

Safety Action A Elective Caesarean Section Capacity Report

Trust Board
24 September 2026

Presented for:	Information and Assurance
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Previous Committees:	WQAG

Freedom of Information Act (FOIA) Exemption	☐ YES (restricted from the FOIA) ☒ NO (available to the public under the FOIA)
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Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Governance, Management and Sustainability
<u>Regulatory Impact</u>	Regulation 17: Good governance

Key points	Purpose
1. Elective caesarean activity increased by 40% between 2020/21 and 2025/26, reaching 1,483 procedures against annual planned capacity of approximately 1,250.	<i>Information and Assurance</i>
2. Demand above planned capacity is currently managed through ad hoc sessions and non elective theatres without a recurrent workforce and theatre scheduling increase. This approach is unreliable and unsustainable; the associated business case is currently under review by the Trust Expenditure Review Group.	Information and Assurance
3. Maternity and neonatal OPEL data demonstrate sustained operational pressure and limited system resilience. This is compounded by increasing maternity case complexity, neonatal cot constraints, delays to planned care and the need to transfer some babies to other units.	Information and Assurance

<u>Risk Appetite Framework</u>			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact

Workforce Risk	Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Operating within
Operational Risk	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Cautious	Operating within
Clinical Risk	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Operating within
Financial Risk	Choose an item.	Choose an item	Choose an item.
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Operating outside

1. Summary

This report provides assurance to the Trust Board that elective caesarean section demand and capacity are subject to regular, systematic review. The assessment considers the entire perinatal pathway rather than theatre availability in isolation, providing oversight of whether clinical and operational capacity is sufficient and appropriately configured to meet demand safely. Capacity is reviewed alongside workforce availability and includes the adequacy of clinical space, theatre access, equipment, recovery provision and downstream bed capacity. This integrated approach supports the timely identification, mitigation and escalation of constraints that could affect the safety, quality or continuity of elective caesarean section perinatal care.

The capacity element of Safety Action A of year 8 of the Maternity Incentive Scheme requires the Trust to undertake an annual demand and capacity mapping exercise for planned caesarean birth, covering the complete pathway: preoperative assessment, planned operating lists and theatre availability, anaesthetic and perioperative support, recovery, and transfer to an appropriate postnatal bed. The review must compare expected activity and case mix with available capacity, identify constraints or delays, and demonstrate that planned provision does not compromise emergency activity or other maternity services.

2. Discussion

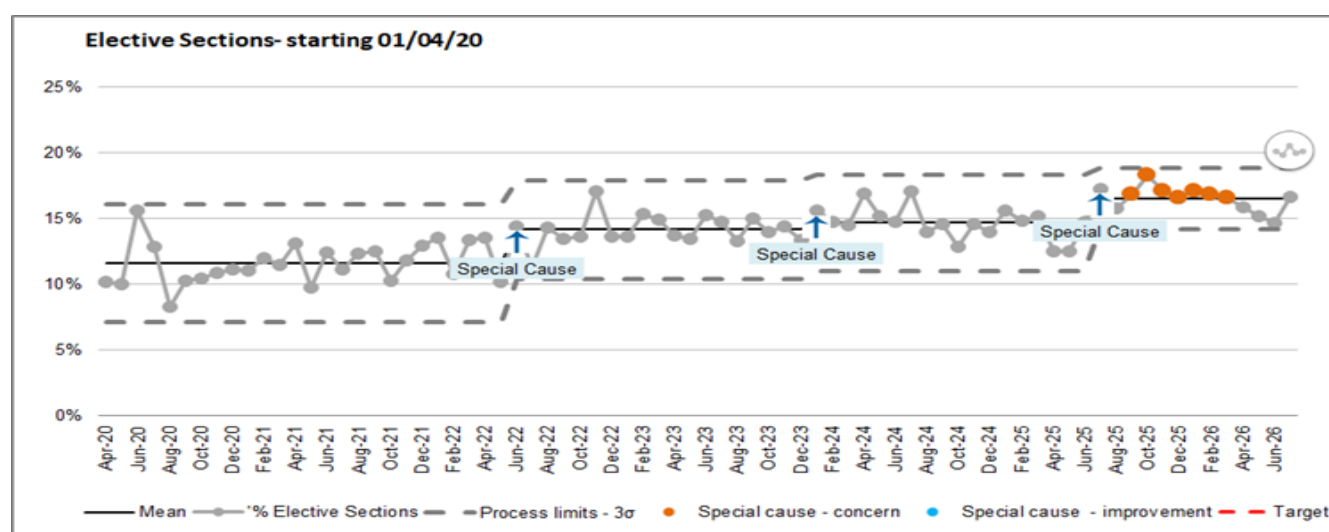
Current activity and capacity

The Women's Clinical Service Unit provides maternity services across Leeds General Infirmary and St James's University Hospital. Five elective obstetric theatre lists are currently scheduled each week, with activity alternating between the two sites. To mitigate increasing demand, a weekly afternoon session in the David Beevers Unit has been introduced for cervical suture insertion and removal, releasing capacity for up to three additional elective caesarean sections

each week. Although this provides some additional capacity, it is insufficient to meet current and forecast demand.

Demand for elective caesarean section has increased significantly and is reported to be 40% higher than in 2020/21. The average elective caesarean section rate at LTHT rose from 9.24% in 2019/20 to 16.02% in 2025/26, without a corresponding increase in dedicated elective obstetric theatre capacity or staffing. This growth exceeds the Royal College of Obstetricians and Gynaecologists' forecast and reflects increasing maternal and clinical complexity, rising maternal age and informed maternal choice. The statistical process control chart below demonstrates the sustained increase in elective activity and the table beneath shows the raw numbers.

Figure 1 Elective Caesarean section SPC



The SPC chart demonstrates a sustained upward shift in elective caesarean activity, supported by a 40% increase from 2020/21 to 2025/26. Demand now materially exceeds the capacity of the five list model, indicating a capacity gap rather than normal variation and therefore supporting the permanent establishment of additional elective theatre provision.

Figure 2. Elective Caesarean section data

Year	20/21	21/22	22/23	23/24	24/25	25/26
LTHT elective C-sections	1057	1030	1295	1306	1413	1483
LTHT % increase		-2.5%	25.72%	0.8%	8%	4.9%
National % increase		15%	9%	8%	11%	

Current demand is being managed using non-elective theatre lists and an additional ad hoc weekly list. Between July 2025 and April 2026, 51 patients underwent an elective caesarean section on a non-elective list. Reliance on emergency theatre capacity is neither appropriate nor sustainable and presents a clinical risk if the acute theatre is required while an elective procedure is in progress. It may also adversely affect patient experience by increasing the likelihood of delay or cancellation in response to emergency activity.

A review of the data has shown that over a 2-year period approximately 10% (28) of women had their caesarean section rescheduled due to operational pressures and list capacity. It is therefore evident that there is a need for additional capacity to meet the immediate demand requirements and continued ongoing demand increase. Delays in Elective Caesarean section >24 hrs are also captured on the intrapartum Birthrate Plus acuity tool as a clinical action in response to increased acuity versus workforce availability. A review of the tool for both sites indicates that there have been 9 delayed elective section births from April 2026 to date.

The current five list model provides a maximum theoretical capacity of 25 elective caesarean sections per week, based on five standard operating slots per list. In practice, available capacity is reduced by the complexity and duration of a significant proportion of cases.

In 2025/26, 120 elective caesarean patients were classified as major cases, each requiring two operating slots, and a further 14 were classified as complex cases, primarily referrals to the tertiary placenta accreta service, each requiring approximately half an operating list. As a regional tertiary centre for fetal medicine, maternal medicine and specialist obstetric care, including the highly specialised Placenta Accreta Spectrum service, LTHT manages a high proportion of cases requiring extended theatre time. Overall, major and complex cases accounted for 9% of elective caesarean sections in 2025/26, an increase of 1.6 percentage points from 2024/25, reducing deliverable capacity within the five list model and requiring appropriate reflection in demand and capacity planning.

The current model provides annual capacity for approximately 1,250 elective caesarean section births. In 2025/26, 1,483 procedures were undertaken, with activity above the planned capacity delivered through a combination of ad hoc sessions and non-elective theatre lists.

Proposed capacity response and future planning

Average national growth in elective caesarean section activity has been 9.5% per year over the past three years, compared with 4.5% at LTHT over the same period. Despite the lower local growth rate, current activity already exceeds planned capacity and reliance on temporary arrangements is not sustainable. The demand and capacity assessment therefore supports the permanent establishment of a sixth elective theatre list at the earliest opportunity.

Based on sustained year on year growth in demand, a second additional elective theatre list is expected to be required as part of business as usual provision by 2027/28. Introducing two additional weekly lists, one at each site, would enable the service to implement the proposed maximum of five patients per list.

In 2025/26, 31% of elective obstetric lists at Leeds General Infirmary and 33% at St James's University Hospital finished late, indicating that routinely scheduling six cases per list is not achievable given the complexity of the case mix. Until additional capacity is established,

however, six cases will continue to be scheduled where necessary to provide timely access to elective caesarean section and minimise reliance on non elective theatre capacity.

Each site has two maternity theatres, so when one is used for elective activity, a second remains available for acute cases. There is currently no evidence that acute activity has been delayed because theatres were occupied. However, accommodating more than seven weekly elective lists could reduce this resilience and adversely affect the safe and efficient delivery of both acute and planned care.

The capacity and demand review has focused on the current and anticipated trajectories for the next 1-2 years. However, it is important that it continues to be monitored for ongoing increase in demand as part of a longer-term plan noting that under current trends an eighth list would be needed from 2030. At this stage it would not be feasible to continue running elective lists concurrently with acute activity and a long term plan would be essential to separate planned and unplanned care with a dedicated elective caesarean section hub.

Workforce requirements

The table below sets out the multidisciplinary perinatal workforce requirements associated with the proposed expansion in elective theatre capacity from an intrapartum perspective. A business case has been submitted to the Trust Expenditure Review Group and an outcome is awaited. This is based on 7 lists per week and considers theatres and anaesthetics and womens CSU requirements and associated costs.

Professional judgement has been applied to the current postnatal registered midwife establishment and concluded that no additional postnatal midwifery capacity would be immediately required, provided the daily establishment of five midwives plus a Newborn (NIPE) examiner and 3 maternity support workers on days and 4 midwives and 2 support workers on nights is consistently maintained. However, it is important to note that a further service wide Birthrate Plus review has been commissioned with a planning meeting scheduled on the 3rd of December and a final report anticipated in April 2027 and this may suggest that the overall staffing levels on the postnatal ward need to be increased due to generally increasing complexity in the last 3 years since the last assessment was undertaken.

Figure 3. Additional perinatal workforce requirements

Role	CSU	Grade	WTE	26/27 Cost
Midwives	Womens	Band 6	2.84	153,347
Nurses/ODP	T&A	Band 6	0.65	35,097
Nurses/ODP	T&A	Band 5	1.31	57,841
CSW	T&A	Band 2	0.65	20,831

Nurses PACU	T&A	Band 5	0.40	17,661
Consultants	T&A	Consultant	0.50	88,777
Ward Clerks	Womens	Band 2	3.96	126,911

* In addition to the staffing costs there is an additional consumables cost of 57,465.

Case mix

The Birthrate case mix is monitored quarterly on the maternity services dashboard to monitor any trends and themes and is shown in the tables below. This will be assessed formally as part of the commissioned Birthrate Plus review scheduled to commence in December 2026. It will be triangulated with activity data and other key metrics to identify whether a further increase in overall registered midwifery staffing is indicated.

Figure 4. LGI September 2025 – July 2026 case mix

	Sept 25	Dec 25	Mar 26	Jun 26
Cat i	0%	0%	0%	0%
Cat ii	8%	7%	0%	8%
Cat iii	15%	14%	17%	13%
Cat iv	30%	31%	23%	34%
Cat v	47%	48%	59%	45%

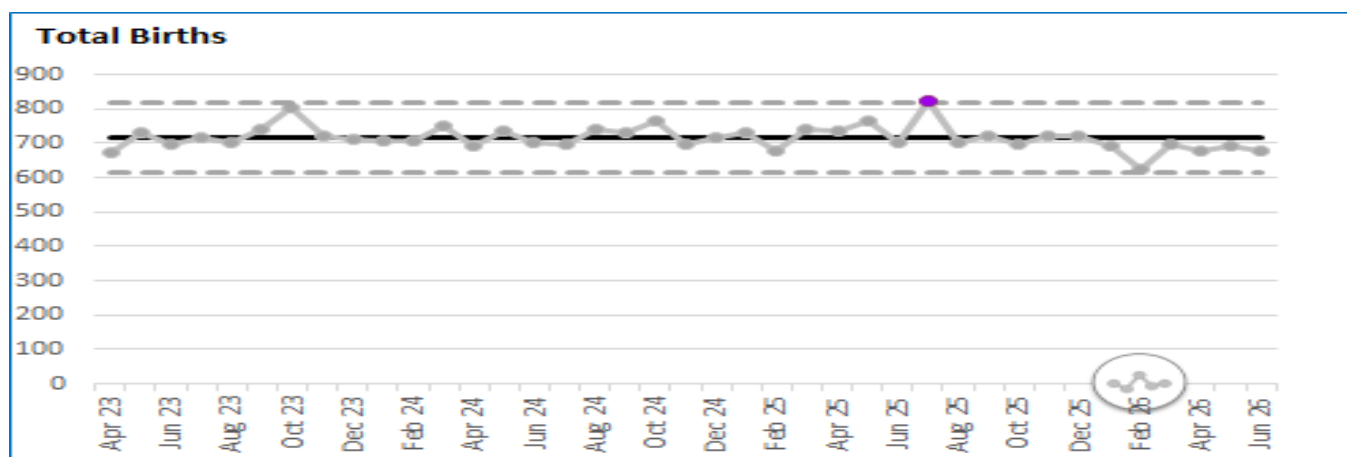
Figure 5. SJUH September 2025 – March 2026 case mix

	Sept 25	Dec 25	Mar 26	Jun 26
Cat i	0%	0%	0%	0%
Cat ii	5%	4%	0%	0%
Cat iii	11%	12%	13%	14%
Cat iv	32%	30%	25%	28%

Cat v	51%	54%	63%	58%
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- Both sites show sustained high acuity. Categories IV and V account for 77%–82% at LGI and 83%–88% at SJUH across the four reporting points.
- SJUH has the consistently higher-acuity profile. Category V ranges from 51% to 63% at SJUH, compared with 45% to 59% at LGI.
- March 2026 was the highest acuity point at both sites. Category V reached 59% at LGI and 63% at SJUH; Categories IV and V combined totalled 82% and 88%, respectively.
- The latest reported position remains significant. In June 2026, Categories IV and V combined accounted for 79% at LGI and 86% at SJUH.
- Lower-acuity activity is limited. Category I remained at 0% at both sites throughout. Category II was 0% in March at both sites and remained 0% at SJUH in June, compared with 8% at LGI.
- LGI shows greater quarterly fluctuation. Category V reduced from 59% in March to 45% in June, while Category IV increased from 23% to 34% however, the combined Category IV–V proportion remained high.
- SJUH shows a more consistently concentrated high acuity profile. Category V remained above half of the case mix at every reporting point.

Figure 6. Total Birthrate SPC

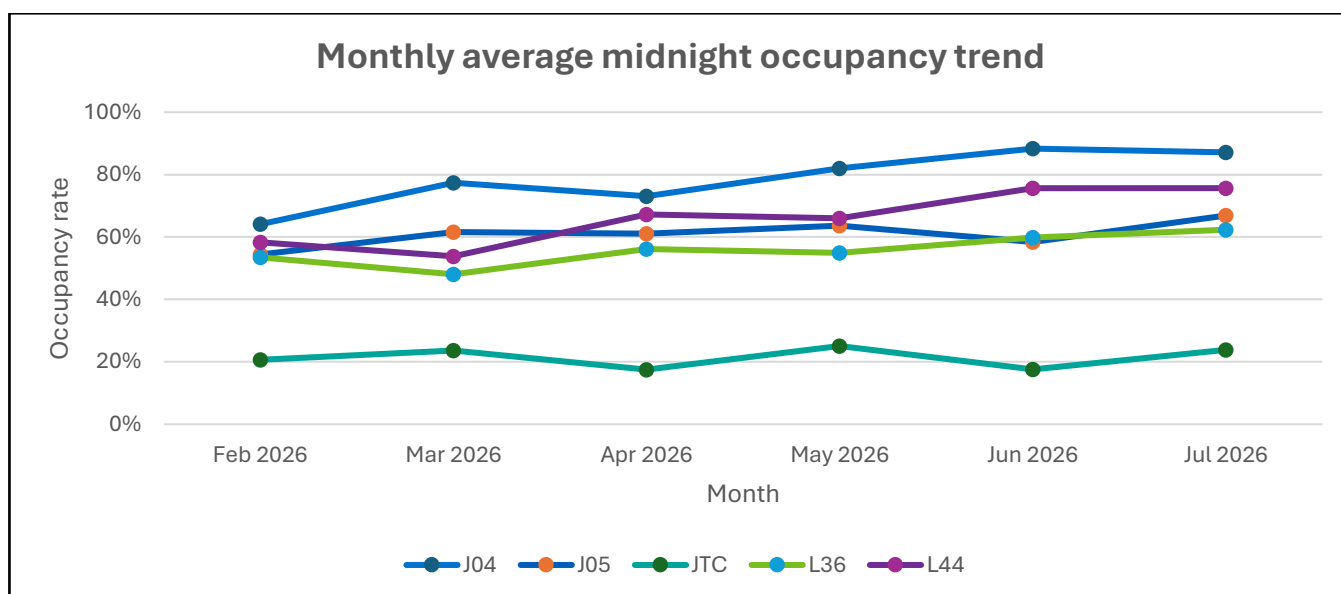


Overall birth volume is statistically stable, with one high special cause point and a recent period of lower activity. Increasing service pressure is therefore more likely to reflect changes in case mix, complexity and elective caesarean demand, rather than growth in total birth numbers alone. Staffing and capacity planning will continue to triangulate total births with acuity, dependency, theatre demand and postnatal workload.

Wider maternity and neonatal capacity

Bed capacity

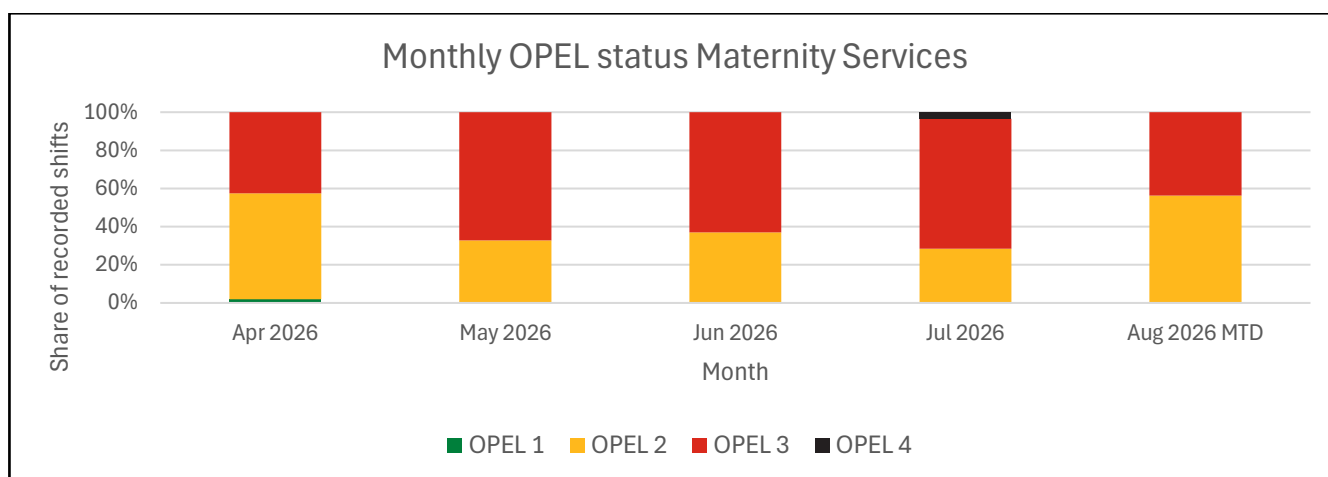
Figure 5. Average monthly antenatal and transitional care capacity



J04 (antenatal ward) is operating close to a high occupancy threshold, increasing the risk of reduced flow, delayed transfers and limited resilience during activity peaks. L44 (antenatal ward) also requires close monitoring because of its sustained increase. J05 (postnatal) shows a clearer upward trajectory, whereas L36 (postnatal) remains relatively stable. The relatively low JTC occupancy could present opportunities to review bed configuration or patient flow pathways, although this needs to be assessed alongside the clinical purpose, staffing model and suitability of beds. As the chart shows monthly averages rather than daily peaks, it understates periods when occupancy approaches or exceeds full capacity which are managed internally and tend to be predominantly associated with intrapartum and antenatal capacity.

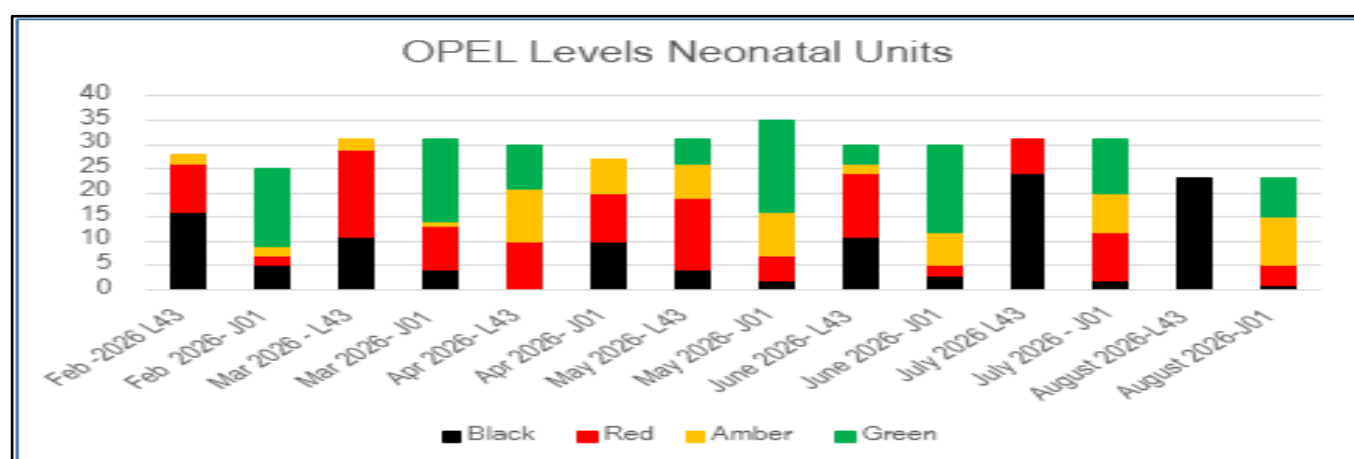
Whilst it is acknowledged that there are peaks and troughs within the monthly average, the overall position indicates that there is sufficient capacity to accommodate the increased numbers of caesarean section births. Further work is required over a longer period to identify if there is any demonstrable increase in length of stay that may negatively impact capacity over time.

Figure 6. OPEL Status Maternity Services (combined both sites)



The chart demonstrates persistent operational pressure across maternity services, with limited resilience and frequent reliance on escalation actions. This supports the case for additional capacity and workforce investment, particularly because expanding elective caesarean activity without additional resource could increase pressure on theatres, staffing, postnatal beds and emergency pathways.

Figure 7. OPEL Neonatal Services



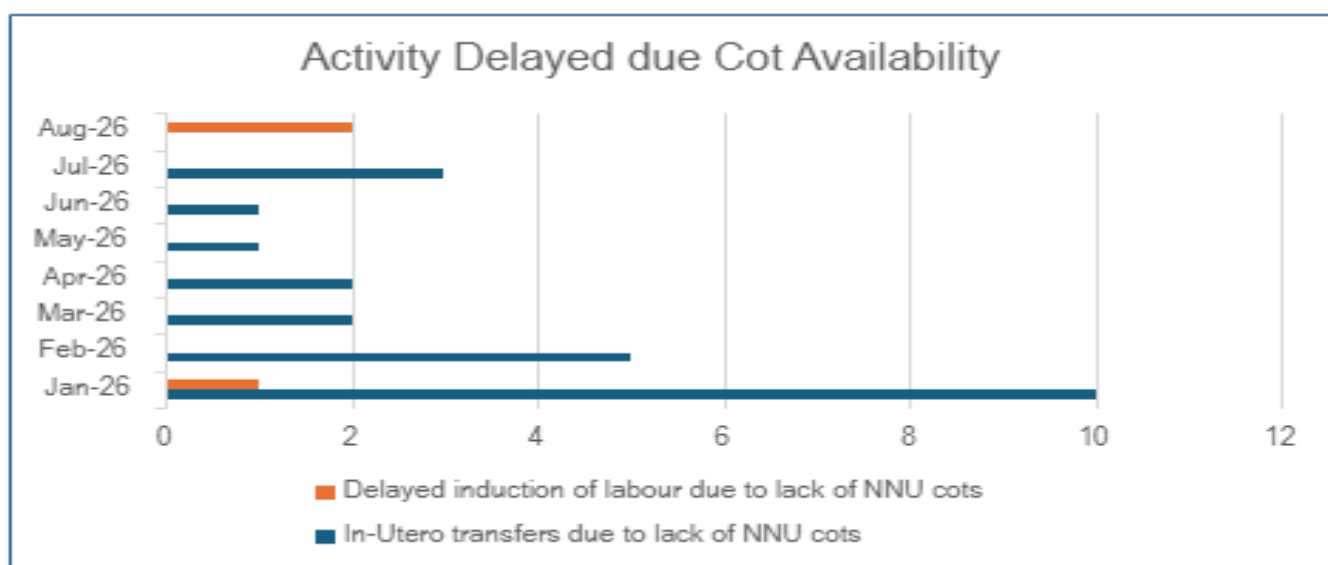
The chart indicates limited neonatal resilience, particularly at L43, with prolonged Black and Red status suggesting persistent cot capacity, staffing and patient flow constraints. It is not anticipated that a significant number of babies from the increased caesarean sections will need admission to the neonatal unit, however it is imperative not to lose sight of the potential impact on the neonatal services. Sustained levels of occupancy above recommended capacity increase operational risk, reduce flexibility to accommodate fluctuations in demand, and impact patient flow across the wider maternity and neonatal pathway.

For babies on the tertiary fetal medicine pathway, delay to a planned caesarean section will carry greater clinical and operational consequences because birth timing is often coordinated around a known fetal condition and the availability of specialist obstetric, fetal medicine, neonatal, anaesthetic and, where required, paediatric teams. Delay may prolong maternal and fetal monitoring, increase the risk of deterioration or unplanned emergency birth, disrupt agreed neonatal stabilisation and cot plans, and create additional distress and uncertainty for families. Where neonatal capacity is already constrained, clear multidisciplinary prioritisation, escalation

and contingency arrangements are therefore essential to ensure that time critical births proceed safely and that any delay is clinically reviewed and communicated.

A robust process is required to record, monitor and review caesarean sections delayed because of neonatal cot capacity. Maternity and neonatal services need to use a single, shared repository to provide consistent oversight of delays, clinical impact, escalation actions and emerging themes. At the current time there are some data quality issues that need further interrogation and therefore the number for cot delays attributable to caesarean sections are not included in this report.

The chart below shows overall activity delayed due to cot availability within the neonatal unit. The increased demand for neonatal cots and the higher acuity of infants significantly impacts the availability of capacity for fetal medicine referrals and women admitted to the antenatal ward with threatened preterm labour. In July, this resulted in an increase in in-utero transfers, with Leeds based women requiring transfer to other tertiary neonatal units across the Yorkshire and Humber region due to the anticipated gestation and care requirements of their babies. Such delays can have a considerable emotional and psychological impact on families, particularly where significant congenital abnormalities have been identified antenatally and families are awaiting induction and subsequent care planning for their baby.



Conclusion

The review confirms that elective caesarean demand has outgrown the current five list model, with 1,483 procedures undertaken in 2025/26 against planned annual capacity of approximately 1,250. Increasing case complexity, sustained high maternity acuity, rising occupancy and recurrent maternity and neonatal escalation further reduce system resilience and make continued reliance on ad hoc and non-elective theatre capacity neither appropriate nor sustainable. Permanent establishment of a sixth list at the earliest opportunity and a seventh from April 2027 is therefore required.

3. Financial Implications

The proposed expansion to seven elective caesarean section lists per week requires an additional 10.31 WTE across Women's CSU and Theatres and Anaesthetics, with workforce costs of £500,465 in 2026/27. A further £57,465 is required for consumables, giving a total financial requirement of £557,930. These recurrent costs are necessary to establish the additional lists safely and reduce reliance on ad hoc and non-elective theatre capacity; a business case has been submitted to the Trust Expenditure Review Group and an outcome is awaited.

4. Risk

The primary risk is that elective caesarean demand continues to exceed the capacity of the current five list model, resulting in delays or cancellations, continued use of non-elective theatre capacity and reduced resilience for emergency activity. This may adversely affect patient experience and increase clinical risk, particularly for women and babies on complex maternal, fetal medicine and neonatal pathways where birth timing and specialist team availability are critical.

Failure to secure the recurrent investment and expansion of the service may prolong reliance on unsustainable temporary arrangements. These risks will be mitigated through phased implementation, ongoing demand and capacity review, monitoring of acuity, occupancy, delays and cancellations, and escalation through the risk register and perinatal governance route as indicated.

5. Communication and Involvement

The demand and capacity review has been developed through multidisciplinary engagement across Women's CSU, obstetrics, midwifery, fetal medicine, neonatology, anaesthetics, theatres, recovery, postnatal services, operations, workforce and finance. Women and families will receive timely information about planned caesarean arrangements and any unavoidable delay or change, supported by clear clinical review and escalation processes. Ongoing involvement will include staff feedback and monitoring of activity, acuity, occupancy, delays, cancellations, patient experience and safety outcomes to inform implementation and further service development.

6. Impact on Equality & Health Inequalities

Increasing dedicated elective caesarean capacity has the potential to reduce health inequalities by improving timely and consistent access to planned birth, particularly for women and babies with complex maternal or fetal conditions. Delays, cancellations and short notice changes may disproportionately affect families with limited financial or social support. Implementation should therefore include monitoring of delays, cancellations, outcomes and patient experience by relevant demographic and deprivation measures to identify and address any unequal impact.

7. Publication Under Freedom of Information Act

This paper may be published under the Freedom of Information Act 2000.

8. Recommendation

The Trust Board is asked to note the sustained increase in elective caesarean section demand, the current capacity gap and the associated clinical, operational risks, support the permanent establishment of a sixth elective theatre list at the earliest opportunity and a seventh list from April 2027.

Supporting Information

None