	4364	4441	4550

Table 2: Maternity reason for consult

	Maternity New Patients	% breakdown
Pelvic girdle pain	1502	45%
Other*	901	27%
Urinary incontinence	272	8%
Pregnancy related carpal tunnel syndrome	176	5%
OASIS	111	3%
Pelvic organ prolapse	94	2%
Coccyx pain	93	2%
DRAM	57	2%
Pelvic floor pain / dyspareunia	39	1%
Urinary urgency	31	1%
Thoracic/rib pain	26	1%
Faecal incontinence	14	1%
Respiratory	9	1%
Urinary retention	8	1%
Faecal urgency	4	-
Prev OASIS symptomatic	4	-
Prev OASIS asymptomatic	4	-
C-section complications	2	-
Total	**3347**	**100%**

**'Other' refers to options currently not available for selection on the MN-CMS and include the following sciatica/hip pain/lower back pain*

Table 3: Women's health reason for consult

	Women's Health	% breakdown
Bladder dysfunction	205	33%
Peri-operative care	184	29%
Prolapse	81	13%
Pelvic pain/dyspareunia	71	11%
Pelvic floor dysfunction	68	11%
Bowel dysfunction	10	2%
Respiratory assessment	2	1%
Total	**621**	**100%**

Table 4: Neonatal reason for consult

	Neonatal Inpatients	Neonatal Outpatients
Neurodevelopmental	189	111
Talipes	39	54
Reduced upper limb movement	13	13
Brachial plexus injury	10	10
Fractures	11	11
Developmental dysplasis of hip – pavlik harness application	12	CHI follow up
Other	26	15
Head & neck assessment	21	48
Total	**321**	**261**

The Physiotherapy Team.

Psychosexual Therapy

The Psychosexual Therapy Clinic continues to be very active with external referrals received from General Practitioners and hospitals within the HSE Dublin South and East Region.

Internal referrals were received from a variety of clinics within the Hospital including gynaecology, fertility, post-natal, physiotherapy, complex menopause, social work, perinatal mental health, adolescent gynaecology, oncology and consultant clinics.

As in previous years, there remains a lengthy waiting list to be seen with vaginismus (difficulty with vaginal penetration during sexual or non-sexual activities including tampon insertion and gynaecological exams) continuing to be the primary concern for women referred for assessment and treatment. Other referrals to the clinic included a range of sexual concerns requesting help for painful intercourse, anorgasmia, desire discrepancies, erectile dysfunction, sexual intimacy and medical conditions affecting sexuality.

Much of the focus has been on trying to reduce the waiting list but also to upgrade the technical side of the work, updating website information and liaising with other clinics in the Hospital with education and information sessions.

A new 'opt in' initiative was started in January 2025. All 2025 referrals were sent an 'opt in' letter asking that they email the Department if they wish to avail of the service and be placed on the waiting list. Those who replied were subsequently contacted by return email to offer them an initial appointment within six weeks. The rationale for the new procedure allows for early assessment of referrals, to gauge client motivation and provide brief intervention as appropriate. We hope to assess the efficacy of this new procedure when regular therapy appointments are being offered to 2025 referrals.

Trainee Psychosexual Therapist, Julia Daly completed her training in June 2025 and was successful in achieving the London Diploma in Relationship and Psychosexual Therapy; the hope remains that she sets up a Psychosexual Therapy Clinic.

Corinne Bezy-Henry and Meg Fitzgerald, NMH Psychosexual Therapists at a 'Ladies Lounge event during the year. The INMO Ladies Lounge event is a popular, nurse-led educational series focusing on women's health, featuring topics like menopause, pelvic floor care, and dermatology.

We presented at the Ladies Lounge INMO Event and continue to provide lectures to Medical Students throughout the year as well as participating in the ICGP Community Gynaecology Course in March.

The Psychosexual Therapy Department hosted a very successful training day with the Integrated Psychosexual Development Group (IPDG) which is a collaborative group of Psychosexual Therapists on the Island of Ireland interested in developing understanding of psychosexual practice from an integrated perspective.

A blended approach to counselling work continued throughout 2025. Clients are seen for Initial Assessments in person and if suitable are offered the option to attend for further counselling sessions online or in-person in the clinic.

134 new referrals were received in 2025: 85 referrals came from a waiting list from 2024 and 26 cases continued therapy from 2024.

Meg Fitzgerald
Psychosexual Counsellor

Table 1: Dysfunctions and Outcomes in 2024 and 2025

		2024	2025
Female	Vaginismus	120	125
	Dyspareunia	58	58
	Inhibited sexual desire	29	29
	Anorgasmia	9	12
	Relationship issues	0	10
	PGAD	0	1
Male	Erectile dysfunction	9	6
	Premature ejaculation	3	0
	Delayed ejaculation	2	2
	Unconfirmed	14	2
Total		**244**	**245**

Referral Sources	2024	2025
Consultant/NMH Staff	103	101
General practitioners	77	83
Other agencies/hospitals	47	41
Self-enquiries	17	20
Total	**244**	**245**

Outcome	2024	2025
Engaged in weekly/fortnightly therapy or brief intervention	80	69
Reviewed but did not avail of contact	46	35
Placed on waiting list for 2024	85	14
Referred to private clinic	15	16
Referred to external/local PST services	18	27

New 'opt in' initiative	2024	2025
Seen for 'opt in' meeting and placed on waiting list for 2026	-	46
Declined to avail of service and removed from waiting list	-	38
Total	**244**	**245**

Radiology

The Radiology Department is a core component of hospital operations, providing essential imaging and image-guided services that support diagnosis, treatment, and ongoing patient management. It serves as a bridge between clinical suspicion and confirmed diagnosis, enabling healthcare teams to make informed, timely, and effective decisions. The department provides diagnostic services to both adult and neonatal patients. The department is staffed by a multi-disciplinary team including radiologists, radiographers, sonographers, nursing and admin support staff.

The main radiology department is located on the ground floor with MRI located on basement level. It is equipped with a general radiography, fluoroscopy suite, ultrasound, MRI and a portable x-ray and ultrasound service.

Adult Investigations	Neonate Investigations
General radiography	General radiography
Fluoroscopy studies, Cystograms, Hystereosalpinogram	Fluoroscopy studies, Barium/Swallow meal, contrast enemas
Ultrasound – Gynae and body imaging	Ultrasound neonatal Imaging
MRI Imaging: Fetal, placental and gynae	MRI neonatal imaging

Prof Gabrielle Colleran, Head of Radiology and Katie Campbell Clinical Specialist Radiographer.

Magnetic Resonance Imaging Unit

The National Fetal MRI service continues to grow in numbers with 369 scans performed in 2025, an increase of 37% in the past three years alone.

The MRI gynae service introduced in 2024 has continued to grow with the addition of Dr Mary Renton to our already established adult radiologist team; this now allows for all reporting to be done in house. This has successfully reduced reporting waiting times and improved the continuity of patient care with direct support provided within the Hospital.

The field of fetal medicine is characterised by continuous innovation and collaboration, of which research plays a significant role. In 2025, MRI commenced a research partnership with The Rotunda Hospital to investigate Intrauterine Growth Restriction (IUGR) and hopes to continue to actively contribute to fetal imaging research throughout 2026.

Radiology Ultrasound

The adult gynae ultrasound service has continued to grow in 2025 with an additional sonographer weekly clinic supported by the increase in radiologists. This has successfully reduced the waiting list whilst also providing immediate access to urgently requested scans for faster diagnosis and treatment initiation for patients.

The team streamlined the booking process in 2025 to optimise workflow efficiency, reduce patient DNA's as well as providing increased information through patient leaflets received ahead of their appointments.

Portable ultrasound within the Neonatal Intensive Care Unit continues to be busy and dynamic with an increasing level of births seen at The NMH last year.

The National Hip programme continues to grow rapidly with an increasing volume of referrals. 2025 saw additional staff trained in this area of expertise to facilitate these growing requests.

General X-ray

The general x-ray service operates emergency cover 24/7, 365 days a year for general and mobile x-ray in addition to fluoroscopy examinations. Over 90% of x-ray activity is neonatal in nature, including portable imaging for critically ill and premature neonates.

The adult service supports gynaecological and fertility diagnostics under fluoroscopic guidance as well as general radiographic imaging for the Emergency Room and hospital patients.

The service operates within a strong radiation-protection governance framework, ensuring examinations are clinically justified and radiation dose is optimised to achieve diagnostic quality while minimising exposure to patients in line with internationally recognised radiation protection principles. Cross-site collaboration with other Dublin-based maternity hospitals ensures best practice guidelines are consistently adhered to.

During the year, 'Imageshare' was introduced; this is a national project that allows efficient electronic study transfer across sites within Ireland, UK and directly to specialist referrers thus enhancing our overall imaging service.

***Laura Moyles,* Radiographic Services Manager and *Prof Gabrielle Colleran,* Head of Department**

Administration

Compliance and Data Protection

Compliance

Compliance at The National Maternity Hospital reflects a sustained commitment to strong governance, public accountability, and the highest standards of organisational stewardship. As a voluntary hospital operating within a complex regulatory landscape, we continue to meet extensive reporting obligations to the HSE, HIQA, the Charities Regulator, and other oversight bodies. Compliance remains a central focus of the Executive Committee (The Board), supported by its sub committees and staff, who monitor requirements closely and provide structured reporting to ensure full alignment with rules and regulations.

Our annual reporting to the Charities Regulator's Code of Governance demonstrates our adherence to recognised best practice. Corporate governance arrangements, including Board structures and responsibilities, are benchmarked against the Code of Practice for the Governance of State Bodies and the HSE Code of Governance. Board members participate in annual refresher seminars to maintain a high level of awareness and capability in governance matters. Through the Annual Compliance Statement, we outline our position across governance, finance, procurement, risk management, taxation, remuneration, and compliance with the HSE Service Arrangement. This process reinforces our commitment to transparency and continuous improvement.

Data Protection

Our Data Protection Management System is fully aligned with GDPR, and staff maintain a strong understanding of their responsibilities in safeguarding personal information. Data protection considerations are embedded in planning and operational decision making.

We continue to reduce off site storage of departmental records, supported by a revised Retention and Destruction Policy that strengthens the processes for transferring and disposing of material. A comprehensive register of third party vendor contracts provides full oversight of renewal timelines and procurement requirements.

Patient Chart Requests

The Hospital upholds the right of individuals to access their personal information. Activity levels have remained consistent, with more than 1,400 requests completed during the year, the majority from patients directly. The completion of the 'From Request to Report' project has enabled the secure digital provision of records. This approach has improved efficiency, reduced costs, and been positively received by patients and clients.

Training

Staff training continues to play a central role in maintaining high standards of data protection. Mandatory General Data Protection Regulation (GDPR) training is completed by all staff every two years, with additional training provided to new starters. Data protection awareness is integrated into the induction programme, and regular communications help reinforce good practice and confidentiality obligations.

Breaches

The Hospital maintains a culture of transparency in the reporting and management of data breaches. Staff are supported by an internal online reporting system that ensures clarity and accessibility. Fewer than 25 breaches were reported during the year, representing a reduction of 10 compared with the previous year.

Significant breaches are notified to the Data Protection Commission and are subject to internal review. Where necessary, processes are strengthened to reduce the likelihood of recurrence and to support continuous improvement in data protection practices.

Carl Alfvag
Compliance and Operations Manager / Data Protection Officer

Development Project Office

The National Maternity Hospital (NMH) at Elm Park

Advanced enabling works continue at the St Vincent's Hospital site and are expected to be completed by mid-2026, preparing the campus for the development of the new National Maternity Hospital at Elm Park.

The new Programme Board for the NMH at Elm Park held its inaugural meeting in February 2025. NMH is represented by two senior staff members and the team continues to provide ongoing support. The Board holds responsibility for the planning, design, construction, equipping, transition, and operational commissioning of the new NMH at Elm Park. Main contract tenders were issued in April 2024, followed by a detailed evaluation process. A preferred bidder was identified and a letter was issued for a Pre-Contract Services Agreement. The Final Business Case (FBC) has been reviewed and updated by The NMH and the Programme Board, this was submitted to Government for Approval Gate 3 ('approval to proceed'). Subject to approval, the main construction works are anticipated to commence on site mid 2026.

Digital Health Steering Group (DHSG)

The DHSG formally stood down in October 2024 however, work continues across a number of ICT work streams. The Single Sign-On project was successfully completed, marking the first ICT enabling project delivered in preparation for the NMH's move to Elm Park. The NMH is one of the first hospitals to implement it. The team continues to support and work with HSE Estates and the new Programme Board.

NMH Project Office

We provide project management support, input and advice for digital health projects to ensure that they are aligned with the Hospitals current needs and future requirements of the NMH at Elm Park project. The team were involved with the following NMH at Holles Street projects in 2025:

- Nurse call upgrade
- Paging system upgrade
- Translation device implementation
- Winpath upgrade
- Development of a ICT Strategy Roadmap

Zoho

A Zoho Administrator was appointed to oversee Zoho with a focus on strengthening governance, enhancing regulatory compliance, reinforcing data protection standards, and implementing structured operational controls. A comprehensive governance database of all applications, users, roles, and permissions was developed and will be maintained to ensure traceability, accountability, and improved oversight of system access. The following was also accomplished:

- Enhanced access control measures were introduced, including IP-based login restrictions within the hospital network and the enablement of multifactor authentication for Zoho account access, reducing unauthorized access risks and strengthening safeguards around sensitive staff and patient-related information.
- The policy for the use of Zoho was reviewed and updated in conjunction with the Zoho Applications Platform Committee to better define platform scope, development responsibilities, access governance, and acceptable use standards.
- A new Zoho ticket support application was built to strengthen governance, formalise development and amendment requests, introduce structured approval workflows, and provide measurable oversight through reporting and task tracking.

Shay Moriarty* and *Sarah McCourt
Project Office

- Microsoft 365
- Network and Information Systems 2 directive
- Swiftqueue
- Single Sign On

Hospital Inpatient Enquiry (HIPE)

The HIPE system collects information on hospital day cases and inpatient activities in Ireland. The HIPE system and associated coding will determine the invoicing and future budget of the Hospital.

In 2025, there were a total of 17,356 discharges recorded on HIPE. HIPE staff review the electronic patient record and extract principal diagnosis and procedures. Medical classification codes are then assigned as per ICD-10-AM 12th Edition or Turbo Coder (e-book). A principal diagnosis and up to 29 additional diagnosis as well as a principle procedure and up to 19 additional procedures. These are then grouped into a DRG (Diagnostic Related Group) which categorises patients into groups based on clinical similarities and resource consumption. They are then exported monthly to the Healthcare Pricing Office (HPO) with a strict 30 day deadline. The Hospital budget will be set based on agreed/ commissioned Activity Based Funding target levels and monies will only be provided when activity is carried out and invoiced i.e. coded.

***Liz Mahon,* HIPE Supervisor.**

Table 1: HIPE discharges and bed days used 2025

	Total	%	ALOS	Inpatient Bed Days	Day Case	Average Age (yrs)	Inpatient WU	Day Case WU
Obstetrics	14352	83.7	2.4	29449.5	2277	33.5	14788.3	362.9
Gynaecology	1475	8.5	2.0	1112.0	944	46.2	1093.0	686.3
Neonatology	1272	7.3	8.2	10394.5	0	0.0	6216.0	0.0
Anaesthetics	77	0.5	1.0	1.5	76	46.0	1.1	13.7
Total	**17356**		**2.9**	**40957.0**	**3297**	**32.2**	**22098.4**	**1062.8**

WU = weighed unit

Staff Midwife Joy Adekanmbi Baka with Eimear O'Doherty in the Antental Ward.

Human Resources

The Human Resources Department (HR) provide the Human Resources and Pension Management functions for the Hospital. This includes providing employment advice and guidance on employment best practices, talent acquisition and retention, optimising employee relations and other issues.

Talent Retention

The biggest challenge for HR professionals continues to be people related, particularly within the current backdrop of the wider HSE National Pay and Numbers Strategy. The recruitment, retention, succession planning, completion of mandatory training and provision of opportunities for further development continues to be challenging. Monitoring and analysing employee turnover helps in identifying areas for improvement. HR provide quarterly activity report to the People and Organisation Committee. Staff at the Hospital who reach 25 years' service are awarded 5 extra day's holidays as a once off recognition of their dedication and loyal service. A ceremony is also held annually in recognition.

Some members of the HR Team.

Some retired members of staff at the Coffee Morning for Retirees.

Recruitment

We continue to be impacted by the HSE National Pay and Numbers Strategy, which limits our ability to attract talent, fill open posts and further develop services such as Menopause, Endometriosis, Fertility, Genetics, Urogynaecology, and Perinatal Mental Health.

The Hospital has encountered some challenges in recruiting particular categories of staff with the relevant skill requirements within Midwifery & Nursing and Health & Social Care Professionals. HR continue to create new links with institutions in other countries to attract staff to the Hospital and also engages with the HSE national framework for international recruitment. There is also support provided to aid candidates in achieving Nursing and Midwifery Board of Ireland (NMBI) registration.

Pensions Management

The NMH as an organisation is fully compliant with the Single Public Service Pension Scheme (SPSPS) across the three key areas of statutory responsibility (Section 43 of the Act). The National Maternity Hospital was requested to be represented on the Single Scheme Compliance Forum Group to assist other Hospitals with compliance.

HR Information Systems

HR has continued to evolve its HR system (Softworks) and e-learning system (Totara). Since their upgrade in 2023 and 2024 the HR team have continued to automate data.

NMH Strategy 2024 – 2028

HR progressed forward with the Hospital's Strategic Goal 2. This involved engagement with EMT and Staff, analysis and identifying our strengths, weaknesses, opportunities and threats to plan our next steps to achieve our goal 2 of 'Be the Employer of Choice'.

Absenteeism

The average absenteeism rate for the hospital in 2025 was 4.3% at year-end; this still includes absences due to the Covid-19 pandemic (0.1%). The HSE national target for absenteeism in normal circumstances is 4%. Our overall sick leave figure continues to be in line with the HSE average when absence due to the Covid-19 pandemic is omitted.

Employee Assistance Programme (EAP)

This is an independent confidential service provided by VHI for the Hospital; 38 staff availed of the service of advice on personal and legal matters, counselling sessions etc.

***Caoimhe de Brun,* Human Resources Manager**

Figure 1: NMH's corporate strategy 2024 – 2028

Figure 2: NMH strategic goals

Information Management

Health information management is an important and essential resource: hospital data from various clinical and administrative systems is validated and analysed in order to produce meaningful reports to support and improve decision making, for staff and patient information, national returns, clinical audit, research publications and presentations, medical coding and billing.

The main source of data is from the electronic patient record that every patient across all specialties has on the national Maternal and Newborn Clinical Management System (MN-CMS) and the national Patient Management System iPMS. MN-CMS reporting revolutionised clinical data analytics in The NMH and ongoing challenges in developing and rolling out reports have eased over the years. Where clinical systems are not available, local measures are taken to ensure essential data is captured and audited.

Improving information management practices is a key focus for many organisations across both public and private sectors and we are no exception. Generating interest in reporting and outcomes plays a significant role in improving practices and can provide motivation to ensure high quality data is recorded in order to return high quality reporting. However, it is not always simple: daily, weekly, monthly and annual validation checks undertaken on data across many systems takes time and requires the expertise of busy staff in particular the MN-CMS Department, Quality, Risk and Patient Safety Department, Labour & Birthing Unit Staff, Clinic Supervisors and iPMS Administrators. Efforts become all the more worthwhile as the benefits of high quality reporting are seen.

A full redesign of the main dashboards was completed during the year, incorporating feedback from the Communications Team and the MN-CMS Team, to enhance clarity, visual appeal and usability. In addition to this, a new comparison dashboard was produced in order to analyse trends from different years and improve awareness of changes in clinical practice.

Working with the Master's Office, a review of birth numbers over the past 80 years was conducted and analysed. This was part of an overall effort throughout the year of providing the Master of the Hospital with monthly activity reports on relevant clinical data and overall hospital activity. Such efforts also culminated in using these figures to showcase hospital activity in a dashboard for The NMH Culture Night.

Following a change to the Irish Maternity Indicator System (IMIS) reporting periodicity which is managed by the National Women and Infants Health Programme (NWIHP), The NMH began reporting the IMIS returns and Ten Groups Summary on a monthly basis. Further coordination with NWIHP on improving the IMIS continues into 2026.

The Department has many functions across all areas of the Hospital:

- Extract and analyse information from hospital information systems to assist local management decisions and highlight changing/emerging trends across all departments.
- Organise Health Service Executive returns including Outpatient Cancellations, Bed Closures, Monthly Data Returns and Waiting Lists.
- Produce hospital activity reports for the Scheduled Care Committee, Clinical Governance Executive Committee, Executive Management Team, Finance Committee, Quality Risk and Safety Patient sub-committee of The Board as well as the Executive Committee (The Board).
- Coordinate the Irish Maternity Indicator System (IMIS) returns.
- Prepare and publish the monthly NMH Maternity Safety Statement online.
- Coordinate the completion and submission of all eligible perinatal death notification forms to National Perinatal Epidemiological Centre (NPEC).
- Project manage the Hospital Annual Report.
- Manage the submission of all eligible babies to the Vermont Oxford Network led by Breda Coronella.
- Fulfil ad-hoc, activity, audit and research requests for staff and students.

***Fionnuala Byrne*, Information Officer**

Information Technology

The IT Department provides technical support to all users across the Hospital. The main systems under the OES (Operator of Essential Services defined by National Cyber Security Centre) are Powerchart (Electronic Patient Record), IPMS, Winpath (Lab), Viewpoint (Fetal Assessment Unit), AGFA RIS-PACS (Radiology) and Mediscan (Colposcopy). We also act as the first point of contact for another 30 applications approximately e.g. E-Financials, Angel Eye, HSSD Systems, G2 Speech (Lab), Telephony Support and Microsoft applications.

Outcomes

- Viewpoint upgrade to Version 6 completed.
- Telephony upgrade was completed and old Nortel PABX was finally shutdown.
- SSO (Single Sign On) Project completed.
- 20 new laptops acquired
- 30 new PCs acquired
- Microsoft 365 preparatory tasks progressed
- Winpath upgrade project progressed.
- NIS2 Compliance work progressed. (Network and Information Security 2)
- Network Upgrade Project – work in progress and 32 new switches installed.

2026 Goals

- Winpath Upgrade to Enterprise version scheduled to be completed Q3.
- Network Upgrade scheduled to be completed Q3.
- Microsoft 365 – Pilot for 50 users to be targeted by end of Q2.
- SAN Refresh Project – scheduled to be completed by end of Q2. (Storage Area Network)
- Medical PCs (CTG Carts + Eview Carts) used for Powerchart – replace as Windows 10 is end of life.
- Upgrade of Windows 10 PCs (342) to Windows 11.

The IT Department continues to provide updates on our cyber security status to auditors like Crowe, PwC, the HSE CISO Department and NCSC. The introduction of NIS2 will mean continuous work on updating policies and adhering to any new requirements. Third party risk management in particular is a major area of concern. The four main systems that continue to protect the NMH Infrastructure are monitored and kept up to date.

- Juniper Firewalls with SKY ATP (Anti-threat Protection).
- Cisco Ironport for email scanning and filtering.
- McAfee Anti-Virus Software (now Trellix) was extended out to all PCs, Laptops and Servers as funding was provided by the HSE for Cyber Security initiatives.
- Darktrace – reporting on any unusual behaviour from any PC, Laptop or Server on the network.

The Network Upgrade Project funded by the HSE commenced during the year. 34 new Juniper switches were installed by year end. This upgrade work will see areas where the new switches are installed connect to the core switches at a speed of 10gbps.

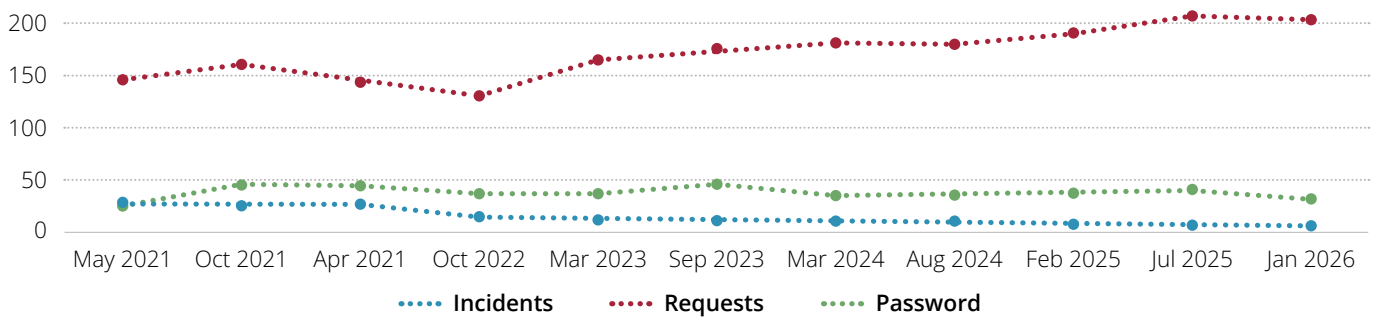
Figure 1 below shows the workload trends continuing on from last year's and starting in May 2021.

- Blue line represents Category 1 (break /fix) items.
- Green line represents Category 2 (password reset) items.
- Red line represents Category 3 (requests for assistance) items.

The drop in Requests logged (red line) during 2022 probably reflects a return of more stable operations after the effects of Covid-19 in 2020 and the cyber-attack in May 2021.

Con Grimes
IT Manager

Figure 1: IT workload trends 2021 – 2025



Patient Services

The Patient Services Department is a source of information and channels service users' queries in relation to Hospital services to the relevant areas. Service users' needs and care pathways are constantly changing and we are determined to meet these challenges.

The Patient Services Department aims to support other departments by providing effective and efficient administrative support to both clinical and non-clinical areas throughout the Hospital.

In 2025, we took part in the National Maternity Experience Survey: www.yourexperience.ie. 440 of our Patients who delivered in January or February completed the online HSE Survey. It was only the second one since 2020. The results were very positive: 86% of participants who gave birth at the Hospital said that they had a good or very good overall experience; this is higher than the national average (83%). Thirteen questions scored significantly above the national average for participants at The National Maternity Hospital. Between 2020 and 2025, there was a significant increase in the scores for five areas of care experience at The National Maternity Hospital. There were no significant decreases in scores for any survey questions.

In 2026, we will be implementing the Quality Improvement Plans associated with the National survey report and our own in-house experience surveys.

Freedom of Information

In 2025, there were 1,876 written requests in total received under Freedom of Information, Administrative Access and Data Protection. This was an increase of 10.5% on the previous year. 16 FOI requests received were corporate non-personal requests. 85% of the personal requests were for copies of medical charts.

Alan McNamara
Patient Services & FOI Officer

Ray Foley and Austin Omosigho, Patient Services Staff.

Jejel Choudary and Anna Lou Gedelanga, Theatre Staff Nurses.

Purchasing and Supplies

We continue to face immense challenges to the supply chain as a result of huge increases in shipping issues/costs, a worldwide shortage of raw materials and the ongoing war in Ukraine. The Medical Device Regulations continue to present challenges resulting in product withdrawal, inability to supply and various other issues impacting the supply chain. We were forced on an increasing number of occasions to seek alternative products for stock/non stock items. The flexibility, understanding and support of Department Managers throughout the Hospital in relation to these issues was very much appreciated. At all times during this year, we remained focused on the requirements of our Hospital Departments and Clinics whilst mitigating the impact of these market conditions.

Audits including the annual audit took place in 2025 and as always our full co-operation was provided. These audits are an essential part of what we do in the Department to ensure best practice is adhered to at all times.

The Stores Department received a renovation during the year which has created a far superior working environment for our Supplies Team.

We continue to work closely with the Tendering Department, holding monthly meetings where we receive contract updates and exchange relevant information.

The business of the Department is to provide maximum service with minimum risk whilst at all times striving to provide a high quality patient focused service.

Lorraine McLoughlin & Linda Mulligan
Purchasing & Supplies Managers

Tendering

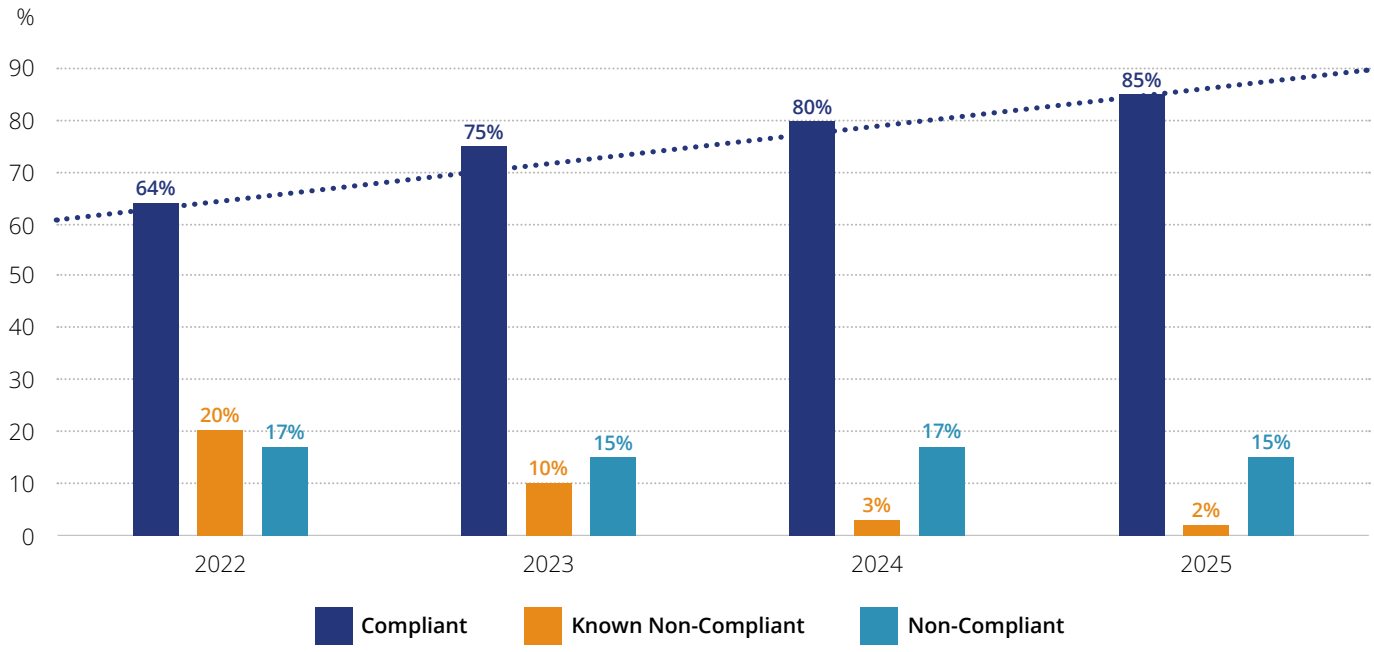
The objective of the Tendering Department, which works collaboratively with The Coombe Women & Infants University Hospital, is to ensure compliance with National and European procurement guidelines for expenditure throughout The National Maternity Hospital (NMH).

Activity and interaction between NMH, HSE Procurement and the Office of Government Procurement (OGP) continued and when financially advantageous, we benefited by utilising the national frameworks and contracts.

The focus for the year was to maintain the Hospital's high compliance rate with Public Procurement rules while exploring value for money opportunities as they arose; this was done by running compliant competitions resulting in more medical and surgical consumables being covered under formal contracts. This was only achieved because of the support and cooperation of all departments across the Hospital.

***James Byrne,* Tendering Manager**

Figure 1: Hospital compliance rates in relation to public procurement guidelines for non-salary spend.



Support Services

Catering

The Catering Department at NMH plays a central role in supporting patient care, staff wellbeing, and the overall hospital experience. The department delivers high-quality, safe, and nutritious meals to patients across all wards, operates the staff canteen, and provides hospitality services for meetings, training, and hospital events.

All meals are freshly prepared on-site with a strong focus on minimal processing and wholesome ingredients. Soups, main meals, baked goods, and desserts are largely produced in-house to maintain freshness, nutritional value, and strict control over food safety standards.

Patient nutrition is treated as an integral part of clinical care. The team works closely with dietitians and clinical staff to provide meals to patients with diet requirement, allergen-controlled options, and culturally appropriate choices. In a maternity setting, particular attention is given to the nutritional needs of mothers during pregnancy and postnatal.

The staff canteen provides healthy, affordable food options, offering daily variety including hot meals, salads, soups, and sandwiches. This service supports staff wellbeing, which directly contributes to patient care and overall hospital performance.

Hospitality services are delivered with a strong emphasis on presentation, quality, and punctuality. The department caters for Board meetings, study days, conferences, and official Hospital functions, tailoring menus to suit each event.

Sustainability and local sourcing remain key priorities. Fresh fruit and vegetables are sourced from a local supplier in Rush, Dublin, while Irish beef, eggs, and milk are staples in daily production. Supporting Irish producers strengthens local supply chains while maintaining high quality standards.

The department operates under a certified ISO 22000 Food Safety Management System, ensuring robust governance, traceability, and continuous improvement.

FSPA Food Safety Assurance Accreditation

Original Date: February 2011:
Version 08: Reissue Date: 10-10-23: Approved FSPA Mgmt Committee

Date of Audit 21.10.2025 **Audit Report :** National Maternity Hospital **Auditor:** Noel Marrey

	Overall Score (149/149)	**100%**	**Distinction**

This is a fantastic result and very well deserved. The staff are a credit to the Hospital and the Catering Department, and this is a result which reflects the high standard of food safety. Every member of staff was engaging and extremely proactive in answering questions about their role and responsibility and each had the knowledge and confidence to support their answers.

The National Maternity Hospital should be a benchmark in best practice for other Hospital Catering Departments. Operating a 3rd party accreditation system (ISO 22000 FSMS) with no issues / nonconformances identified is an achievement within the HSE environment. The management team deserve credit for maintaining food safety standards.

As this is my last year in the audit cycle, I wish the team the very best and continued success in future audits. Well done all.

AUDITOR: Noel Marrey **DATE**: 26 Oct 2025

In 2025, the department's excellence was nationally recognised when it won Gold for Caterer of the Year – Healthcare at the Healthcare 2025 Gold Medal Catering Awards for its service at The National Maternity Hospital. The awards marked a major milestone for Ireland's catering industry with over 150 entries in its first year, the programme was created to highlight exceptional standards across Irish catering. Winning Gold reflects the department's commitment to quality, safety, innovation, and patient-centred service.

Key Outcomes in 2025

- Successfully maintained ISO 22000 certification, demonstrating continued compliance with international food safety standards.
- Achieved high results in Environmental Health Officer inspections and hygiene audits.
- Awarded Gold – Caterer of the Year (Healthcare category) at the Healthcare 2025 Gold Medal Catering Awards, recognising excellence within a competitive national field.
- Maintained strong patient and staff feedback regarding food quality and service.
- Continued commitment to Irish suppliers and sustainable sourcing practices.
- Ongoing staff training in HACCP and food safety to strengthen internal compliance culture.

Goals and Targets for 2026

- The department aims to build on its strong foundations of quality, safety, and national recognition.
- Key priorities include maintaining ISO 22000 certification and strengthening food safety culture through continued training, internal audits, and the expanded use of digital monitoring systems such as Kelsius for temperature control and traceability.
- Improving patient experience remains central. Menu cycles will be reviewed to incorporate more seasonal dishes, expanded plant-based options, and continued alignment with clinical nutrition guidelines in collaboration with dietitians.
- Sustainability goals include reducing food waste through improved forecasting and portion control, reducing single-use plastics, and exploring environmentally friendly packaging solutions.
- Staff development will continue through enhanced training in food safety, culinary skills, nutrition awareness, and customer service. The department also plans to strengthen feedback systems to support continuous improvement and service innovation.

Staff Highlights and Achievements

- The department's success is driven by the dedication and professionalism of its team. In 2025, staff maintained high food safety standards, upheld ISO 22000 certification, and achieved strong audit outcomes.
- The highlight of the year was winning Gold for Caterer of the Year – Healthcare at the Healthcare 2025 Gold Medal Catering Awards. This achievement reflects the collective effort of chefs, catering assistants, supervisors, and management in delivering high-quality, patient-focused services.
- Staff actively engaged in HACCP and food safety training, contributed to menu development initiatives, and maintained high presentation standards across patient and hospitality services. Strong teamwork during busy service periods and special events further demonstrated the resilience and commitment of the team.
- Overall, 2025 showcased the department's professionalism, innovation, and unwavering focus on quality and patient-centred care within the NMH.

Liz Byrne
Catering Manager

Chaplaincy

We provide spiritual, emotional, grief and bereavement support to bereaved patients / families who have experienced early miscarriage, mid trimester loss, stillbirth, neonatal death and compassionate induction of labour.

Spiritual/Religious and Practical Support

The Chaplaincy Department recognises and values all belief systems in a developing multi-cultural society through co-ordination of appropriate chaplaincy services with representatives and ministers of all faiths and those of none. All services being led by the Chaplaincy Department are viewed through a broad lens therefore delivering a 21st century model of spirituality through providing appropriate support.

Mortuary / Chapel of Rest

The Chaplaincy Department take full responsibility for the management / co-ordination of the mortuary Chapel of rest services.

Activity

Table 1 below shows the areas where support has been provided. The chaplaincy office is used as a quiet space providing spiritual, emotional, grief and bereavement support to bereaved families and to staff members. There is also 'other' unspecified and unplanned support provided: this support often occurs informally with staff, patients and their families throughout the hospital. Also included in the 'other' support, is support provided to families whose baby's death had not been acknowledged in any way in the past. Many years ago, the type of bereavement support which we have today, was not available to bereaved families. In some cases, the loss was never spoken about or acknowledged. Sometimes we are contacted by families (NMH patients) who are stuck in their grief work and journey, or siblings who have only learned about their mothers and fathers unspoken loss in their advancing years. In these situations, we offer the bereaved family appropriate emotional, spiritual, sociological support. We also offer the bereaved family an opportunity to attend our Remembrance Service, including having their baby's details entered into our remembrance book. In some circumstances we have led a very gentle private ritual or prayer service for the bereaved family if we feel it would help them to become unstuck in their grief work and journey forward.

Remembrance

The Chaplaincy Department organized and led liturgies throughout the year in the Hospital. This year's Remembrance Service took place in St Andrews Church Westland Row which was very well attended.

Retirement

Helen Miley, Co-Ordinator of Chaplaincy Services has recently retired. Throughout her many years in the NMH, Helen has, in abundance, provided compassionate and empathic support for parents, their families and staff alike. While Helen is deeply missed in the Chaplaincy Office, on the bereavement team and throughout the NMH, we wish Helen the very best of health and happiness as she embarks in this new and exciting chapter in her life.

***Angela Neville*, Chaplain**

Table 1: Chaplaincy activity

	2024	2025
Stillbirth	113	87
Blessings / Baptisms	77	54
Other support	81	43
Neonatal death	24	13
Termination of pregnancy	7	9
Early miscarriage	2	7

Refers to support offered and not actual cases.
Bereavement CMS now care for patients following a loss <16 weeks estimated gestational age resulting in a decrease numbers since 2024.

Facilities Engineering

It was another busy year across all areas and we have seen increases in demand across all engineering activities on site.

Maintenance

The Maintenance team are responsible for the entire NMH site, its buildings, fabric, structure, plant and equipment. Working with the Environmental Officer we also manage and monitor key environmental aspects include energy usage. The maintenance team operates a 12 hour working system Monday – Saturday inclusive which has been very successful in meeting the needs of the NMH.

There are significant challenges in maintaining the existing ageing assets and infrastructure across the campus. Maintaining services requires an adaptive and flexible approach minimising disruptions.

We continue to carry out planned preventative maintenance repairs and upgrades and replacements of plant and equipment across the campus with over 4,000 repair calls being received. Major safety works have been completed in relation to the generators and HVAC systems. All works are undertaken in a live environment and substantial planning is undertaken to maintain safety.

NMH Projects

Key projects delivered focused on site safety and patient care. New emergency generators commissioned which provide electricity in the event of an ESB failure were completed in 2025. Phase 1 of the emergency lighting project was completed; hot water boilers were replaced and are providing hot water services more efficiently with reduced environmental impacts. Patient WCs and Showers were refurbished in several patient areas, lightning protection was installed on the building, CCTV upgraded and fire doors on the main escape stairs were replaced.

Planning for larger key projects commenced in 2025 and these will carry over into 2026. These include, new lift core (HSE), a new Ambulatory Gynae Facility (HSE), the development of a new Central Decontamination Unit (CDU) facility, pathology and anatomical labs, additional clinic rooms, an upgrade to Neonatal Intensive Care Unit, main space heating boilers, lift systems and Phase 2 of projects on systems such as emergency lighting and building management system.

Environment (Tatjana Bokanova Environmental Officer)

This area aims to ensure the continual improvement and prevention of unnecessary environmental direct and indirect pollutions meeting national, international, and self-established targets.

We set agreed performance targets each year across a broad range of environmental factors which drives environmental objectives to improve the overall Hospital's environmental performance in key areas such as energy management, waste management, water consumption, discharge to drain, green procurement management, training and awareness and general environment management.

All waste produced, energy consumed and water used within the hospital is monitored on a continuous basis, opportunities for improvements identified and reported to the Executive Management Team.

***Neil Farrington,* Facilities Engineering Manager**

	vs 2024
Total energy consumption	-1.7%
Degree day data	+0.44oC
Waste (tonnes)*	+4.9%
Waste (litres)^	+1.5%

** healthcare risk, domestic, chemical, recyclable, hazardous*
^ chemical, grease, cooking oil increase due to additional; in Grease Trap cleaning from monthly to every 3 weeks and large chemical clear outs from a few different areas

General Services

General Services is comprised of the Hygiene, Portering and Laundry, Security, and Switchboard Departments. Employing nearly 100 staff members, these supporting services collectively assist in underpinning the Hospital's clinical operations, often providing the first point of contact for patients and visitors

Hygiene Services

The largest of the General Services Departments, this area is responsible for the environmental cleanliness of all patient, visitor and staff areas of the Hospital, and contributes to the cleaning of medical equipment. We draw upon international best practices for our operating procedures and cleaning methods, and pair these with the latest cleaning technologies.

Over the past year, the Department monitored the Hospital's environmental hygiene through its management of the multi-disciplinary hygiene audits as well as through its involvement in the Hygiene and Infection Control Committees. We also fully participated in the Health Information and Quality Authority (HIQA) inspection of the Hospital, with multiple household staff interviewed by inspectors to assess their proficiency with Infection Prevention and Control requirements.

We continue to provide adaptable, patient-centred services to the Hospital's evolving requirements. To achieve this, we continue to invest in staff training and upskilling and pursue cost-effective products and equipment bearing in mind the impacts to the environment, and most importantly, to our patients.

Mark Anderson
Hygiene Services Manager

Jie Song, Household Assistant cleaning the floor using our newest scrubber dryer.

Portering and Laundry Services

This area provides operational support to the entire Hospital including the labour and birthing unit, theatre, laboratories, laundry services, front hall and stores. Services are delivered on a 24-hour basis and are structured under two principal areas: patient-centred services and facilities-based services. Patient-centred services involve direct engagement with patients, staff, and visitors, ensuring safe and efficient patient transportation and responsive general assistance. These services contribute significantly to patient flow, safety, and overall patient experience. Facilities-based services encompass essential operational functions including waste management and disposal, transportation of furniture and equipment, medical gas cylinder exchange, and grounds maintenance. These activities support clinical areas in maintaining safe, compliant and efficient working environments.

Laundry services include the collection and delivery of all laundered items in the Hospital daily, including scrub suits, bed linen, floor mops, entrance mats, bed curtains, and catering items. Approximately 55,000 items are processed each month.

We continue to prioritise staff education, compliance and professional development. Portering staff participate in mandatory training programmes and contributed to the development and implementation of a new 'Emergency Skills Training' programme in collaboration with the labour and birthing unit, further strengthening emergency preparedness and interdepartmental coordination.

The upgrading of the Hospital's beds was completed as well as the cot replacement program. All patient beds have now been successfully replaced to provide enhanced patient comfort and ease of operation, and improved manual handling safety for staff.

As Hospital services continue to evolve and expand, the Portering Services Department remains committed to delivering a responsive, efficient, and high-quality service while meeting increasing operational demands and maintaining the highest standards of patient and environmental safety.

Security

The Hospital's security services are co-ordinated through Portering, with personnel on-site 24-hours each day, monitoring access control and alarm systems, conducting routine and reactive patrols, and providing incident response services. In 2025, service levels were increased to provide an enhanced presence for key locations and departments such as Social Work.

Claudiu Zselemi
Portering Services Manager

Switchboard

The Hospital's Switchboard staff welcome patients and visitors attending clinics in 65/66 Mount Street as well as being the initial contact for anyone contacting the Hospital by telephone. Switchboard staff are responsible for maintaining the Hospital's paging system and test it daily to ensure emergency preparedness.

Kathleen Maguire
Switchboard Supervisor

Education

Learning and Development

The Learning and Development Department was established in 2024 with the purpose of reviewing the Hospitals' Training and Development by reviewing relevant policies, learning systems, training budgets, training gaps, mandatory training and the learning and development strategy.

The Mandatory Training Governance Committee was established towards the end of 2024. This committee meets to review Mandatory Training for all staff and training policies. Non-compliance is targeted and action is agreed to ensure improvement.

Key Outcomes

The publication of relevant policies such as the learning, training and development overarching policy, mandatory training governance terms of reference and mandatory training study/exam policy were all published in 2025.

Mandatory training classroom learning is held 5 times throughout the year. After each session the individual courses are reviewed by the attendants via a survey.

A virtual Transition Year (TY) programme was set up and run by the Learning and Development team in March 2025 for one day to inform TY students of all Hospital careers. Representatives from most Departments took part in this programme. It is a great opportunity to attract future talent to the Hospital.

The NMH e-learning platform (Totara) offers Hospital staff improved user interface and user experience, enhanced reporting capabilities, improved compliance features and security enhancement. Staff can view their Mandatory Training clearly and record their continuous professional development on the platform.

Fifi Awotundin, Student Midwife.

A number of educational and upskilling opportunities were communicated to staff during 2025 from HSE Leadership and Talent, HSEland, UCD Professional Academy and other free courses run by Tallaght Training centre.

The National Learning and Development Forum serves as a platform to connect, share best practices and discuss the common challenges and opportunities that are faced in Learning and Development roles throughout the country.

A significant amount of work was put into the Patient eLearning Hub Guide on the Hospitals website. These guides were created initially in 2020 and it is important that they are updated with improved and current content. The guides updated included The NMH guide to keeping healthy in pregnancy, The NMH guide to labour and childbirth, The NMH guide to feeding your baby, The NMH guide to caring for yourself and baby after birth and domino and homebirth service at The National Maternity Hospital.

The Learning and Development department will continue to focus on strengthening foundations with other Hospitals and HSE Leadership groups and training institutions, to improve CPD opportunities for our staff. We will continue to improve staff experience of our eLearning platform (Totara), continue to upskill our staff and promote a culture of continuous learning.

The Learning and Development strategy direction and framework, links in with Goal 2 and Goal 3 of the NMH Hospital Strategy and it is work in partnership with the goal leads and other Hospital network strategies.

Erika Martin-O'Shaughnessy
Deputy Human Resources Manager

Table 1: Education and training summary 2025

Area/ Venue - Study Day Conducted	Number of Study Events/ Sessions provided	Number of Staff Attended
HSELand Courses	58 Courses	5155 (combined completion)
NMH Internal Study Days	31 Courses/ 213 Sessions (combined)	2779 (combined attendance)
NMH E-Learning Courses	21 Courses	2660 (combined completion)
NMH Ward Based Clinical Skills	41 Topics / 101 Sessions (combined)	1351 (combined attendance)
Other E-Learning Courses	14 Courses	659 (combined completion)
Centre of Midwifery Education	32 Courses / 55 Sessions (combined)	387 (combined attendance)
Non-Funded External Conferences/ Study Days	28 Events	83 (combined attendance)
External Funded Study Days	19 Events	54 (combined attendance)
Total		**9382 (cumulative participation)**

Medical Education

The education group is multidisciplinary providing ongoing continuous training within the Hospital. Education will always be a priority in order to provide the best possible evidence based care to women, expectant mothers and newborns.

Key outcomes

University affiliated teaching: The NMH is a busy clinical unit with a strong and proud history as a teaching hospital for both undergraduate and postgraduate students in all disciplines: medical, midwifery, nursing, physiotherapy, social work, laboratory science, dietetics, and paramedics. Nearly four hundred medical and midwifery students undertake training here every year. There is ongoing training and support for students in the Masters in Ultrasound and Graduate Certificate in Professional Ultrasound. Dietetics, Nutrition, Physiotherapy, Medical Social Work, Medical Laboratory, Psychosexual Counselling and other health and social care professional (HSCP) students. There are also multiple masters and doctorate students (MD/PhD) working on research within the Hospital.

NCHD Training and Fellowships: Most of the non-consultant hospital doctors (NCHDs) are registered for training with the Royal College of Physicians (pathology/paediatrics/obstetrics and Gynaecology/Microbiology), the College of Anaesthetists or the Irish College of General Practitioners. The NMH provides training to fulfill the criteria for basic and specialist training in the specialties of obstetrics and gynaecology, anaesthesia, paediatrics and pathology.

Dr Mohamed Mustafa, Senior Registrar in Obstetrics.

Our fellowship programmes in Maternal Fetal Medicine, Labour Ward Management, Maternal Medicine, Placenta Accreta Spectrum, Neonatology, Urogynaecology, Obstetric Anaesthesia and Advanced Medical Education continue to be popular choices for highly trained and motivated trainees.

Multidisciplinary Major Emergency Simulations: We run two major simulations in the operating theatre, the first on vascular injury at laproscopic surgery and the second on the new postpartum haemorrhage/major obstetric haemorrhage guideline. Both are highly successful and stimulated extensive discussion within the multidisciplinary team including Medical Scientists.

Ongoing training: Extensive ongoing training for staff for the MN-CMS system, staff health and wellbeing, medication safety, medication reconciliation and continuing professional development are ongoing. The annual study day for General Practitioners also took place. The Labour and Birthing Unit (LBU) hold multidisciplinary weekly skills teaching and 'LBU Topic of the month'; there is ongoing training within the antenatal, postnatal and gynaecology wards and the antenatal clinic appropriate to their work.

PROMPT – Practical Obstetric Multi-professional Training: We ran more frequent PROMPT training sessions, significantly increasing the number of staff with updated certifications.

Lavanya Lakshmanan will be the midwifery representative for the National Learning Analytics Group. We are delighted that Lavanya will be working on their project in the Slaintecare Integration Innovation Fund, for which the NMH is a pilot research site.

Prof Mary Higgins
Consultant Obstetrician & Gynaecologist

Midwifery and Nursing Education and Practice Development

The Midwifery and Nursing Education and Practice Development Department leads the planning, coordination, and delivery of continuing education and professional development for both qualified staff and student midwives and nurses. The department's primary objective is to ensure that midwives and nurses are equipped with the knowledge, skills, and competencies required to deliver high-quality, evidence-based, and patient-centred care within a rapidly evolving healthcare environment.

A strong culture of lifelong learning is actively promoted, with staff encouraged to engage in a broad range of internal and external educational opportunities, including study days, seminars, conferences, and formal academic programmes. Many staff members are currently undertaking postgraduate, MSc, and PhD studies. The department acknowledges with gratitude the ongoing support of the Nursing and Midwifery Planning and Development Unit in funding education and research initiatives.

In collaboration with the Centre of Midwifery Education, the National Maternity Hospital provides a comprehensive programme of continuous professional development for nurses and midwives. Through sustained partnerships with higher education institutions, the Hospital remains committed to excellence in midwifery and nursing education for both students and qualified staff. This commitment supports the maintenance of high professional standards in education, training, and clinical practice, promotes professional conduct, and ultimately safeguards public health.

In 2025, the NMH continued to offer education and clinical placements for BSc and Higher Diploma Midwifery programs. Additionally, the NMH facilitated maternity care placements for approximately 200 UCD General, Children's & General Nursing, Public Health Nursing students and Health Care Assistants.

Congratulations to the following midwifery students who will be awarded prizes at the 2026 Charter Day Ceremony for having the highest GPA's. Gold Medal recipients: April Hayden (Higher Diploma) and Áine Denise Castaneda (BSc). Elizabeth O Farrell Medal recipients: Lucia Jiménex de Parga Moller (Higher Diploma) and Joy Oluwatimileyin Adekanmbi Baka (BSc).

Lucille Sheehy
Assistant Director of Midwifery & Nursing, Education & Practice Development

Lucille Sheehy (left), Assistant Director of Midwifery & Nursing; Education & Practice Development and Martina Cronin, CMM3 Labour and Birthing Unit (right) with Joy Oluwatimileyin Adekanmbi Baka (BSc Midwifery) who was awarded the Elizabeth O'Farrell Medal for achieving the overall second highest marks in the National university of Ireland exams and Áine Denise Castaneda (BSc Midwifery) who was awarded the Hospital Gold Medal for achieving the overall highest overall marks in the National University of Ireland exams.

Research and Innovation Symposium Exhibition – RISE

The fifth RISE Symposium was held in May. Established in 2020, RISE continues to showcase multidisciplinary research and innovation across the Hospital. A total of 67 abstracts were submitted (34 research, 33 innovation). Twenty-three were selected for oral presentation, with the remainder presented as posters. Submissions reflected strong engagement from clinical, academic and allied health teams throughout the Hospital.

The symposium featured a keynote address by Cormac McCarthy, Deputy Director of the UCD Clinical Research Centre, who highlighted the vital role of clinical trials and the supports available to investigators.

Award Winners – RISE 2025

Oral Presentation - Research

- Research Colm O'Herlihy Medal (1st): Dr Gillian Corbett - Oral Bifidobacterium breve supplementation alters Faecal Metabolome in Pregnancy with Reduced Risk of Gestational Diabetes
- 2nd Place: Dr Emmanuella Oluwaferanmi Akinsooto - Associations between dietary scores and metabolic health 10 years after pregnancy (ROLO study)
- 3rd Place: Dr Eva Hartigan - Induction of labour - does parity matter?

Oral Presentation - Innovation

- Innovation Declan Meagher Medal (1st): Dr Venita Broderick & Ms Niamh Murray - Development of a Video Animated Patient Information Resource for Ambulatory Gynaecology
- 2nd Place: Dr Sarah Petch - Does PICSI improve embryo euploidy in PGT-A cycles?
- 3rd Place: Ms Sinead Stakelum - Implementing the Extended Working Week in a Medical Social Work Department

Poster Presentation - Research

- 1st Place: Ms Grace Mealy - Stress and depression risk in early pregnancy associates with suppressed TNF-α levels
- 2nd Place: Ms Ailbhe Harrington - Growth and Feeding Among Infants Born at Different Stages of Prematurity
- 3rd Place: Dr Sarah Petch - Impact of e-cigarette use on ovarian reserve and ART outcomes (systematic review)

Poster Presentation - Innovation

- 1st Place: Ms Bronwyn Redmond - Timing of dressing removal post caesarean section
- 2nd Place: Ms Ciara Coveney - Pregnancy with Type 1 Diabetes Mellitus at NMH
- 3rd Place: Ms Lorna O'Connor - "Feeding my baby at home after NICU" online class: a quality improvement initiative

Special Awards

- Best Audit: Dr Róisín Ní Dhomhnaill - Outcomes after Elective Caesarean Section according to ERAS Standards
- Best Student: Mr Jack Diviney - Preterm Prelabour Rupture of the Membranes and Maternal Morbidity in Mid Trimester Loss

Further details of all projects and photographs from the event are available in the NMH Annual Research Report.

***Prof Fionnuala McAuliffe,* Consultant Obstetrician & Gynaecologist and *Grace Mealy,* Research Coordinator**

Prof Shane Higgins with Dr Venita Broderick whom, along with her colleague Dr Niamh Murray, were awarded the Declan Meagher Innovation Medal for their presentation, "Development of a Video Animated Patient Information Resource for Ambulatory Gynaecology".

Research Ethics Committee

The National Maternity Hospital Research Ethics Committee is both a Local and National Ethics Committee. It is approved by the Department of Health to review National Perinatal Studies. It reviews Obstetric, Neonatal, Anaesthetic, Gynaecology and Perinatal Pathology research.

Monthly meetings are held with the exception of August. There is one quarter lay attendance and a quorum is required at each meeting.

Generally, the applications are approved at each meeting; if not approved the Chairman will request clarification on a particular issue. A final decision is always made at the second review of the Committee. The average length of time between receipt of an application and a final decision by the Committee is 4-8 weeks.

In 2024 the Research Ethics Committee received 52 new research application proposals, this was an increase from 2023 when we received 44.

42 of the applications were approved at first review, 6 needed further clarification. 4 were deferred with no further submission.

***Prof John Murphy,* Research Ethics Committee Chair**

Prof Declan Keane with Eve Lehane who was awarded the RCSI/NMH medal for obtaining the highest marks in her final Obs/Gynae exam.

Royal College of Surgeons in Ireland

Thirty-five undergraduates from the Royal College of Surgeons in Ireland (RCSI) attended The National Maternity Hospital (NMH) in 2025 for their six weeks' rotation in Obstetrics, Gynaecology and Neonatology; 19 students in January/February and 16 in February/March.

The programme was co-ordinated by Professor Declan Keane and Dr Ita Shanahan, the tutor. Caroline McMillan provided invaluable administrative support to the students. Teaching was provided by Consultants and various other members of Hospital staff. In addition to the obligatory e-learning programmes, the students rotate through all areas of the hospital, including the labour and birthing unit, postnatal wards, antenatal ward, theatre, gynae clinics and also receive lectures, tutorials and bedside demonstrations.

Eighteen students achieved honours in their final obstetrics and gynaecology examination at the RCSI. Five of these achieved first class honours. Ms Eve Lehane was awarded the RCSI/NMH Medal for achieving the highest marks amongst the RCSI students who attended The National Maternity Hospital.

On the postgraduate front, Dr Orfhlaith O'Sullivan successfully completed her MD entitled 'Surgical Training in Obstetrics and Gynaecology' Dr Ellen McMahon is near completion of her work looking at dystocia in nulliparous women with particular focus on those of advanced maternal age and increased BMI.

***Prof Declan Keane,* Department of Obstetrics and Gynaecology, Royal College of Surgeons and Consultant Obstetrician & Gynaecologist**

The Joint Research Network

The Joint Research Network (JRN) continues to support research across midwifery and nursing within The National Maternity Hospital, in collaboration with University College Dublin and clinical teams. Throughout 2025, the network focused on developing clinically relevant research that reflects the experiences of women, families, and staff, while strengthening opportunities for midwives and nurses to participate in research within their clinical roles.

Throughout the year, the JRN continued to foster a collaborative research culture within the Hospital by supporting staff involvement in projects, encouraging interdisciplinary working, and sharing learning across clinical areas. By keeping research closely connected to clinical practice, the JRN helps ensure that service development is informed by women's voices, staff experience, and evidence generated within the NMH itself and existing international evidence.

JRN Philosophy: *Midwives, Nurses, Academics and Students Working Together in a Community of Practice and Research.*

Research Projects

Completed

- *Birth Reflections Service Evaluation at The National Maternity Hospital*
  This study explored women's experiences of attending a structured postnatal debriefing service. Findings have provided valuable feedback to support the ongoing development of reflective maternity care practices and improved communication following birth.
- *MatWell Study*
  The MatWell study examined staff wellbeing across multidisciplinary maternity teams, providing an important snapshot of workforce experiences, including workload pressures, job satisfaction, and organisational factors influencing wellbeing. The findings are informing ongoing discussions regarding staff support and sustainable service delivery.
- *Labour Hopscotch Phase 2 Project*
  Phase 2 of the Labour Hopscotch project focused on digital development and the translation of a locally developed midwifery innovation into an accessible educational resource. The project concluded with the co-design and testing of a Labour Hopscotch App prototype informed by feedback from women and clinicians.

In progress

- *Evaluation of midwifery care within the Fetal Medicine Clinic*
  This study continues to explore women's experiences within a specialist clinical setting, with a focus on understanding the role of midwifery support during complex pregnancies and identifying opportunities to enhance service delivery.
- *Pregnancy After Loss Support (PALS) Study*
  This longitudinal qualitative study explores women's experiences of attending a structured pregnancy-after-loss support group facilitated by bereavement specialist midwives and psychology services. Data collection and analysis are ongoing, with early interviews contributing to emerging insights into emotional support, peer connection, and navigating pregnancy following loss.

Planned

- *Emergency Room Early Pregnancy Study (2026)*
  Planning is underway for a new research initiative exploring women's experiences of attending the Emergency Room with early pregnancy bleeding and pain. The study aims to inform future service development and improve early pregnancy care pathways through evidence-based recommendations.

Jean Doherty, **Staff Midwife / Research Midwife, Co-Chair, Joint Research Network, Occasional Lecturer, University College Dublin**

University College Dublin Obstetrics & Gynaecology

UCD Obstetrics & Gynaecology at The National Maternity Hospital has a large and vibrant teaching programme delivered by Prof Fionnuala McAuliffe, Prof Mary Higgins, Prof Donal Brennan, Prof Colm O'Herlihy, and organised by Ms Stephanie Begley and Ms Vaniya Patil. Tutors Dr Clare Kennedy, Dr Sara Mohan, Dr Maggie O'Brien and Dr Ruth Matthew provided excellence in teaching throughout the year. The John F. Cunningham Medal was awarded to Dr Louise Murphy, the Kieran O'Driscoll Prize to Ms Sara Brady.

We have an energetic and enthusiastic team of researchers ranging from research assistants to MD/PhD students who are working on a wide variety of projects spanning all aspects of obstetrics and gynaecology.

Awards

Dr Cathy McNestry awarded NFOG scholarship for her paper 'pregnancy complications and later life women's health' which was the most highly cited in Acta Obstet Gynecol Scand in 2023.

The National Maternity Hospital Research Innovation Symposium (RISE): O'Herlihy Medal for best research Dr Gillian Corbett 'Bif breve impacts on gut metabolome reducing gestational diabetes' and best medical student Research Presentation Emanuella Oluwaferanmi

RCPI William Stokes runner up Dr Gillian Corbett 'Bif breve impacts on gut metabolome reducing gestational diabetes'.

UCD Global Women's Health Fellowship, Dr Sara Mohan successful for this UCD funded post.

Prof Fionnuala McAuliffe, was elected as FIGO Division Direct Elect of Maternal and Newborn Health, and onto the executive council of the International Federation of Gynecology and Obstetrics (FIGO) for 2023-2025. FIGO, with member societies in 139 countries/territories, is the only organisation that brings together professional societies of obstetricians and gynecologists on a global basis. Ireland will contribute though the development of clinically relevant guidelines and easy to use clinical toolkits, and through the promotion of optimal nutrition in high, middle and low income countries.

Prof Higgins was successful in establishing the first ASPIRE Education fellowship and also in the first Irish Clinical Education Training ICET fellowship and received UCD College of Health and Agricultural Sciences Teaching Award University College Dublin 2025. She is Treasurer of the Royal College of Physicians of Ireland and was promoted to Professor in 2025.

Prof Donal Brennan was appointed National Clinical Lead for Cancer Research in Ireland at the National Cancer Control Program and is also Chairperson of the National Clinical Trials Oversight Group in the Department of Health.

Submission of MD/PhDs

Dr Fiona O'Toole awarded her MD thesis on Iron deficiency anaemia in pregnancy.
Dr Gillian Corbett was awarded PhD for thesis on Microbiome and preterm birth
Dr McNestry awarded MD from UCD on impact of breastfeeding on later life maternal health.
Dr Clare Kennedy, ICET and MD student and Dr Shahad Al-Tikriti, ASPIRE education Fellow submitted MDs
Dr Liz McGovern submitted her PhD on breastfeeding amongst B2B study mothers

UCD Perinatal Research Centre

(www.ucd.ie/medicine/perinatal, X @UCDPerinatal, instagram @ucd_perinatal)
The centre's work aim is excellence in reproductive health and perinatal research to improve clinical outcomes for mothers and their infants.

Research funding

Funding for our multidisciplinary research is supported by grants from Research Ireland, Frontiers for Future, EU Transforming health and Care systems and Personalised mHealth Maternal Nutritional Education for Equitable Nutritional Access and Improved Maternal and Offspring Health Outcomes in Sub-Saharan Africa (AMEN), Health

Research Board Ireland, The role of protein glycosylation in the pathogenesis of endometriosis and association with microbiome, Irish Cancer Society, Precision Oncology Ireland.

Research projects at National Maternity Hospital

UCD Perinatal Research Centre www.ucd.ie/medicine/perinatal, Twitter @UCDPerinatal was established in 2014 in recognition of the significant size, output and impact of the group. Ongoing research projects are listed below.

ROLO kids: This is a follow-up study at age 2, 5 and 9-10 years of mothers and infants from the ROLO study Randomised control trial of low glycaemic index diet to reduce recurrence of macrosomia. This includes ROLO families advisory group and ROLO Young Persons advisory group.

Microbiome Mum: role of maternal microbiome in influencing neonatal microbiome and impact of a probiotic on maternal and fetal health. This study examines the inter-relation between mother and baby microbiome and whether a probiotic given to Mum can have positive impacts on maternal and infant health.

Prepop: This is a randomised controlled trial of probiotic vs placebo in the prevention of preterm birth.

Bump to Baby and me B2B: A multifaceted m health and health coach supported intervention to reduce GDM in at risk women at NMH, Bristol, Granada and Melbourne continued recruitment, PI Prof Sharleen O'Reilly.

FIGO Pregnancy Nutrition and Obesity Initiative: We are developing clinical guidelines and a FIGO nutrition checklist that can be used globally to assist healthcare professionals caring for pregnancy women to advise them about appropriate nutrition before, during and after pregnancy.

Prof Fionnuala McAuliffe (Right) with Dr Gillian Corbett who was awarded the Research Colm O'Herlihy Medal (1st) for her research poster presentation entitled "Oral Bifidobacterium breve supplementation alters Faecal Metabolome in Pregnancy with Reduced Risk of Gestational Diabetes".

Breastfeeding friendly city indicators: Study ongoing in Penang and Dublin developing indicators that a city is breastfeeding friendly.

VR baby and VR Bakri balloon: We are developing a virtual reality model of pregnancy to enhance medical and midwifery students and trainees experience of learning and also a VR Bakri balloon insertion model.

FeMo Fetal movement monitor: In collaboration with Prof Niamh Nowlan, UCD Prof Biomedical Engineering, NMH is trialling a novel fetal movement monitor.

IronMother: This is UCD Clinical Research Centre supported RCT of treatment of iron deficiency anaemia in pregnancy, run by multidisciplinary team at NMH led by Prof Jennifer Walsh.

Alcohol screening in pregnancy: This anonymous study continued in 2023 in collaboration with Prof Aiden McCormick and Dr Ciara McCormick, Dr Liz Dunn (Wexford) and Dr Alfonso Rodriguez Herrera (Kilkenny).

National Maternity Cardiac database (A Smyth, C Canniffe, FMcAuliffe, NPEC) established the first national cardiac in pregnancy database.

AI Premie: This is a multidisciplinary study examining the role of AI in the prediction of pre-eclampsia.

Healthcare training: One Safe Act in the Labour and Birthing Unit, and Communication in Obstetric Emergency Birth are ongoing studies.

Medical Education ("MedEd") Electives Prof Mary Higgins: We run highly successful electives in Medical Education with medical student participants. As well as students gaining increased knowledge in MedEd theories.

Medical education: Prof Mary Higgins is spear heading research into the transition from clinical to research work for healthcare workers, patients as educators, transition to specialist training.

Publications from UCD Obstetrics & Gynaecology in 2025, 55 in total, are listed in the NMH Annual Research Report.

***Professor Fionnuala McAuliffe,* Consultant Obstetrician & Gynaecologist, University College Dublin and The National Maternity Hospital**

NMH RISE award winners were recognised for excellence in research and innovation. Awards included 1st–3rd place for oral and poster presentations across research and innovation categories, best audit presentation, and best student presentation.

Appendices

Financial Statements

Income And Expenditure

Extracts from the Hospital Income & Expenditure Account For the Year Ended 31 December

	2025	2024
	€000	€000
Ordinary Income		
Miscellaneous	778	426
Treatment Charges	12,105	11,516
	12,883	**11,942**
Ordinary Expenditure - Pay		
Medical NCHD's	8,827	8,477
Consultants	13,935	13,301
Nursing	38,898	36,557
Para-Medical	9,347	8,599
Housekeeping	3,072	2,820
Catering	2,886	2,674
Portering	1,322	1,309
Maintenance	686	541
Administration	10,495	10,013
Pensions	5,784	4,850
	95,252	**89,141**
Ordinary Expenditure - Non Pay		
Medicines, Blood & Gases	2,714	2,424
Laboratory Expenses	3,271	3,216
Medical and Surgical Appliances	4,722	4,691
X-Ray Expenses	156	295
Provisions	1,274	1,227
Heat, Power and Light	979	1,071
Cleaning and Washing	1,179	1,101
Furniture, Hardware and Crockery	181	248
Bedding and Clothing	125	117
Maintenance	1,133	990
Transport and Travel	166	168
Finance/Professional fees	1,140	885
Bad Debt provision	44	47
Office Expenses	861	1,034
Education, Training	546	441
Computer Expenses	997	1,745
Miscellaneous	1,610	1,890
Depreciation	3,711	3,683
Amortisation	(2,976)	(2,929)
	21,833	**22,344**
Surplus for Year		
Net expenditure	**104,202**	**99,544**
Annual Allocation	104,836	100,164
less amount deferred in respect of fixed asset additions	(1,538)	(1,397)
	(904)	**(777)**

Cumulative Figures

Extracts from the Hospital Income & Expenditure Account For the Year Ended 31 December

	2025	2024
	€ooo	€ooo
Surplus / (Deficit) Brought Forward	1,622	1,644
Transfer between reserves from revaluation reserve to Revenue Reserve	735	754
(Deficit) / Surplus for the year	(904)	(776)
Surplus Carried Forward	**1,453**	**1,622**

Balance Sheet

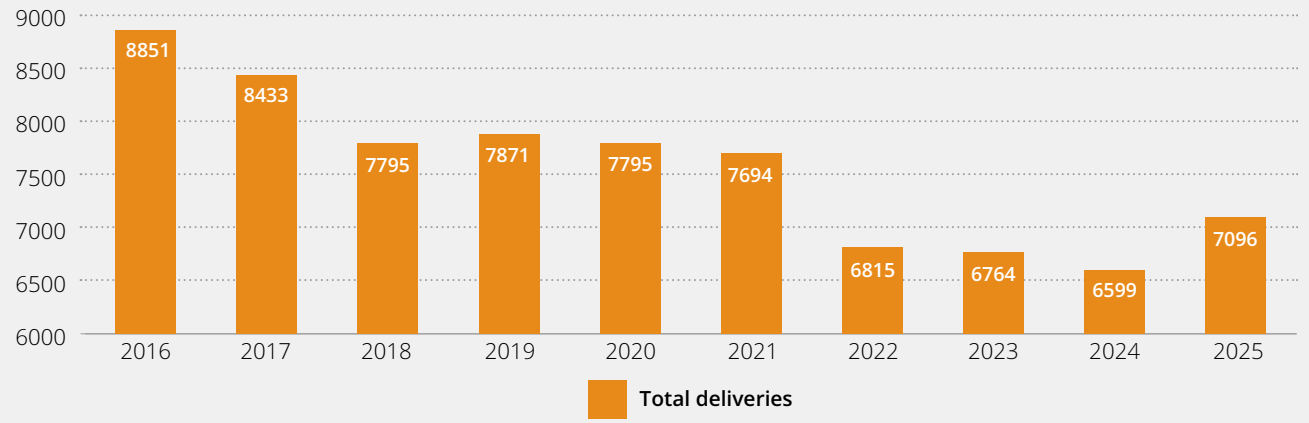
Extracts from the Hospital Balance Sheet as at 31 December

	2025		2024	
	€000		€000	
Fixed Assets		**78,111**		**74,845**
Current Assets				
Stocks	377		371	
Debtors	11,170		18,681	
Cash & Bank	3,200		-	
	14,747		**19,052**	
Current Liabilities				
Creditors	(13,402)		(17,256)	
	(13,402)		**(17,256)**	
Net Current Liabilities		(1,345)		1,796
Creditors (amounts falling due after more than one year)				
Deferred Grant		(46,291)		(42,290)
Loans from Funds		(1,400)		(1,682)
Net Assets		**31,765**		**32,669**
Represented By:				
Revaluation Reserve		30,270		31,005
Accumulated Surplus / (Deficit) at end of year		1,453		1,622
Other Funds		42		42
		31,765		**32,669**

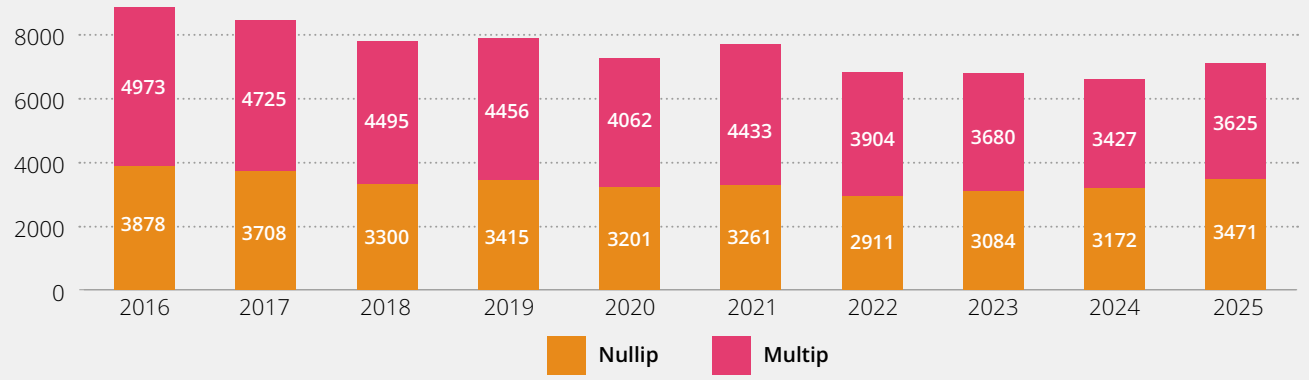
Clinical and Administrative Activity

Mothers Delivered

Mothers Delivered	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Nullip	3878	3708	3300	3415	3201	3261	2911	3084	3172	3471
Multip	4973	4725	4495	4456	4062	4433	3904	3680	3427	3625
Total	**8851**	**8433**	**7795**	**7871**	**7795**	**7694**	**6815**	**6764**	**6599**	**7096**
% Nullip	43.8%	44.0%	42.3%	43.4%	41.1%	42.4%	42.7%	45.6%	48.1%	48.9%

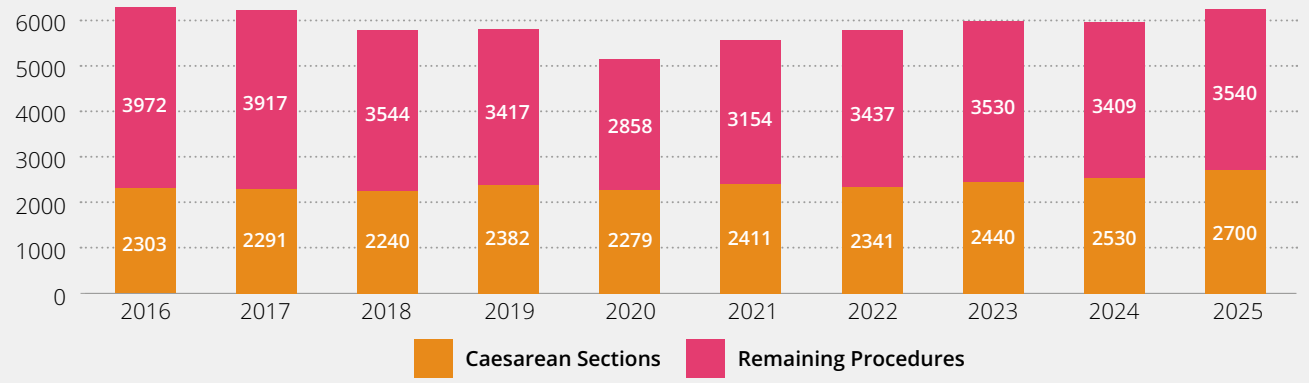


Births by Parity



Theatre Procedures (not patients)

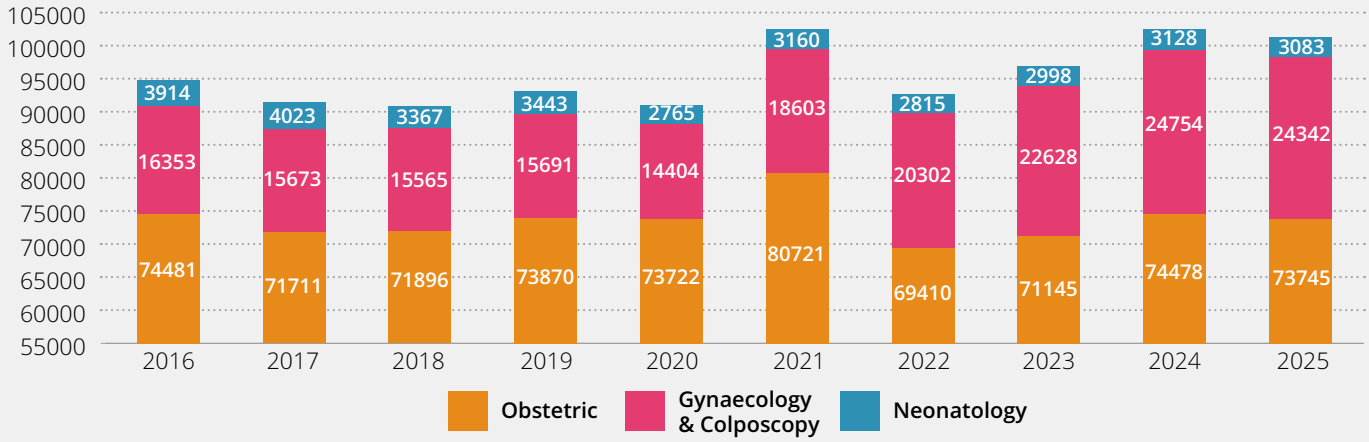
Theatre Activity	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Caesarean Sections	2303	2291	2240	2382	2279	2411	2341	2440	2530	2700
Remaining Procedures	3972	3917	3544	3417	2858	3154	3437	3530	3409	3540
Total	**6020**	**6208**	**6275**	**5799**	**5137**	**5565**	**5778**	**5970**	**5939**	**6240**



Outpatient Activity

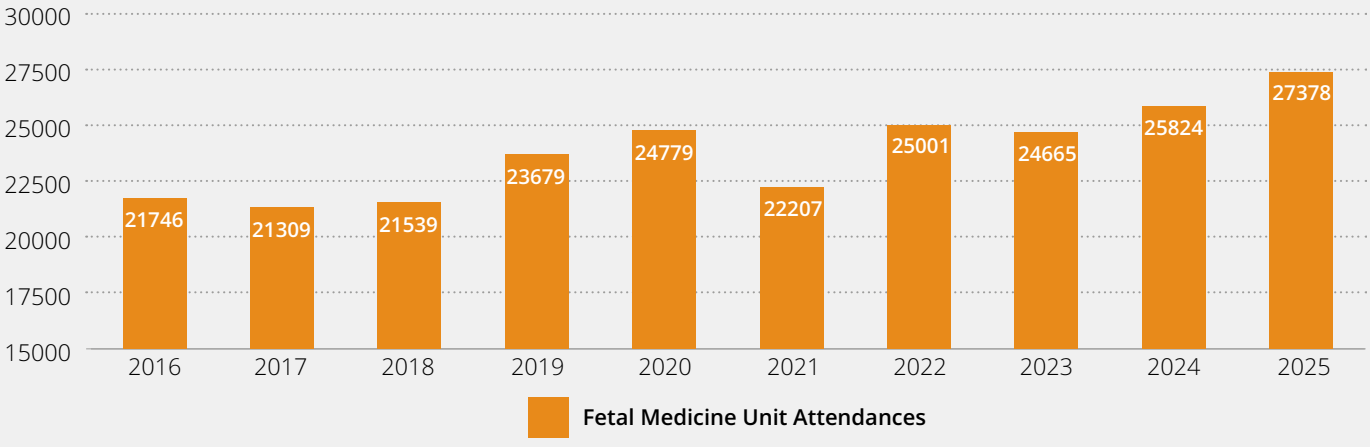
Outpatient Activity	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Obstetric*	74481	71711	71896	73870	73722	80721	69410	71145	74478	73745
Gynaecology & Colposcopy	16353	15673	15565	15691	14404	18603	20302	22628	24754	24342
Neonatology	3914	4023	3367	3443	2765	3160	2815	2998	3128	3083
Total	**94748**	**91407**	**90828**	**93004**	**90891**	**102484**	**92527**	**96771**	**102360**	**101170**

** revised for 2023 report: Includes sub-specialties. Excludes all unbooked attendances*



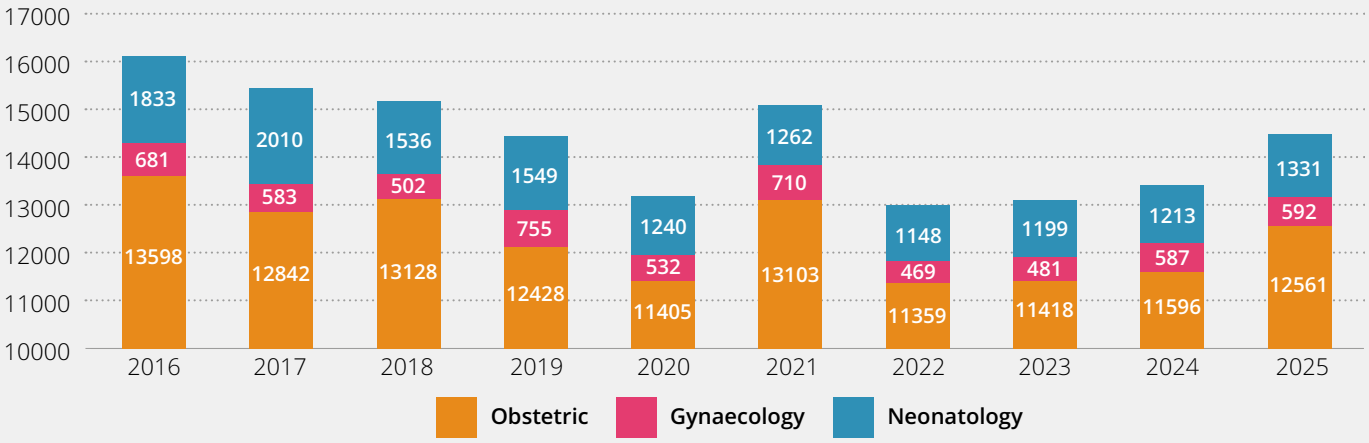
Fetal Medicine Unit

Fetal Medicine Unit	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Booked Attendances	21746	21309	21539	23679	24779	22207	25001	24665	25824	27378



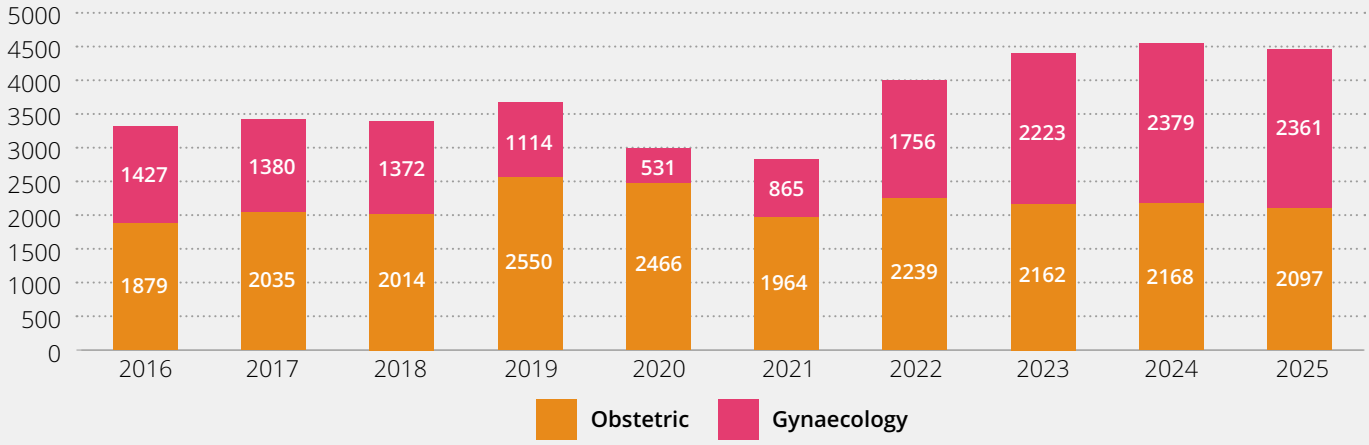
Inpatient Discharges

Inpatient Discharges	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Obstetric	13598	12842	13128	12428	11405	13103	11359	11418	11596	12561
Gynaecology	681	583	502	755	532	710	469	481	587	592
Neonatology	1833	2010	1536	1549	1240	1262	1148	1199	1213	1331
Total	**16112**	**15435**	**15166**	**14732**	**13177**	**15075**	**12976**	**13098**	**13396**	**14484**



Day Cases

Day Cases	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Obstetric	1879	2035	2014	2550	2466	1964	2239	2162	2168	2097
Gynaecology	1427	1380	1372	1114	531	865	1756	2223	2379	2361
Total	**3306**	**3453**	**3386**	**3664**	**2997**	**2829**	**3995**	**4385**	**4547**	**4458**



Emergency Room Attendances	2018	2019	2020	2021	2022	2023	2024	2025
Total	13101	14146	11115	11442	11827	12006	13214	14726

Statistical Analysis Expressed As Percentages Over 10 Years

Percentages of births >= 400g and/or EGA >=23 wks (2025 n=7096):

Age	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
< 20 years	0.8	1.8	0.7	0.6	0.6	0.4	0.5	0.7	0.6	0.5
20 - 24 years	5.5	4.0	4.1	4.2	4.4	4.2	4.3	4.3	3.6	3.8
25 - 29 years	15.8	12.0	12.0	12.6	11.6	11.0	12.4	11.6	12.1	11.8
30 - 34 years	40.9	36.8	33.5	34.5	34.8	34.5	34.6	34.8	35.1	36.4
35 - 39 years	32.9	36.8	37.9	38.5	37.9	39.2	36.6	36.9	37.1	36.9
40+ years	7.1	8.6	8.2	9.6	10.7	10.8	11.6	11.7	11.5	10.7
Not available	0.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Parity	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
0	43.8	44.0	42.0	43.4	44.1	42.4	42.7	45.6	48.1	48.9
1,2,3	60.4	60.2	56.3	55.0	54.1	56.2	55.8	52.8	50.5	49.6
4+	1.8	1.8	1.7	1.6	1.8	1.4	1.5	1.6	1.4	1.5

Percentages of babies >= 400g and/or EGA >=23 wks (2025 n=7218)

Birthweight	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
<500g	n/a	n/a	0.1	0.0	0.1	0.0	0.1	0.1	0.1	0.2
500 - 999	0.6	0.6	0.7	0.8	0.8	0.8	0.8	1.0	0.6	0.7
1000 - 1499	0.7	1.0	0.6	0.7	0.8	0.6	0.8	0.7	0.8	0.7
1500 - 1999	1.4	1.3	1.6	1.0	1.3	1.2	1.4	1.2	1.0	1.4
2000 - 2499	2.6	3.1	2.9	2.7	3.0	3.2	2.9	3.5	3.6	3.5
2500 - 2999	10.5	10.3	10.1	10.5	11.0	10.2	12.4	12.0	13.1	12.7
3000 - 3499	30.3	30.1	30.1	30.8	29.6	32.2	33.2	33.4	32.9	34.2
3500 - 3999	36.2	35.7	35.2	35.0	36.2	35.2	33.7	34.3	34.2	32.6
4000 - 4499	14.9	15.0	14.9	15.7	14.7	13.9	12.7	11.7	11.9	12.1
4500 - 4999	2.6	2.7	2.8	2.5	2.3	2.4	1.9	1.9	1.7	1.6
5000+	0.2	0.2	0.3	0.2	0.2	0.3	0.1	0.2	0.1	0.2
Not available	0.0	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Gestation	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
< 26 weeks	0.4	0.3	0.4	0.3	0.5	0.5	0.4	0.5	0.3	0.5
26 - 29 + 6 days	0.5	0.7	0.8	0.8	0.9	0.6	0.9	0.7	0.8	0.8
30 - 33 + 6 days	1.7	1.7	1.5	1.5	1.6	1.6	1.5	1.7	1.5	1.8
34 - 36 + 6 days	4.5	4.7	4.5	4.0	4.5	4.6	5.2	4.9	4.5	5.1
37 - 41 + 6 days	88.9	88.8	88.0	90.2	89.9	90.6	90.6	91.0	92.3	91.5
42 + weeks	4.0	3.8	4.0	3.2	2.6	2.1	1.4	1.3	0.6	0.4
Not available	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0

10 Year Comparative Table

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Total Births (inc. <400g)	9790	9357	8671	8700	8158	8567	7515	7559	7415	7851
Births (>=400g and/or 23 wks)	8851	8433	7774	7871	7263	7694	6815	6764	6599	7096
Para 0	3878	3684	3271	3415	3201	3261	2911	3084	3172	3471
Para 1+	4973	4759	4503	4456	4062	4433	3904	3680	3427	3625
Nulliparous %	*43.8*	*43.7*	*42.1*	*43.4*	*44.1*	*42.4*	*42.7*	*45.6*	*48.1*	*48.9*
Maternal Mortality	1	0	0	0	0	0	0	1	0	0
Babies Born (>=400g and/or 23 wks)	9037	8619	7914	8009	7402	7855	6948	6880	6723	7218
Perinatal Mortality*	53	54	60	74	66	64	53	42	45	54
Perinatal Mortality Rate	5.9	6.3	7.6	9.2	8.9	8.1	7.6	6.1	6.7	7.5
Congenital Anomalies	23	19	26	32	19	19	18	24	18	15
Corrected Perinatal Mortality Rate	3.3	4.1	4.3	5.3	6.4	5.7	5.1	2.6	4.0	5.4
Caesarean Section %	*26.0%*	*27.2%*	*28.9%*	*30.3%*	*31.4%*	*31.3%*	*34.3%*	*36.1%*	*38.3%*	*38.1%*
Operative Vaginal Delivery %	*14.2%*	*13.0%*	*13.7%*	*12.5%*	*12.7%*	*12.3%*	*11.3%*	*12.1%*	*10.7%*	*11.9%*
Normal Delivery %	*59.8%*	*59.8%*	*57.0%*	*57.2%*	*55.9%*	*56.5%*	*54.4%*	*51.8%*	*51.0%*	*50.0%*
Induction %	*28.6%*	*29.8%*	*27.8%*	*31.0%*	*34.0%*	*34.4%*	*38.3%*	*38.5%*	*40.5%*	*41.6%*

Comparative Table of Pre-Viable and Hydatidiform Moles

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Mothers delivered <500g	842	828	808	809	798	761	632	705	736	674
Hydatidiform moles	27	27	29	14	31	44	24	34	16	34
Ectopic pregnancies	70	69	60	65	66	68	46	56	64	47

Perinatal Mortality Analysis

Births by Mothers' Age on Delivery	Perinatal Deaths	PNMs %	Rate per '000 Births	Total Births
< 20 years	1	2.2%	31.3	32
20 - 24 years	4	8.9%	14.8	271
25 - 29 years	7	15.6%	8.2	857
30 - 34 years	22	48.9%	8.4	2620
35 - 39 years	15	33.3%	5.6	2670
40 + years	5	11.1%	6.5	768
Total	*54*			*7218*

Gestation	Perinatal Deaths	PNMs %	Rate per '000 Births	Total Births
< 26 weeks	22	48.9%	628.6	35
26 - 29 + 6 days	9	20.0%	155.2	58
30 - 33 + 6 days	6	13.3%	46.9	128
34 - 36 + 6 days	5	11.1%	13.7	365
37 - 41 + 6 days	12	26.7%	1.8	6602
42 + weeks	0	0.0%	0.0	30
Total	*54*			*7218*

Births by Parity	Perinatal Deaths	PNMs %	Rate per '000 Births	Total Births
0	30	66.7%	8.5	3538
1,2,3	23	51.1%	6.4	3576
4+	1	2.2%	9.6	104
Total	*54*			*7218*

Birthweight	Perinatal Deaths	PNMs %	Rate per '000 Births	Total Births
<500	13	28.9%	928.6	14
500 - 999g	18	40.0%	333.3	54
1000 - 1499g	3	6.7%	55.6	54
1500 - 1999g	3	6.7%	29.7	101
2000 - 2499g	3	6.7%	11.9	252
2500 - 2999g	5	11.1%	5.5	917
3000 - 3499g	5	11.1%	2.0	2468
3500 - 3999g	2	4.4%	0.8	2355
4000 - 4499g	2	4.4%	2.3	876
4500 - 4999g	0	0.0%	0.0	116
5000g +	0	0.0%	0.0	11
Total	*54*			*7218*

10 Year Analysis of Perinatal Mortality

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Total Perinatal Deaths	53	54	60	74	66	64	53	42	45	54
PNMR per '000 Births	5.9	6.3	7.6	9.2	8.9	8.1	7.6	6.1	6.7	7.5
Antepartum Deaths	19	26	27	29	35	27	19	10	18	23
Percentage of Total	35.8	48.1	45.0	39.2	53.0	42.2	35.8	23.8	40.0	42.6
Intrapartum Deaths	0	0	0	0	0	0	0	0	0	7
Percentage of Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.0
Early Neonatal Deaths	11	9	7	13	12	18	16	8	9	9
Percentage of Total	20.8	16.7	11.7	17.6	18.2	28.1	30.2	19.0	20.0	16.7
Congenital Anomalies	23	19	26	32	19	19	18	24	18	15
Percentage of Total	38.3	35.2	43.3	43.2	28.8	29.7	34.0	57.1	40.0	27.8

Infants whose birthweight was >=400g and/or with EGA >=23 wks and liveborn infants who died within 7 days.

10 Year Analysis of Perinatal Mortality Excluding Congenital Anomalies

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Total Births >=400g and/or >=23 wks	9037	8619	7914	8009	7402	7855	6948	6880	6722	7218
Births >=400g and/or >=23 wks less lethal congenital anomalies	9014	8600	7895	7977	7383	7836	6930	6856	6704	7203
Stillbirths	19	26	27	29	35	27	19	10	18	30
Stillbirth rate per '000 births	2.1	3.0	3.4	3.6	4.7	3.4	2.7	1.5	2.7	4.2
Early Neonatal Deaths	11	9	7	13	12	18	16	8	9	9
ENND rate per '000 births	1.2	1.0	0.9	1.6	1.6	2.3	2.3	1.2	1.3	1.2
Total Perinatal Mortality	30	35	34	42	47	45	35	18	27	39
Corrected Perinatal Mortality Rate	3.3	4.1	4.3	5.3	6.4	5.7	5.1	2.6	4.0	5.4

Dublin Maternity Hospitals Comparitive Tables

Table 1: Patients Attending	
Mothers Delivered >= 500g	7096
Mothers Delivered < 500g	674
Ectopic Pregnancies	47
Hydatidiform Moles	34
	7851

based on histologically confirmed samples

Table 2: Maternal Deaths	0

Table 3: Babies Born (23 wks EGA and/or >= 400g)	
Singletons	6982
Twins	106
Triplets	7
Quadruplets	1
Total Births	**7096**

Table 4: Obstetric Outcome	%
Spontaneous Vaginal Delivery	50.0%
Forceps	1.3%
Ventouse	9.4%
Ventouse/Forceps	1.2%
Total Operative	*11.9%*
Caesarean Section	38.1%
	100.0%
Induction	2950 (41.6%)

Table 5: Perinatal Deaths	
Antepartum Deaths	23
Intrapartum Deaths	7
Total Stillbirths	*30*
Early Neonatal Deaths	9
Congenital Anomalies (SBs and ENNDs)	15
Total Perinatal Deaths	**54**
Total External Referrals	22
Total External Referrals (Excluding CA)	13
Late Neonatal Deaths	5

Table 7: Age of Mothers Delivered	Nullip	Multip	Total	%
< 20 yrs	32	0	32	0.5%
20 - 24 yrs	192	75	267	3.8%
25 - 29 yrs	530	309	839	11.8%
30 - 34 yrs	1523	1060	2583	36.4%
35 - 39 yrs	969	1650	2619	36.9%
40 + yrs	225	531	756	10.7%
Total	**3471**	**3625**	**7096**	**100.0%**

Table 8: Parity of Mothers Delivered	Total	%
Para 0	3471	48.9%
Para 1, 2, 3	3522	49.6%
Para 4+	103	1.5%
Total	**7096**	**100.0%**

Table 9: Body Mass Index (WHO ranges)		%
Underweight: <18.5	102	1.4%
Healthy: 18.5 - 24.9	3163	44.6%
Overweight: 25 - 29.9	2166	30.5%
Obese class 1: 30 - 34.9	915	12.9%
Obese class 2: 35 - 39.9	312	4.4%
Obese class 3: >40	134	1.9%
Not Recorded	*304*	*4.3%*
Total Deliveries	**7096**	**100.0%**

Table 10: Ethnicity of Mothers Delivered	Total	%
Irish	4321	60.9%
Any other White background	1242	17.5%
Any other Asian background	697	9.8%
Any other Black background	193	2.7%
Other including Mixed Background	233	3.3%
Irish Traveller	39	0.5%
Not Known	371	5.2%
Total Deliveries	**7096**	**100.0%**

National Census classification

Table 6: Perinatal Mortality Rates		
Overall Perinatal Mortality Rate per 1000 births	54/7218	7.5
Perinatal Mortality Rate corrected for lethal congenital anomalies (15)	39/7203	5.4
Perinatal Mortality Rate corrected for external referrals (13) and lethal congenital anomalies (15)	26/7190	3.6
Overall Perinatal Mortality Rate including late neonatal deaths (5)	59/7218	8.2
Overall Perinatal Mortality Rate excluding external referrals (22)	32/7196	4.4
Perinatal Mortality Rate corrected for lethal congenital anomalies (17) and excluding early deaths and stillbirth external referrals (12)	26/7190	3.6

5 Late Neonatal Deaths and 10 Early/Late Infant Deaths
External referrals = 22: 9 anomalies, 13 normally formed

Table 11: Birthweight of Babies Born	Nullip	Multip	Total	%
<500g	9	5	14	0.2%
500 - 999g	36	18	54	0.7%
1,000 - 1,499g	34	20	54	0.7%
1,500 - 1,999g	58	43	101	1.4%
2,000 - 2,499g	149	103	252	3.5%
2,500 - 2,999g	532	385	917	12.7%
3,000 - 3,499g	1254	1214	2468	34.2%
3,500 - 3,999g	1066	1289	2355	32.6%
4,000 - 4,499g	347	529	876	12.1%
4,500 - 4,999g	48	68	116	1.6%
5,000g +	5	6	11	0.2%
	3538	**3680**	**7218**	**100.0%**

Table 12: Sex of Babies Born	Nullip	Multip	Total	%
Male	1703	1811	3514	48.7%
Female	1835	1869	3704	51.3%
Not determined	0	0	0	0.0%
Total Babies Born	**3538**	**3680**	**7218**	**100.0%**

Table 13: Gestational Age of Babies Born	Nullip	Multip	Total	%
< 26 weeks	23	12	35	0.5%
26 - 29 + 6 days	31	27	58	0.8%
30 - 33 + 6 days	74	54	128	1.8%
34 - 36 + 6 days	195	170	365	5.1%
37 - 41 + 6 days	3194	3408	6602	91.5%
42 + weeks	21	9	30	0.4%
Total Babies Born	**3538**	**3680**	**7218**	**100.0%**

Table 14: Perineal Trauma after Spontaneous and Operative Vaginal Delivery (SVD & OVD)	Nullip	Multip	Overall
Episiotomy	1144	268	1412
Incidence % of VDs	*54.9%*	*11.6%*	*32.1%*
First Degree Tear	142	510	652
Incidence % of VDs	*6.8%*	*22.1%*	*14.8%*
Second Degree Tear	511	683	1194
Incidence % of VDs	*24.5%*	*29.6%*	*27.2%*
Third Degree Tear	77	25	102
Incidence % of VDs	*3.7%*	*1.1%*	*2.3%*
Fourth Degree Tear	8	0	8
Incidence % of VDs	*0.4%*	*0.0%*	*0.2%*
Intact	201	823	1024
Incidence % of VDs	*9.6%*	*35.6%*	*23.3%*
Total Vaginal Deliveries	**2083**	**2309**	**4392**

includes Episiotomy with sphincter damage (n=37)

Table 14(a): Perineal Trauma after Spontaneous Vaginal Delivery (SVD)	Nullip	Multip	Overall
Episiotomy	522	182	704
Incidence % of SVDs	*38.2%*	*8.4%*	*19.8%*
First Degree Tear	135	497	632
Incidence % of SVDs	*9.9%*	*22.8%*	*17.8%*
Second Degree Tear	475	668	1143
Incidence % of SVDs	*34.7%*	*30.7%*	*32.2%*
Third Degree Tear*	41	24	65
Incidence % of SVDs	*3.0%*	*1.1%*	*1.8%*
Fourth Degree Tear	2	0	2
Incidence % of SVDs	*0.1%*	*0.0%*	*0.1%*
Intact	193	808	1001
Incidence % of SVDs	*14.1%*	*37.1%*	*28.2%*
Total Spontaneous Vaginal Deliveries (excl. Operative)	**1368**	**2179**	**3547**

includes Episiotomy with sphincter damage (n=7)

Table 14(b): Perineal Trauma after Operative Vaginal Delivery (OVD)	Nullip	Multip	Overall
Episiotomy	622	86	708
Incidence % of OVDs	*87.0%*	*66.2%*	*83.8%*
First Degree Tear	7	13	20
Incidence % of OVDs	*1.0%*	*10.0%*	*2.4%*
Second Degree Tear	36	15	51
Incidence % of OVDs	*5.0%*	*11.5%*	*6.0%*
Third Degree Tear*	36	1	37
Incidence % of OVDs	*5.0%*	*0.8%*	*4.4%*
Fourth Degree Tear	6	0	6
Incidence % of OVDs	*0.8%*	*0.0%*	*0.7%*
Intact	8	15	23
Incidence % of OVDs	*1.1%*	*11.5%*	*2.7%*
Total Operative Vaginal Deliveries	**715**	**130**	**845**

**includes Episiotomy with sphincter damage (n=11)*

Table 15: Severe Maternal Morbidity	Major SMM only*
Major Obstetric Haemorrhage	19
Renal / Liver Dysfunction	8
Eclampsia	4
Cerebral Vascular Accident	3
Interventional Radiology	3
Pulmonary Embolism	3
ICU/CCU admission**	2
Peripartum Hysterectomy	2
Septic Shock	2
Acute Respiratory Dysfunction	0
Anaesthetic Problems	0
Cardiac Arrest	0
Coma	0
Pulmonary Oedema	0
Status Epilepticus	0
Uterine Rupture	0
Total	**46 patients 49 SMM events**

Some women had more than one SMM – in this table only the major SMM is reported

Table 16: Neonatal Encephalopathy	Inborn	Outborn
Neonatal Encephalopathy - with HIE	5	4
Neonatal Encephalopathy - no HIE	0	3
Seizures – No Encephalopathy	0	0
Therapeutic Hypothermia	5	7

Theatre Procedures

Please note, these are procedures and not patients. A patient may have more than one procedure in an overall operation.

Procedure	Total
Emergency caesarean section	1423
Elective lower segment caesarean section	1276
ERPC Antenatal	564
Hysteroscopy D&C	249
Hysteroscopy	209
Diagnostic laparoscopy	159
Hysteroscopy D&C with Mirena insertion	146
Manual removal of placenta	128
Cystoscopy	122
IUCD - Fitting of Intrauterine Contracep	123
Examination under anaesthesia	111
Repair of Third Degree Tear	104
Injection of Nerve Block	84
Truclear polypectomy	69
Cystoscopy and Botox injection therapy	62
Polypectomy	61
Injection of urethral bulking agent	60
Posterior repair	53
IUCD insertion/change	66
Anterior repair	46
Dilatation and currettage	45
Laparoscopic treatment of ectopic pregna	41
Marsupialization of Bartholin's cyst/abs	38
Dye injection at laparoscopy	38
Ovarian cystectomy- laparoscopy	35

Procedure	Total
Vaginal hysterectomy	33
Cystoscopy and Injection of Botox	33
Shirodkar's cervical cerclage	31
Endometrial ablation	29
Combined anterior and posterior vaginal repair	27
Total laparoscopic hysterectomy	27
Bilateral tubal ligation	27
Blood Patch	27
Cervical smear	21
Instrumental delivery in theatre	32
Hysteroscopic myomectomy	18
Salpingo-oophorectomy	17
Perineal repair	99
Total abdominal hysterectomy	16
Removal of Mesh exposure	15
Salpingectomy	15
Bilateral salpingo-oopherectomy	15
Operative laparoscopy	14
Colposcopy	13
Diathermy of endometriosis	13
Laparoscopic hysterectomy	13
Cystectomy	12
Incision & Drainage of Bartholins absces	11
Others <10	348
Total Procedures (not patients)	**6218**

Sustainability

The National Maternity Hospital is committed to becoming a sustainable organisation. Our long term ambition is to operate as a net zero hospital, and we have already begun taking meaningful steps to reduce our environmental impact. Sustainability is not a standalone initiative—it is embedded across all aspects of our hospital, from clinical practice to corporate governance. We prioritise transparency, uphold strong governance structures, and actively engage with staff, patients, suppliers, and partners.

In January 2023, the Executive Management Committee established the Environmental Committee, bringing together staff from clinical and non clinical areas. The Committee meets regularly to coordinate environmental initiatives. Ireland's national targets—a 50% reduction in greenhouse gas emissions by 2030 and net zero emissions by 2050—provide a clear framework for our work. We align our efforts with the Public Sector Climate Action Plan and the HSE Climate Action Strategy.

Strategy

Our Strategic Plan has a dedicated Environmental, Social and Governance (ESG) section, reflecting the central importance of sustainability to the Hospital's future direction.

Waste Management

We have enhanced waste infrastructure by introducing more user friendly bins across the campus. A food waste bin has been reinstated in the canteen. Several departments, including Lactation, Laboratory and Pharmacy, have replaced some single use plastic bottles with reusable alternatives.

Carbon Footprint Reduction

Energy efficient measures such as PIR sensors and LED lighting have been implemented. We continue to explore renewable energy options and optimise waste and resource management.

Education and Awareness

Staff, patients, and visitors all play a role in our sustainability journey. Sustainability is now included in mandatory training and will be incorporated into staff induction. A monthly sustainability newsletter is being issued to all staff. Members of the Environmental Committee have completed HSE provided training and attend relevant seminars and conferences. The Board have been informed about the work of the Environmental Committee.

Certification

The Laboratory got its first My Green Lab accreditation and is participating in the global Freezer Challenge to improve cold storage efficiency. The Catering Department retained its ISO 22000:2018 Food Safety Management Systems certification.

Procurement

All procurement processes now incorporate environmental award criteria in line with HSE Green Procurement Guidelines. We proactively seek information on product and packaging recyclability and invite suppliers to propose sustainability initiatives.

Digitisation

We have begun transitioning from paper based to digital processes, both internally and with external partners. Laptops have been issued to many staff to support blended working and digital meetings.

Blended Working

Several departments have introduced formal blended working arrangements, reducing commuting emissions and supporting improved work life balance.

Telemedicine

Virtual clinics continue where clinically appropriate, contributing to reduced travel and improved sustainability outcomes.

Carl Alfvag
Chair of the Environmental Committee

Healthy Ireland

The Healthy Ireland (HI) Group at The National Maternity Hospital (NMH) remains committed to supporting the wellbeing of both staff and patients. Our activities are guided by the pillars of the national Healthy Ireland program and aligned with the Ireland East Hospital Group (IEHG) Healthy Ireland Implementation Plan 2023–2027.

The principles of 'Making Every Contact Count' (MECC) ensures health promotion is integrated into routine antenatal assessments. Patients also benefit from specialist support in areas such as breastfeeding, smoking cessation, nutrition, and mental health.

The NMH continues to operate as a Smoke Free Campus, providing vital smoking cessation input for women and staff.

Staff Health and Wellbeing Highlights

- January: Body composition assessments (BMI, height, weight). Staff canteen survey was completed, and efforts were reorganized for the Irish Heart Foundation canteen audit to maintain our Gold Award status.
- February: Collaborating with the Green Committee, promotion of sustainable travel options including the bike library and "Ready, Set, Cycle" program. Specialized bone density screening for men's health.
- March: Launched the Marchathon walking challenge with a community Park Walk & lunch
- April: Staff Wellness Day on April 30th, with health promotion stand and a range of events organised by the HR department; promotion of Employee Assistance Programme (EAP) and the Wrkit/BeneKit wellbeing app.
- June: Health awareness during International Men's Health Week.
- July: Partnered with the NMH Foundation for a 100km cycle challenge. Promoted the HSE "Minding Your Wellbeing" online course.
- September: Conducted follow-up health assessments for January participants.
- October: Combined events for World Mental Health Day and staff Autumn Vaccination Program. Broadcast 'Nature Connections' presentation. Launched the Walktober walking challenge.
- November: Marked World Diabetes Day and promoted men's health awareness. The "Bike Fairy" returned to provide lights for staff commuting in the dark.
- December: Promoted the HSE Countdown to Christmas Calendar and the NMH Foundation December Dip.

The HI committee utilized the NMH Staff App to host the events calendar. Digital communication through emailing and social media remained primary tools for disseminating information on topics including bone health, nutrition, and mental health resources.
We extend our gratitude to the staff who participated in these initiatives and to the committee members: Helen McCrimmon, Sarah Browne, Caoimhe De Brun, Damian McKeown, Carl Alfvag, Claire-Daisy O'Reilly, Liz Byrne, Orla Bowe, Jenny Fitzgerald and Laura Harrington.

Sinead Curran
Chair of the Healthy Ireland Committee

NMH Staff taking part in the national fun team Step Challenge - Marchathon!

Staff Listing

This list includes every individual who worked in The NMH at any point during 2025, regardless of how long they were employed. It also includes, paid training posts and Consultants that may be shared with other hospital sites. Please note that some roles are job-shared or reduced hours, and therefore not all individuals represent full-time (WTE) posts.

Master

Prof Shane Higgins

Director of Midwifery & Nursing

Mary Brosnan (to Jun)
Annmarie Sliney (from Jul)

Secretary/ General Manager

Ronan Gavin

Administration

Abiodun Niniola
Adam Murray
Alan Mc Namara
Alannah Ruane
Alina Augusta Breban
Alison Giffney
Alistair Holland
Amanda O'Connor
Andrea Roche
Angelina Straszok
Ann Barry
Ann Courtney-Reade
Aoife Cassidy
Ashling O'Connor
Audrey Gallagher
Austin-Osarobo Omosigho
Barbara Doyle
Bernadette Lavin
Bernadine O'Driscoll
Binu Balakrishnan
Brenda Sheehan
Brian Byrne
Calin Buie
Caoimhe de Brun
Carina Carew
Carl Alfvag
Carmel Cullen
Carol O'Brien
Caroline Kavanagh
Caroline McMillan
Catherine Dunne
Cathy Sheehan
Celine Graham
Ciara Francis
Ciara Luckie
Cillian Power
Ciprian Gulea
Clare Gray
Claudia Murphy
Claudine Kearns
Con Grimes
Damian McKeown
Danielle Core
Danielle Scanlon
David Allen
Declan Corrigan
Deirdre Roche
Delia Lacambra
Dermot McMahon
Erica Gongora
Edgars Daukulis
Eimear Collier
Elizabeth Lawlor
Elizabeth Mahon
Emma Gaughran
Emma McDonnell
Erika Martin O'Shaughnessy
Fionnuala Byrne
Francis Rogers
Gary Sinnott
Geraldine Kennedy
Gibin Babu
Gillian Webster
Grainne Doyle
Helen Finnegan
Helen Gannon
Helen McCrimmon
Ian Manners
Ieva Neilande
Ioana Pacurar
Jacinta Bohan
Jacinta Scully
James Byrne
Jane Fitzpatrick
Jane McKenna
Jenny McCrea
Jenny Rosetes
Jerry Cheruvannoor
Jim Fox
Jithin Jose
Joan Hyland
Jodie Griffith
Karla Gallagher
Kathryn Power-Hendrick
Katie Callaghan
Kim Carolan
Laura Moran-O'Shaughnessy
Laura O'Connor
Lauren Ennis
Lauren Spearing Gibbons
Lauryn Gough
Lee Anne Phillips
Linda Mc Cormack
Linda Mulligan
Lisa Sweetman
Lisa Bell
Lisa Murray
Lorraine Mc Loughlin
Lorraine McGillivary
Louise Kenny
Ludmila O'Toole
Lynn Kavanagh
Mairead Mannion
Mandy Desay
Marcella Maher
Margaret Keane
Marguerite Lohan
Maria Castro
Maria Mahon
Maria Patricia Costin Fuellas
Mark Howitt
Martin Creagh
Martin Crowe
Mary Lagan
Maykim To
Megan O'Brien
Melissa Murphy
Monika Tarnowska
Nadia Karayanidis
Natasha Dowling
Niamh Cunningham
Nicola Harford
Nicola Jordan
Nicole Adams
Nicole Kennedy
Nisha Raj
Noreen Wright
Olivia Gallagher
Orla Morris
Orla Brilly
Pam Robinson
Patricia Misiara
Paul Maher
Paul O'Brien
Pauline Haskins
Peter Fry
Rachel Hiheglo
Rebecca Bagidi
Ria Glavey
Roisin Moran (Admin)
Rosemol Joy
Rosie Moore
Roslyn Farrelly
Saju George
Sam Benson
Sandra Hoye
Sandra Perkins
Saoirse Brady
Sarah McCourt Duff
Seamus Moriarty
Segun Osisanya
Sharon Hynes
Sharon Smith
Siobhan Flanagan
Siobhan Laherty
Siobhan Leonard
Sonya Duffy
Sophie Mac Neice
Stephen Corrigan
Susan Doyle
Suzanne Howard
Syam Sundar Balagurunathan
Tara Duggan
Tara Stacey
Terri Cullen
Titas Belevicius
Valeria Fettache
Valerie Watt
Vanessa Goldwater
Warren Campbell
Yogendra Shakya
Yuliya Homan Ovsyannykova
Yuliya Hrofman
Yvonne Connolly

Health & Social Care Professionals

Adele Kane
Aine Sally
Aine Toher
Aisling Ross
Alicia Grace
Alison Nolan
Amanda Olsen
Angela Angove
Anna McCormick
Anya Curry
Aoife Cullen
Aoife Gill
Aoife Magner
Aoife Menton
Aoife Shannon
Aoife Tonge
Ashley Hendy
Avril Dempsey
Benedetta Soldati
Bernadette Ryan
Bridget Cullen
Cait O'Mahony
Carla Grove
Carol O'Connor
Catherine Chambers
Catherine Doughty
Charlotte Bailey
Ciara Buggy
Ciara McKenna
Ciara Ryan
Clara Nolan
Clodagh Cunniffe
Corinne Henry-Bezy
Damian Lally
Danielle Stanley
David Fitzgerald
Declan Ryan
Deirdre Real
Diane Fitzgerald
Doireann Kavanagh
Donal Noonan
Edel Connolly
Eithne Lennon
Eleanor Ryan
Elga Grimes
Elizabeth Loftus
Ellen MacCourt
Eoghan Hayden
Erin Griffin
Eva Mohan
Farhana Ahmed
Fidelma Shortall
Gillian Corbett
Gillian Mc Murray
Grainne O'Dea
Gwen Connolly
Hannah Kerr
Jennifer Brady
Jessica Smith
Joanne Egan Mc Guckin
John Long
Judith Nalty
Karen McCormack
Katie Campbell
Katie King
Kim Bartley
Kyle De Ronde
Laitan Alabi
Laura Harrington (Dietetican)
Laura Harrington (Social Worker)

Laura Moyles
Leah Flanagan
Lesley Anne Ross
Linda Simpson
Lorna O'Connor
Louise Delany
Lucy Collender
Ma Kristina Cuenca
Mairin Hayes
Marc Kehoe
Margaret Daly
Margaret Deasy
Marie Slevin
Mariela Zalduendo
Mark Power
Meg Fitzgerald
Michelle O'Toole
Miriam Foley
Montserrat Corderroura Ambros
Naomi Carr
Niamh Gilmartin
Nikita Kealy
Oleg Shrolik
Olivia Cody
Orlaith Fahey
Pamela Mac Keogh
Paula Whyte
Peter Ogundipe
Rebecca Rock
Rebecca Seabrook
Roberta Mc Carthy
Roisin Gowan
Rosanna Sheridan
Rosie Kirwan
Saoirse Bolger
Sarah Browne
Sarah Fagan
Sarah Fitzmaurice
Sarah Louise Killeen
Sarah Lovely
Sarah Mullins
Shahad Al-Tikriti
Sinead Curran
Sinead Stakelum
Sophie Delaney
Tak Yeung Ryan Suen
Tara McGrath
Teresa Tormey
Tina Moley
Una Murphy
Vanessa Winn
Wendy Kearney
Zelda Greene

Medical

Prof Aiden McCormick
Mr Alex Blayney
Dr Ann Hanley
Dr Aoife Lally
Dr Bryan Lynch
Dr Cathal O'Sullivan
Dr Chris McGuigan
Dr Colin McMahon
Prof Colm Bergin
Dr Conor O'Brien
Dr Abdalla Babiker
Dr Ahmed Abdallah Ali Mahmoud
Dr Ahmed Mohamed
Dr Ahmed Sherif
Dr AHMEDEISSA
Dr Ahsan Rasool
Dr Aife Kavanagh
Dr Ailbhe Benson
Dr Aisha Abukarog
Dr Aisling Betts
Dr Aisling McDonnell
Dr Aleksandra Sobota
Dr Alison Downes
Dr Ammara Sultana
Dr Amna Elgaali
Dr Andrew O'Donnell
Dr Andrew O'Keeffe
Dr Ann McHugh
Dr Anna Curley
Dr Anna Impiumi
Dr Anthony Rowan
Dr Aoife McEvoy
Dr Aoife Reynolds
Dr Ashfaq Afridii
Dr Augusto Rolle
Dr Aun Muhammad Baig
Dr Avril O'Connell
Dr Aya Taha
Dr Barbara Guerrini
Dr Brian McDonnell
Dr Caitriona Ni Chathasaigh
Dr Caitriona Quinn
Dr Caoimhe Duggan
Dr Caoimhe Hartnett
Dr Carel Le Roux
Dr Carla Canniffe
Dr Carly Keegan
Dr Carmel Moore
Dr Catherine Bezuidenhout
Dr Catherine Connolly
Dr Catherine Hinds
Dr Catriona Hayes
Dr Chane Tufan
Dr Charles Sheil
Dr Chidinma Anyanwu
Dr Chris Lock
Dr Christine Clifford
Dr Ciara Conaty
Dr Ciara Feighan
Dr Ciara McCormick
Dr Ciara Nolan
Dr Claire Aitken
Dr Claire Flahavan
Dr Clare Kennedy
Dr Clare O'Connor
Dr Claudine Vavasseur
Dr Colin Mc Mahon
Dr Colin McGrath
Dr Colin Smyth
Dr Conor Devlin
Dr Conor Ring
Dr Constance Young
Dr Cornelia Carey
Mr Damian McCormack
Dr Danielle O'Connor
Dr Darragh Rooney
Mr Darach Crimmins
Dr David Coleman
Mr David Quinlan
Dr David Webb
Dr David Crosby
Dr David Fennelly
Dr David Mahon
Dr David O'Keeffe
Dr David Rooney
Dr David Sheridan
Dr Deirdre Lundy
Dr Deirdre Sweetman
Dr Donal O'Brien
Dr Ebtihal Abdelaziz
Dr Eihab Elshabrawy
Dr Elaine Kenny Houlihan
Dr Eleanor Burke
Dr Eleanor Dunican
Dr Elizabeth Murphy
Dr Ellen Horgan
Dr Ellen McMahon
Dr Emer Scanlon
Dr Emily Chiao Wei Tan
Dr Emily Loughman
Dr Emma Shanley
Dr Eoghan Mooney
Dr Eoghan Sharkey
Dr Eoin Coughlan
Dr Eoin Donellan
Dr Eoin O'Currain
Dr Erica Curtolo
Dr Erica Lahoud
Dr Eva Hartigan
Dr Evangeline Morris
Dr Fakeha Naeem
Dr Fakhri Danial
Dr Farah Nasir
Dr Fatema Al Falahi
Dr Fatimah Alaya
Dr Fearghal O'Neill
Dr Fiona Martyn
Dr Fiona O'Toole
Dr Fionn Woulfe
Dr Freya Guinness
Dr Gabriela McMahon
Dr Gaithri Veerasingam
Dr Georgia Dugaci
Dr Gerry Agnew
Dr Grace Hennessy
Dr Greg Murphy
Dr Hagir El Tahir
Dr Hayley Jackson
Dr Helena Bartels
Dr Hilary Leeson
Dr Holly Kirwan
Dr Holly Walsh
Dr Ingrid Browne
Dr Irfan Malik
Dr Ita Shanahan
Dr Jack McGrath
Dr Jacqui Clifford
Dr James McDermott
Dr Jan Franta
Dr Jane Coleman
Dr Jean-Francois Bonnet
Dr Jennifer Cook
Dr Jennifer Geraghty
Dr Jennifer Stokes
Dr Jessica Miller
Dr John Garvey
Dr John Holian
Dr Jyothsna Purna
Dr Kainaat Amin
Dr Kara Swan
Dr Kate Coleman
Dr Kate Glennon
Dr Kate Rafferty
Dr Katie Livingston
Dr Kenneth Kuan
Dr Kevin Bates
Dr Kevin Dodd
Dr Kevin Zhou
Dr Killian Marsh
Dr Kimberley Mamo
Dr Kirk Levins
Dr Kristyn Dunlop
Dr Kushan Galav
Dr Laoise O'Brien
Dr Larry Crowley
Dr Launcelot McGrath
Dr Laura Greenan Kennedy
Dr Laura Ryan
Dr Laura Ryan Moran
Dr Laura Stephens
Dr Liam Shaw
Dr Lisa McCarthy
Dr Lisa McDonnell
Dr Louise Marie Lane
Dr Maebh Horan
Dr Maggie O'Brien
Dr Majid Abdelrahim
Dr Marahaini Md Isa
Dr Marguerite O'Brien
Dr Maria Moustakis
Dr Mark Glynn
Dr Mark O'Rahelly
Dr Martin Mulligan
Dr Marwa Abas
Dr Mary O'Dea
Dr Matthew Carter
Dr Max Waterstone
Dr Mayada Ahmed
Dr Meadhbh Collison
Dr Mensud Hatunic
Dr Mia Grace Gasson
Dr Michael Carey
Dr Michael Robson
Dr Misbah Sarmad
Dr Mohamed Elshaikh
Dr Mohammad Ahmed Rasheed
Dr Mohammed Mustafa
Dr Mohsin Akhtar
Dr Mona Joyce
Dr Muhammad Awais Alvi
Dr Muhammad Ramzan
Dr Munikumar Chembeti
Dr Murtaza Farooq
Dr Myra Fitzpatrick
Dr Naomi Shannon
Dr Narain Singh
Dr Nasir Elsalahi
Dr Nasruddien Salih
Dr Nermeen Jamshaid
Dr Niamh Adams
Dr Niamh Beirne
Dr Niamh Fee
Dr Niamh Joyce
Dr Niamh Keating
Dr Niamh O Donovan
Dr Niamh Vaughan
Dr Nicola Naidoo
Dr Nikki Higgins
Dr Nusrat Shaheen
Dr Olufemi Awojoodu
Dr Omar Elabbasy
Dr Omar Tewfik
Dr Orla Bracken
Dr Orla McNerney
Dr Orla Sheil
Dr Ovidiu Lungu
Dr Padraic O'Coisdealbha
Dr Padraig Calpin
Dr Parijot Kumar
Dr Paul Donovan
Dr Paul Downey
Dr Paul Keenan
Dr Paul Reddy
Dr Pauric O'Reilly
Dr Philip Clarke
Dr Rachel O'Keeffe
Dr Rebecca Fahy
Dr Richard Liddy
Dr Robert Brodigan
Dr Robert Ffrench-O'Carroll
Dr Robert Joyce
Dr Roger McMorrow
Dr Roisin Cullinan
Dr Roisin McConnell

Dr Roisin Ni Dhomhnaill
Dr Rory McGuinness
Dr Roseanna Stang
Dr Roseanne Lynham
Dr Rosemary Joseph
Dr Roya Ahmed
Dr Ruta Petkute
Dr Ruth Mathew
Dr Safia Rao
Dr Saira Khalid
Dr Sally Cahill
Dr Samantha Doyle
Dr Sara Ahmed
Dr Sara Mohan
Dr Sarah Brady
Dr Sarah Kasha
Dr Sarah O'Riordan
Dr Sarah Petch
Dr Saran Kennedy Williams
Dr Sean Callinan
Dr Sean Fitzpatrick
Dr Shane Kelly
Dr Sheelagh O'Brien
Dr Siaghal Mac Colgain
Dr Simon Craven
Dr Sinead O'Brien
Dr Siobhan Corcoran
Dr Siobhan Moran
Dr Sophie Shinnors
Dr Sorcha Lynch
Dr Sowmya Mayigaiah
Dr Stephane Maingard
Dr Stephen Carroll
Dr Sumaira Tariq
Dr Susan Hannon
Dr Susan Knowles
Dr Syeda Farah Nazir
Dr Taha Elsherif
Dr Tayla Phillips
Dr Teresa Treacy
Dr Thoshar Naidoo
Dr Umar Ishtiaq
Dr Valerie Nicolay
Dr Vera Papp
Dr Warda Naqvi
Dr Youeil Abdelnour
Dr Yulia Shahabuddin
Dr Zainab Mustafa
Dr Zaineb Elbishari
Dr Zaman Malik
Dr Zara Fonseca Kelly
Dr Zeerak Laila
Mr Feargal Quinn
Mr Gerry Lennon
Prof Hugh E Mulcahy
Dr Janice Redmond
Prof John Allen
Mr John Caird
Mr John Gillick
Dr Juliette Sheridan
Mr Kieron Sweeney
Dr Marie Twomey
Prof Niall Tubridy
Dr Niamh O'Sullivan
Prof Omar El Sherif
Dr Pat Twomey
Dr Paul Oslizok
Prof Cathy Allen
Prof Colm O'Donnell
Prof Declan Keane
Prof Fionnuala McAuliffe
Prof Gabrielle Colleran
Prof Jennifer Walsh
Prof John F Murphy
Prof Mary Higgins
Prof Rhona Mahony
Prof Venita Broderick
Dr Royce Vincent
Dr Sarah Chamney
Ms Tafadzwa Mandiwanza

Midwifery & Nursing

Abby Phillips
Abigail Aquino
Abigail Sikat
Abigail Songcuya
Agnes Licudine
Aine Denise Castaneda
Aine Mc Guinness
Aishat Gazal
Aisling Dolan
Aisling Dowdall
Aisling Kenny
Aisling Khawais
Aisling McDonnell
Aisling McMullen
Ajitha Bhavan
Alana Griffin Lawless
Aleemat Ejide
Alexandra Crowe
Alexandra Rae Gazmen
Aleyamma Joseph
Aliana Jaina Alano
Alice Dunne
Alice Hoffmeister
Alice Tuthill
Alison Hickey
Alison Ryan
Alix Paumelle
Alphonsa Pius
Amanda Murphy
Amandine Barr
Amy McCoy
Amy Peare
Ana Maia
Andrea Ranara
Angel Hobbs
Angela Bray (nee Doyle)
Angela Deegan
Anila Thomas
Anitha Shanti Sequeira
Anjana Baby
Ann Calnan
Ann Marie Dunne
Ann Marie Pilien
Ann Nwagwu
Ann Walsh
Anna Casey
Anna Lou Gedalanga
Anna Lyons
Anna Mockler
Anna Stachowiak
Anna Wilson
Annabel Murphy
Anne Beirne
Anne Flynn
Anne Lopez
Annie Lou Reynoso
Annie Sebastian
Annmarie Bangotan Apilias
Annmarie Murphy Cruse
Anthia Baby
Antje Helbing
Aoife Boland
Aoife Boyle
Aoife Kenny
Aoife Lennon
Aoife Maxwell
Aoife Moran
Aoife O'Friel
Aoise Walsh
April Hayden
Archana Mohan
Archana Rajan
Ariane Balasolla
Arlene Pinca
Ashly Thomas
Athira Mary Romans
Attracta Hennessey
Auri Tavisora
Ava Hanley
Ava Moran
Babitha Mathew
Baby Beena Paulose
Barbara Cathcart
Barbara White
Beatriz Raimundo
Becky Coulahan
Bernadette Cuesta
Beth Murphy
Bethany Leahy Ryan
Beverley Lat Chan
Bexy Mathew
Bianca Hein
Bianca Munteanu
Bincy Anthony
Bincymol Cyriac
Blaithin (Treasa) Quinlan
Blanaid Marron-Ward
Breda Coronella
Breda Ryan
Breid O'Dea
Brenda Casey
Bridget Carew
Bridget Shannon
Brona O'Keeffe
Bronwyn Nicol
Bronwyn Redmond
Busra Kaplan
Caitriona Hayes
Camille Hannah Wei
Caoimhe Horgan
Caoimhe Keegan
Caoimhe NicSeain
Caragh Rutledge
Carina Baker
Carmel Conaty
Carmel Imelda Breen
Carmel O'Brien
Carol Pugh
Carol Turner
Carolanne McGinley
Carolin Holmes Engel
Caroline Brophy
Caroline Mc Cafferty
Caroline Roessing
Caroline Ryan
Carron Fox
Casey Phillips
Catherine Casey
Catherine Comerford
Catherine Cooke
Catherine Gray
Catherine Hearty
Cecilia Mulcahy
Celeste Larkin
Celine O'Brien
Charlotte Gartlan
Chithra Sasidhara Kurup
Chloe Brennan
Chloe Ellison
Chloe Hutchinson
Chriselda Maria Ventura Mallari
Christina Fearon
Christina McNamara
Christina Silas
Christina Van Der Does
Christine Higgins
Christine Meagher
Christine-Mae Freo
Ciara Barry
Ciara Buckley
Ciara Coveney
Ciara Dempsey
Ciara Kenny
Ciara Murphy
Claire Daisy O'Reilly
Claire Howlett
Claire McElroy
Claire McSharry
Claire Sheppard
Clare O'Dowd
Clarence Francisco
Claudia Christie
Clodagh Lynn
Clodagh Maher
Clodagh Manning
Clodagh McConnon
Colette Finegan
Colette O'Neill
Connie Barry
Contessa Cortes
Contras Rachel
Corin Paton
Crystal Nisperos
Dana Hardy
Daria Vives Vancells
Darjure Balonzo
Debbi Appelbe
Deborah Fitzgerald
Deirdre Geoghegan
Deirdre Molloy
Deirdre O'Neill
Denise Mc Quillan
Dhyana Garey Garcia
Dia Musleh
Dianne Marquez
Divya Mol Thomas
Divya Paul
Divya Susan George
Djoana Talabong
Dominique Beltran
Dorota Matuszczyk
Dympna Casey
Edel Cooney
Egle Kilikeviciute
Eimear Forde
Eimear O'Connor
Eimear Rutter
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Glossary

BMI	Body mass index
CMV	Cytomegalovirus
DCDA	Dichorionic Diamniotic
DCH	Diffuse chorioamnionic haemosiderosis
D/C	Dilatation and curettage
DNA	Did not attend
Domino	Domicillary In Out
DVM	Delayed villous maturation
EBL	Estimated blood loss
EFM	Electronic fetal monitoring
ELBW	Extremely low birth weight
EUA	Examination under anaesthetic
FBS	Fetal blood sampling
FD	Fetal distress
FFP	Fresh frozen plasma
FIR	Fetal inflammatory response
FSE	Fetal Scalp Electrode
FVM	Fetal Vascular Malperfusion
GA	General anaesthetic
GBS	Group B Streptococcus
GCT	Glucose Challenge Test
GDM	Gestational diabetes mellitus
GP	General practitioner
GTT	Glucose tolerance test
Hb	Haemoglobin g/dl
HCG	Human chorionic gonadotrophin
HELLP	Haemolysis elevated liver enzymes low platelets
HIE	Hypoxic-ischemic encephalopathy
HR	Heart rate
Hrs	Hours
IOL	Induction of labour
IUCD	Intrauterine contraceptive device
IUD	Intrauterine death
IUGR	Intrauterine growth retardation
IUI	Intra uterine insemination
IUT	Intrauterine transfusion
LLETZ	Large loop exision of transformation zone
LMP	Last menstrual period
MCDA	Monochorionic Diamniotic
MCTA	Monochorionic Triamniotic
MRI	Magnetic resonance imaging
MROP	Manual removal of placenta
MSV	Mauriceau-Smellie-Veit
MVM	Maternal Vascular Malperfusion
ND	Normal delivery
NE	Neonatal encephalopathy
NEC	Necrotising enterocolitis
NND	Neonatal death
N/R	Not recorded
PNW	Postnatal ward
PPH	Post partum haemorrhage
PPROM	Preterm pre-labour rupture membranes
PROM	Preterm rupture of membranes
SA	Spinal analgesia
SCBU	Special care baby unit
SGA	Small for gestational age
SIDS	Sudden infant death syndrome
SMM	Severe maternal morbidity
SROM	Spontaneous rupture of membranes
SVD	Spontaneous vaginal delivery
UTI	Urinary tract infection
VOD	Vermont oxford database
VON	Vermont oxford network

Definitions

Approach to Data Presentation in Clinical Report
Presentation of data in the individual cases is now recorded in tabular form. An explanation of placental terminology is provided in appendix 1. Individual cases are categorised according to the disease process that caused death. Many cases will have multiple pathologies and multiple potential causes of death, and the sequence leading to these is given in the final (diagnostic) line. The approach taken in cases with potentially competing causes of death is that analysis of this data enables calculation of hospital mortality in infants without a lethal or potentially lethal congenital anomaly. IUGR can be variously applied to infants at the 3rd, 5th or 10th centiles. The third centile is the one shown to correlate best with perinatal mortality. The reference ranges for centiles given in this report are those published by the Child Growth Foundation (UK) (updated 2002).

Maternal death: Death of a patient, booked or unbooked, for whom the hospital has accepted responsibility, during pregnancy or within six weeks of delivery whether in the hospital or not.

Stillborn infant: A baby with birthweight greater than or equal to 400g (singleton) or 200g (multiple) and/or 23+0 wks estimated gestational age, who shows no signs of life at delivery.

Early neonatal death: A baby born alive with birthweight greater than or equal to 400g (singleton) or 200g (multiple) and/or 23+0 wks estimated gestational age, who dies within 7 days.

Perinatal mortality rate: The sum of stillbirths and early neonatal deaths per 1,000 total births whose birthweight is greater than or equal to 400g (singleton) or 200g (multiple) and/or 23+0 wks estimated gestational age.

Corrected perinatal mortality rate: The sum of stillbirths and early neonatal deaths per 1,000 total births whose birthweight is greater than or equal to 400g (singleton) or 200g (multiple) and/or 23+0 wks estimated gestational age excluding congenital anomalies.

Gestation: The best estimate is the duration of gestation using the first day of the last normal menstrual period and early ultrasound as appropriate in the clinical circumstances.

Preterm: Less than 37 completed weeks. Postdates: 42 weeks or greater.

Prolonged labour: Labour more than 12 hours - nulliparous.

PATHOLOGY

Thrombophilia screen
Prothrombin Time, INR, APTT, Thrombin Time, Fibrinogen, Lupus Anticoaguloant screen - (Lupus anticoagulant, anticardiolipin antibodies, beta-2 glycoprotein 1 antibody), Anti Thrombin Three, Protein C, Protein S Free, Modified APCR (FVLeiden mutation if appropriate).

Postmortem
The perinatal autopsy involves external examination of body, with appropriate photographs and X-ray. Internal examination includes inspection of cranial, thoracic and abdominal cavities with removal and weighing of organs: organs are retuned to the body before release. Samples are taken for subsequent processing and histologic examination. Extent of sampling of tissue such as spinal cord, nerve and muscle depends on clinical details and on the extent of maceration. The autopsy includes swabs for culture from body cavities and washings for virology. Tissue is frozen for fat stains and may be used for assessment of metabolites. Cytogenetic analysis and where indicated, microarray, may be performed on ether skin or placental tissue. The placenta is reported in conjunction with the autopsy, and maternal blood results are also evaluated in reaching a diagnosis. The quality of the report is benchmarked against standards set in the Faculty of Pathology, RCPI QA/QI programme.

A provisional anatomic diagnosis is issued within two working days (except in Coroner's cases, where it is not issued), and the final report is usually within 8 weeks. Occasional cases take longer due to complexity and/or the necessity for external consultations.

Placental pathology

A triage system is in place for placental examination. The entire placenta is submitted to the laboratory:

a) from cases of Caesarean section

b) from cases born in the delivery ward, where there is an abnormality of pregnancy, labour, delivery or the neonatal period. In other cases, the placenta is kept refrigerated for seven days and retrieved if an indication for analysis becomes apparent. Data from analysis of cases of Perinatal morbidity or mortality is returned in an anonymised fashion to the National Perinatal Epidemiology Centre, UCC, where it is pooled with data from other maternity units and national trends and benchmarks are published. The terminology used is the same consensus terminology as that used by NPEC (Khong TY et al). Some of these terms are expanded on below.

Maternal vascular malperfusion (MVM)

This is a spectrum: at the less severe end is mild accelerated villous maturation, then ischemic villous crowding and latterly infarction, also referred to as uteroplacental insufficiency (UPI). Increasingly, terms such as "shallow implantation" are being used to explain the pathogenesis. Expected findings in a case of severe PET would be a small placenta with recent and old infarcts, located centrally and peripherally in the parenchyma. Atherosis is fibrinoid change in vessels, seen in about half of cases of PET and occasionally in other conditions eg connective tissue disease.

Hypoxic membrane lesions

Laminar decidual necrosis may be regarded as an acute hypoxic lesion, and microcystic change in the chorion as a chronic hypoxic lesion.

Meconium

When present in large quantities, meconium may cause necrosis of muscle cells in the walls of chorionic vessels and possibly lead to vasospasm and ischaemia.

Chorangiosis

More vessels than normal are seen in terminal villi. It may be present as a primary finding or as a reaction where adjacent villi have been destroyed by villitis, and is suggested to be a marker of chronic hypoxia.

PATTERNS OF INFLAMMATION

Chorioamnionitis

The terms "maternal inflammatory response" and "fetal inflammatory response are used with each being staged and graded according to consensus guidelines. There is an association between a severe fetal inflammatory response and brain damage in both term and pre-term infants.

Maternal-fetal immune interaction

This may be manifest as any or all of villitis, intervillositis, chronic chorioamnionitis and deciduitis.

Villitis

Rare cases of villitis are due to infection eg CMV, but most are of unknown aetiology and are immunologically mediated. Villitis is graded as low-grade or high-grade. Overall, villitis is seen in 10% of placentas; highgrade villitis occurs in < 2% and is associated with an adverse perinatal outcome. Villitis may cause damage to fetal vessels in the placenta and this is associated with neurologic damage in term infants. It may recur in subsequent pregnancies.

Intervillositis

Chronic histiocytic intervillositis is relatively rare, but is over-represented in the cases in this report. It is associated with growth restriction and perinatal loss, with a mean gestation of loss of 25/40. It is more common in patients with immune dysregulation, and is likely to recur in subsequent pregnancies.

THROMBOSIS AND HAEMORRHAGE

Fetal vascular malperfusion (FVM)

Occlusions of the fetoplacental circulation are manifest by: extensive avascular villi, obliterated stem arteries, haemorrhagic villitis, and occlusive thrombi. The term fetal thrombotic vasculopathy is also used. Highgrade FVM, in particular, is associated with neonatal encephalopathy.

Non-occlusive mural fibrin thrombi

These are found in large fetal vessels in approx 10% of placentas. They are more common in cases with FTV and abnormal coiling; they reflect impaired fetoplacental flow, but the significance of isolated ones in smaller stem vessels is at present unclear.

Cord coiling

The cord normally has one coil per 5cm. Both hypo- and hypercoiled cords are associated with IUGR, fetal death, cord stricture, thrombosis and an abnormal response to labour.

Abruption and retroplacental haemorrhage (RPH)

RPH may be identified on pathologic examination of the placenta, but have been clinically silent. Conversely, dramatic clinical abruption may leave no changes in the placenta. In many cases RPH causes compression infarction of the placenta.

Diffuse chorioamniotic haemosiderosis (DCH)

This is diagnosed by the presence of haemosiderin-laden macrophages in the membranes and/or chorionic plate. Such placentas are more likely to show circumvallation, old peripheral blood clots and green discoloration. Clinically, DCH is associated with chronic vaginal bleeding, multiparity and smoking. Blood and breakdown products are released into the amniotic fluid. Oligohydramnios, IUGR and a lower gestational age at delivery have been found more commonly in cases with DCH. Persistent pulmonary hypertension and dry lung syndrome are more common in these neonates. DCH may represent chronic peripheral separation of the placenta, possibly from marginal venous bleeding (rather than the arterial bleed of abruption).

ABNORMAL PLACENTAL DEVELOPMENT

Delayed/abnormal villous maturation

This is where the placenta has failed to develop appropriately for gestational age, partially or completely. It is a poorly understood entity, and is associated with diabetes. It is associated with an increased risk of stillbirth. Some cases may receive a descriptive diagnosis eg abnormal maturation or variable villous maturation where there is a mixed picture, with some areas showing delayed maturation and other areas accelerated maturation. The term "distal villous immaturity" is also used.

Increased perivillous fibrin

Localised increases in fibrin are common, but a diffuse increase, sometimes in a pattern called "maternal floor infarction" is associated with an adverse outcome.

Placental weight

In general, the term placenta weighs between one sixth and one seventh of the infant's weight, but a wide range of placental weights is seen in normal infants. The weight is given in the cases discussed where it is felt to be markedly abnormal. Fetoplacental weight ratio (median of around 7 at term) are sometimes used.

Khong T Yee, Mooney EE, Ariel I et al. Sampling and definition of placental lesions. Amsterdam Placental Workshop Group 252 Consensus Statement. Arch Pathol Lab Med 2016;140:698-713.

Appendix 2: Classification of indications for caesarean section in spontaneous labour or after having had labour induced

Fetal reason

Caesarean section for fetal indication before any oxytocin has been given.

Dystocia

Inefficient uterine action/inability to treat/fetal intolerance

Problem is inadequate progress with no fetal problems until oxytocin is started.

Inefficient uterine action/inability to treat/overcontracting

Problem is inadequate progress but oxytocin does not reach maximum dose as per protocol in unit because of overcontracting uterus.

Inefficient uterine action/poor response

Problem is inadequate progress which does not improve after being treated with the maximum dose of oxytocin according to the protocol in the unit.

Inefficient uterine action/no oxytocin

Problem is inadequate progress which for whatever reason has not been treated with oxytocin.

Efficient uterine action/CPD/POP*

Adequate progress (1cm/hr) and in nulliparous women would need to have been treated with oxytocin) but vaginal delivery not possible.

*In multiparous women the term CPD/POP is replaced with obstructed labour.

CLASSIFICATION OF INDICATIONS FOR INDUCTIONS OF LABOUR

Fetal reasons

Includes all indications for induction that are carried out for the benefit of the fetus.

PET/Hypertension

Includes all indications for induction that are carried out for hypertensive disorders.

Post Dates

Includes all inductions that are carried out specifically for 42 weeks gestation or greater.

SROM

Includes all inductions for spontaneous rupture of the membranes.

Maternal reasons/Pains

Includes all indications for induction that are carried out for the benefit of the mother including pains not in labour.

Non medical reasons/Dates< 42 weeks

Includes all indications for inductions where there is no absolute medical indication or for dates but less than 42 weeks.

The National Maternity Hospital Annual Report

Photography in the Report
Some professional images in the report were sent in by patients and we are grateful for their contribution. Other images included are from Mark Griffin Photography, Denis Towell, Andrew Watchorn, press releases, the NMH Staff Newsletter and other photos staff shared with us and we are grateful to have them all.

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The Linen Guild
The National Maternity Hospital

The Linen Guild is a discretionary charity founded in 1912 which provides emergency assistance to mothers and babies in need who attend The National Maternity Hospital.

It is a 100% voluntary charity organisation. All members are volunteers who give willingly of their time and share our common objective of wanting to help mothers and newborn babies in difficult circumstances at a vulnerable time.

We are self-funding through donations and a variety of fund raising initiatives during the calendar year. 100% of all the money raised go directly to help mothers and babies who need emergency financial and practical support.
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The NMH Foundation raises vital funds for The National Maternity Hospital, advancing women's and neonatal health in Ireland. We invest in research, provide essential equipment and technology, and support the care teams and services looking after mothers and tiny babies. Every donation makes a BIG difference. The NMH Foundation is helping women and babies, thrive, arrive, survive.

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The National Maternity Hospital

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