University Hospitals Sussex
NHS Foundation Trust

Modernising Urgent and Emergency Care at RSCH

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Care
Everywhere

We are compassionate. We are inclusive. We are respectful.

Introduction

Nigel Kee

"The urgent and emergency care system is a complex web of services...

The term 'system' is used because these services are highly interdependent: a change in one will almost certainly affect others.

This complexity is compounded by the fact that the terminology used to describe these services has shifted over time

…and different terms are often used to describe the same thing."

The King's Fund *Urgent and Emergency Care: A guide to the system in England*, 2021

What is UEC or “urgent and emergency” care?

UEC is an umbrella term for services treating illness or injury requiring immediate attention.

- **Urgent Care:** For illnesses or injuries that are not life-threatening but still require swift attention such as sprains, minor burns, or infections. These are managed by Urgent Treatment Centres (UTCs).
- **Emergency Care:** For life-threatening or critical conditions, such as chest pain, loss of consciousness, or severe trauma. This is the primary role of the Emergency Department (ED).

The **Acute Floor at RSCH** is where these two services meet, alongside diagnostic services and rapid assessment units, to ensure patients are "streamed" to the right specialist swiftly.

Our **Acute Floor Reconfiguration programme** (AFR) includes what most people refer to as A&E - which is what we call ED - as well as a variety of other UEC services.

Modernising UEC care in Brighton

1970 - the current A&E opened on the ground floor of the newly built Thomas Kemp Tower – purpose-designed for a *new era of medicine* and to replace "Casualty" services at the front of the old Barry Building.

20,000 patients - the new A&E was intended to manage around 20,000 patients per year – but it now sees more than 100,000 patients per year.

Acute Floor Reconfiguration - in 2014, the CQC rated the service inadequate, and said the 1970s footprint was *no longer fit for purpose*. But options to change were limited as it was too late to change the 3Ts redevelopment plans that did *not* include UEC services.

Casualty at the front of the Barry Building

Thomas Kemp Tower being built in 1968

Key moments

2009	**3Ts redevelopment mooted**	Former CEO Duncan Selbie announces the "Trauma, Teaching, and Tertiary" care redevelopment and emergency helipad.
2012	**Major Trauma Centre status**	RSCH becomes regional lead for life-threatening injuries across Sussex and plans for the new helideck take off.
2014	**3Ts stages 1-3 approved**	HM Treasury gives "green light" for major transformation.
2017	**New leadership team begins**	Various plans to improve UEC by expanding current area or adding to Stage 2 of 3Ts rejected by HM Treasury.
2022	**Urgent Treatment Centre opens**	A new "front door" for walk-in patients with non-life-threatening issues.
2023	**Louisa Martindale Building opens**	Services move into LMB, freeing up space around A&E for the first time to support expansion.
2023	**Acute Floor Reconfiguration**	NHS Sussex commissioners provide £48m for a multi-year modernisation programme of UEC services at RSCH.
2024	**Surgical Assessment Unit opens**	SAU opens on Level 6 of Millennium Wing to complete Phase 1a of Acute Floor Reconfiguration programme.
2025	**Acute Medical Unit opens**	AAU and EACU move into new home on Level 5 of Millenium Wing and become AMU and Medical SDEC.

Acute Floor Reconfiguration programme

Craig Marsh

Nikki Mead

Current challenges

RSCH operates under sustained pressure - patient flow is often challenged because our "back door" is “blocked” by patients unable to leave

- Their medical care has finished - but what they need next isn’t ready for them
- Often vulnerable and elderly patients - they have "no criteria to reside" (NCTR)
- When NCTR patients cannot leave, unwell patients in ED cannot be admitted
- This leads to “exit block” and “corridor care” in ED
- Poor flow compromises patient safety and dignity, and distresses staff

Discharge delays are mainly driven by complex challenges affecting our partners in mental health, community care, social care and the private sector

- 100 -140 beds every day at are occupied by NCTR patients
- UEC services never close - so bottlenecks lead to corridor care
- At peak times, 80% of RSCH medical beds are occupied by NCTR patients

A picture sent to The Argus by a concerned family in 2024

Two main challenges require dual solutions

1. Demand has massively outstripped the size of our constrained 1970s A&E footprint

2. Patient flow is fundamentally challenged due to system issues and challenges our partners face

So, we need a dual approach to solving our challenges.

Bricks and mortar alone cannot address patient flow.

We need to modernise UEC facilities and work in new ways with partners to improve flow and discharges.

Today we are focusing on improving our UEC facilities at RSCH.

AFR is a multi-million-pound modernisation programme

Our vision is clear…

Our UEC services at RSCH will provide excellent care for our patients in modern, safe and dignified environments - *whether they walk in for urgent treatment, arrive by ambulance for expert assessment, or land in a helicopter for major trauma care.*

…but so are the challenges we face

- Facilities no longer meet national standards
- Configuration doesn't optimise patient flow
- Our environment is not fit for purpose
- Funding is limited and works expensive
- The Emergency Department can never close

Complex and complicated multi-year programme

Our Acute Floor Reconfiguration programme is a complete modernisation of our UEC services (2023-30)

"It's like performing open-heart surgery on the hospital while we continue to provide life-saving urgent and emergency care, 24 hours a day, seven days a week, for 100,000 patients a year."

Dr Andy Heeps, Chief Executive

Significant constraints:

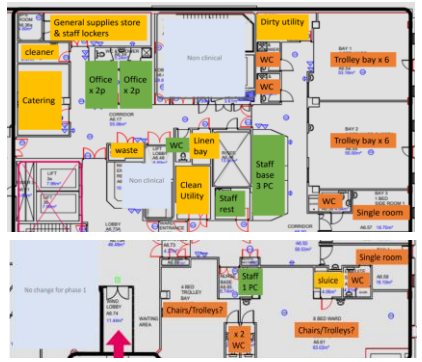
- Continuous service delivery: The Emergency Department must remain 100% operational throughout the construction period.
- Shared environment: Building works are happening directly next to critical clinical areas that care for hundreds of patients a day.
- Adapt and overcome: The programme has faced various design and budget challenges as clinical guidelines, standards and costs have changed.

Phase 1 completed in December 2025

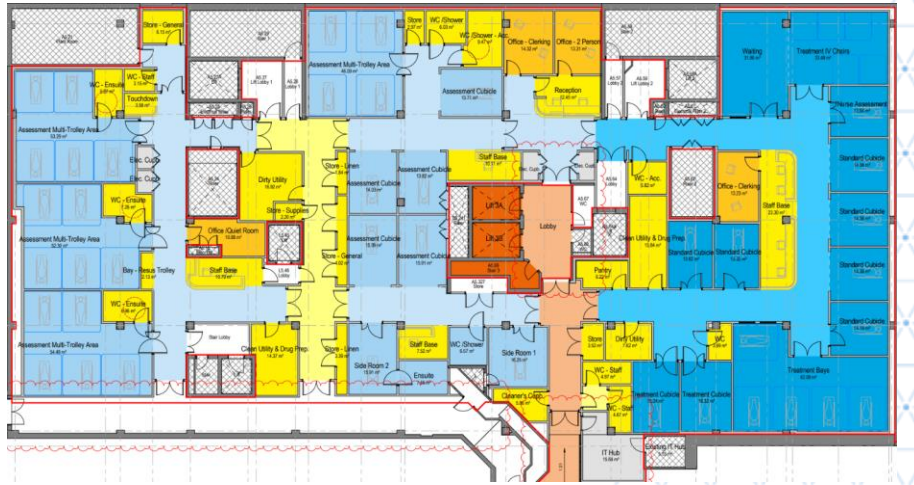
In Phase 1 we delivered two Acute Floor assessment units to stream patients to the right specialist swiftly.

- **Surgical Assessment Unit (SAU):** A dedicated space for rapid surgical review, reducing the time patients spend in the main ED. Located on Level 6 above AMU.
- **Acute Medical Unit (AMU):** A high-turnover assessment unit which aims to treat, discharge or transfer patients to a specialist within 12 hours. AMU also contains a new Medical Same Day Emergency Care unit (MSDEC), which is now available for patients *24 hours a day*.

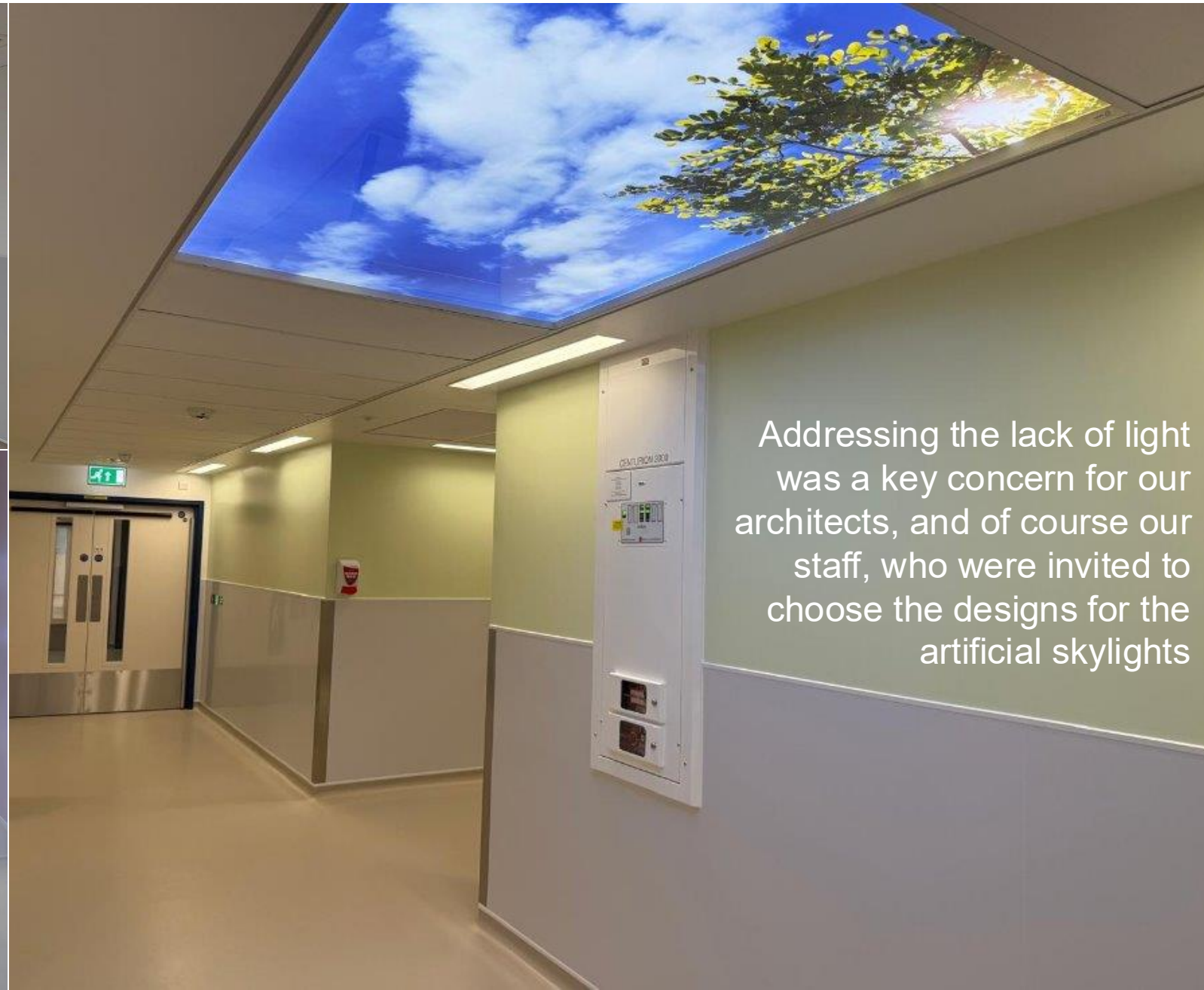
These units ensure patients are seen sooner and they act as relief valves for ED in the modern Acute Floor model.



Colleagues from AMU above, and floorplans for SAU L6 and AMU L5 left and below



AMU – a modern, spacious and bright clinical environment - despite being located underground



Addressing the lack of light was a key concern for our architects, and of course our staff, who were invited to choose the designs for the artificial skylights

Looking ahead – the future of the Acute Floor

Phases 2 and 3 will double the footprint dedicated to our most critically unwell patients and expand the Urgent Treatment Centre

ADP designed Guy's & St Thomas' new Emergency Department, pictured below

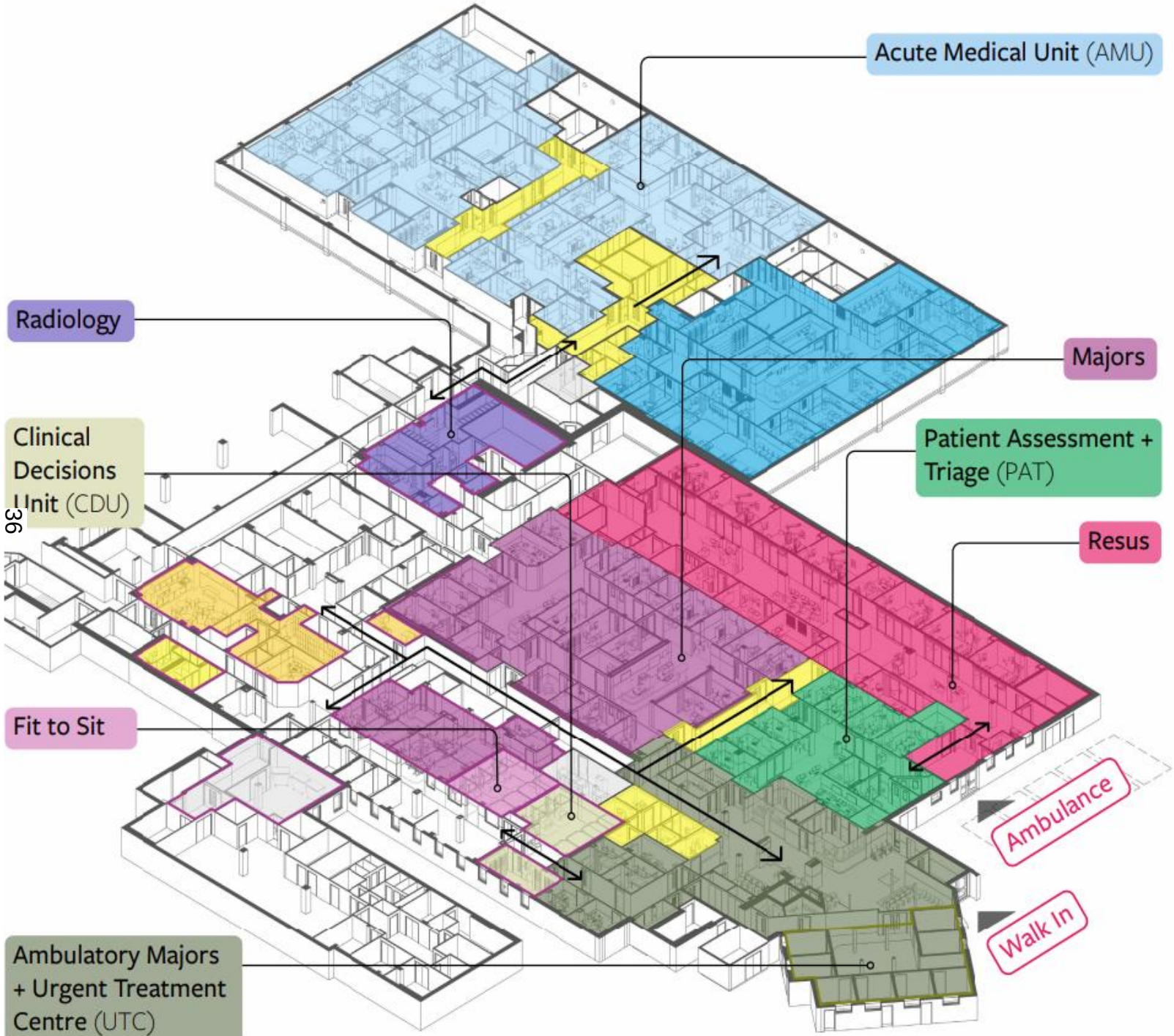
Phase 2: Majors & Resus (target completion: December 2028)

- Upgraded "Resuscitation" area - fit for Major Trauma Centre standard with addition of two more treatment cubicles.
- Modern "Majors" area – with improved clinical cubicles and purpose-designed mental health assessment facilities.

Phase 3: PAT and UTC (target completion: Mid-2030)

- "Patient Assessment and Triage" - larger with new isolation suite and point of care testing lab.
- "Urgent Treatment Centre" - larger with improved waiting area and four additional consultation rooms to reduce waiting times.

Our partners ADP also designed the Breast Care Centre and Emergency Floor at Worthing Hospital



Acute Floor Redevelopment

Royal Sussex County Hospital, Brighton

Proposed Final Design

Increased Capacity:

- Majors: **13** patient spaces
- Ambulatory Majors + UTC: **35** patient spaces

TROUP BYWATERS + ANDERS

P&M

acp

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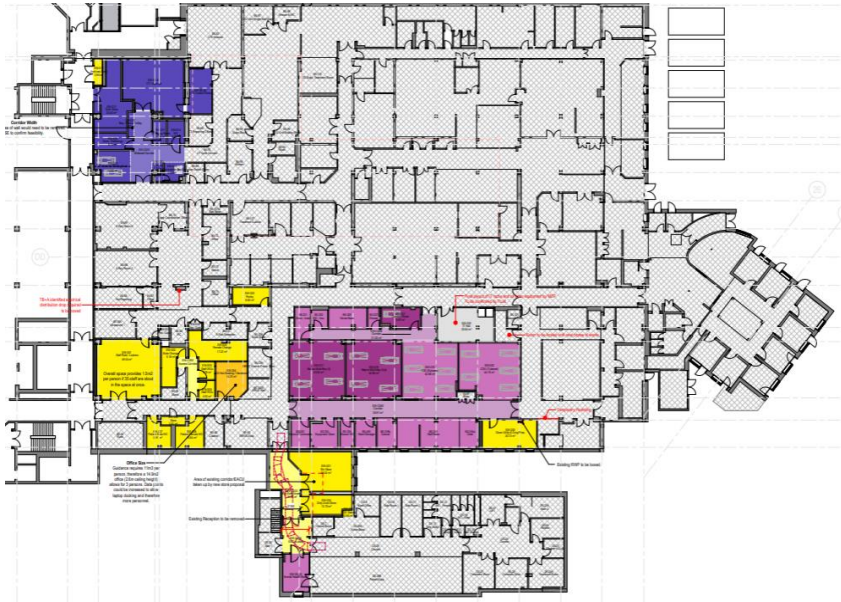
Challenging ED modernisation programme ahead

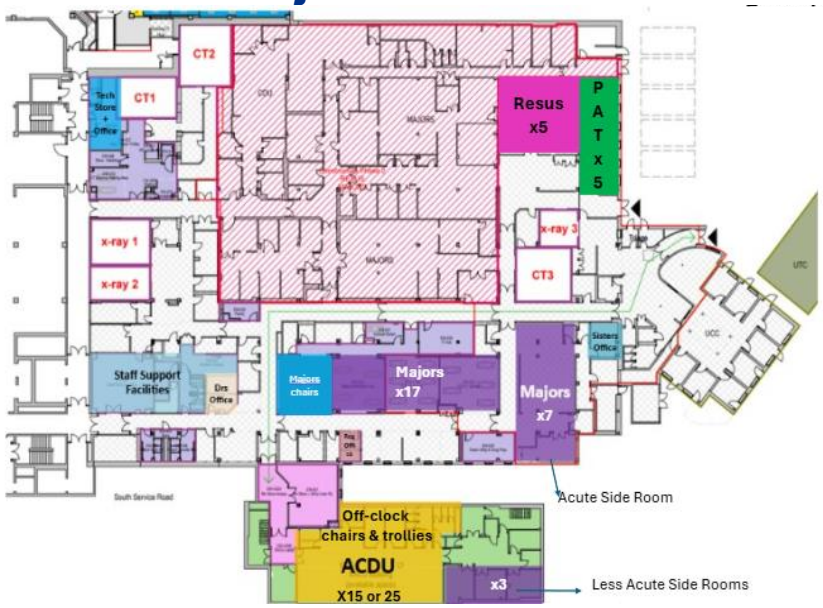
The next phases of the Acute Floor Reconfiguration programme are the most challenging.

- We will be moving high-acuity team such as “Resus” and “Majors” into new temporary areas.
- First, enabling works must ensure these new areas meet rigorous clinical standards
- Temporary areas must accommodate thousands of patients, 24 hours a day, for up to three years.
- During this period, different teams will work from different temporary homes while their permanent facilities are rebuilt. The works are due to complete by 2030.

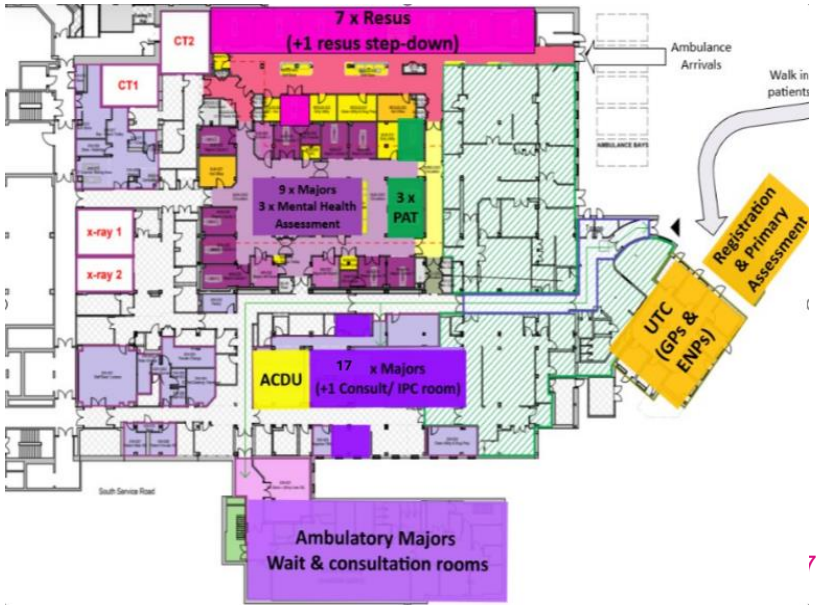
Enabling works



Phase 2 – Majors & Resus



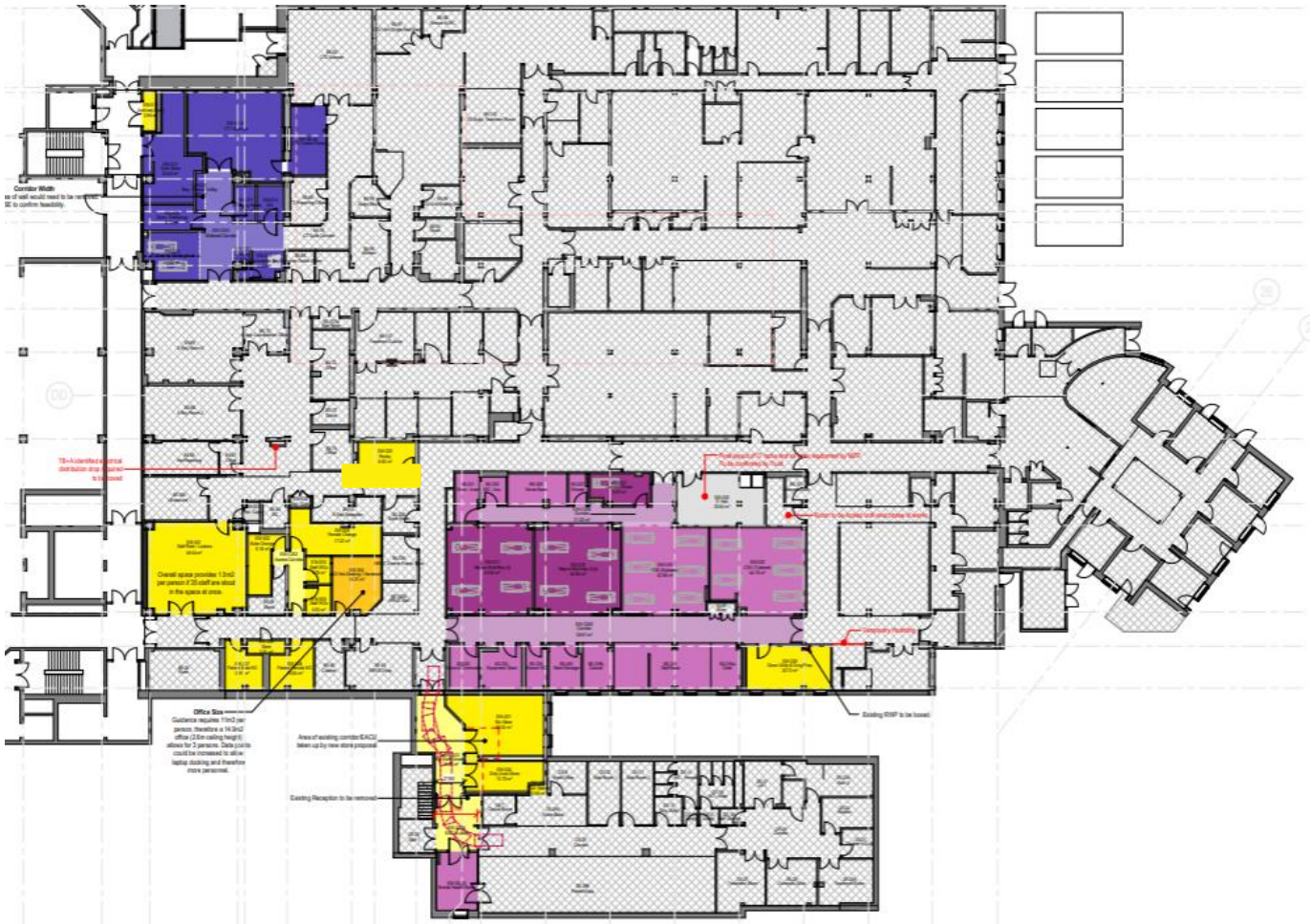
Phase 3 – PAT & UTC



Enabling Works Overview

Start: Oct 26 | **End: Apr 27**

Key
Coloured areas: Enabling Works areas



What we're delivering

- Critical infrastructure: IT hub, waste store, catering space and Air Handling Units
- Refurbishment of future Majors South clinical area
- Improved staff support hub (staff rest, change and WCs)

How we'll deliver it

- No change to the front door for either walk in or ambulance arrivals or current clinical areas
- Impact to public areas will be co-ordinated between the contractor, the Hospital Director and affected clinical teams

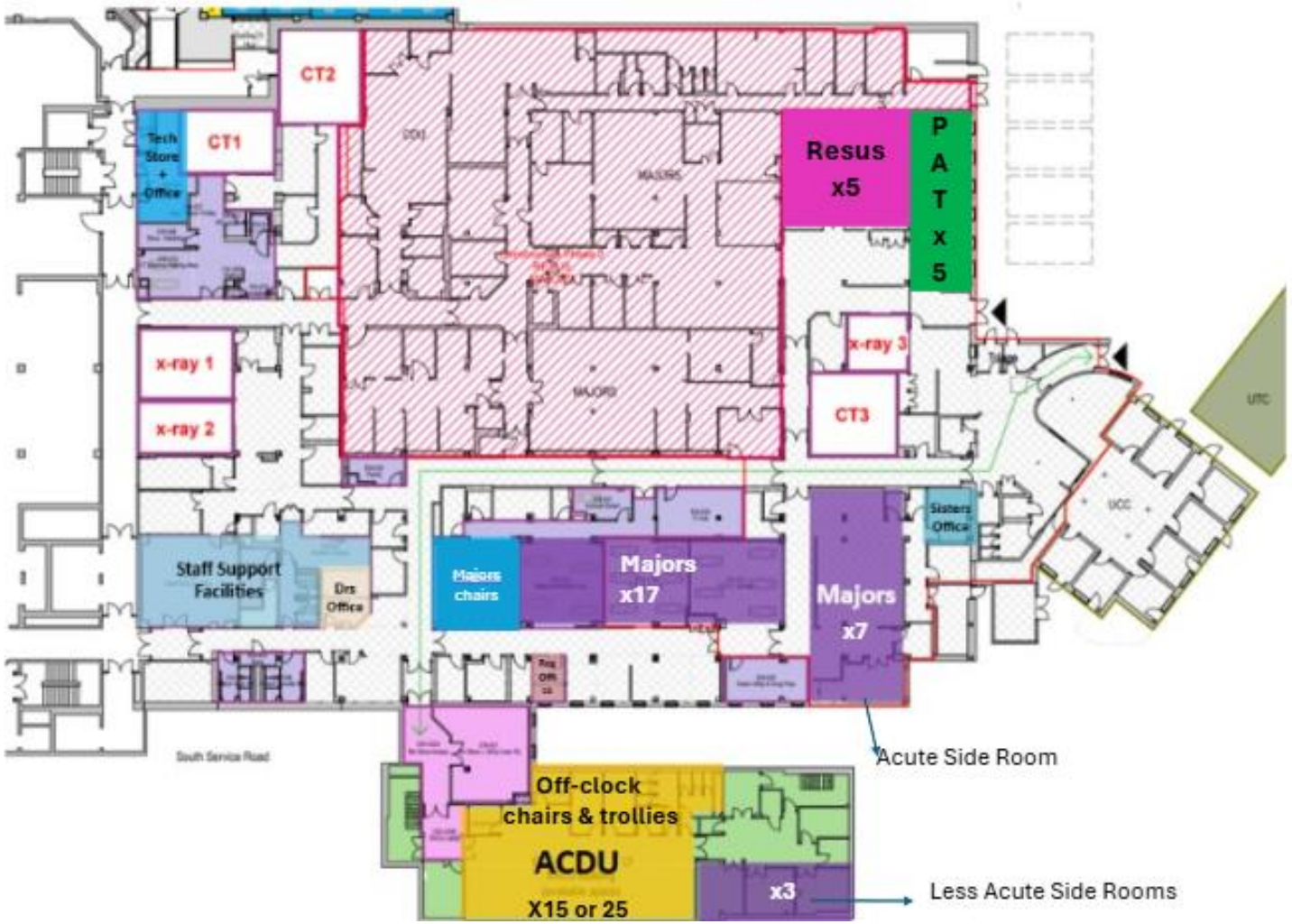
Enabling Works Risks

	Key Risks	Mitigations
1.	**Logistics -** Maintaining safe separation of construction activities from public and clinical areas	- Joint detailed planning and risk assessment between UHSx teams and contractors to identify and mitigate risks

Phase 2 Overview

Start: May 27 | **End: Dec 28**

Key
Red hatch: Construction zone



What we're delivering

- Resus department (90% in this phase), compliant with modern standards for a Major Trauma Centre
- Majors North, with 100% individual cubicles, improving patient privacy and dignity as well as infection prevention

How we'll deliver it

- No change to the front door for either walk in or ambulance arrivals
- No change to resus
- Majors will decant to Majors South and the decant space; +2 majors cubicle spaces
- Introduction of dedicated bay for Majors Chairs
- Opportunity to improve non-admitted flow through increased Ambulatory Clinical Decision Unit (ACDU) capacity

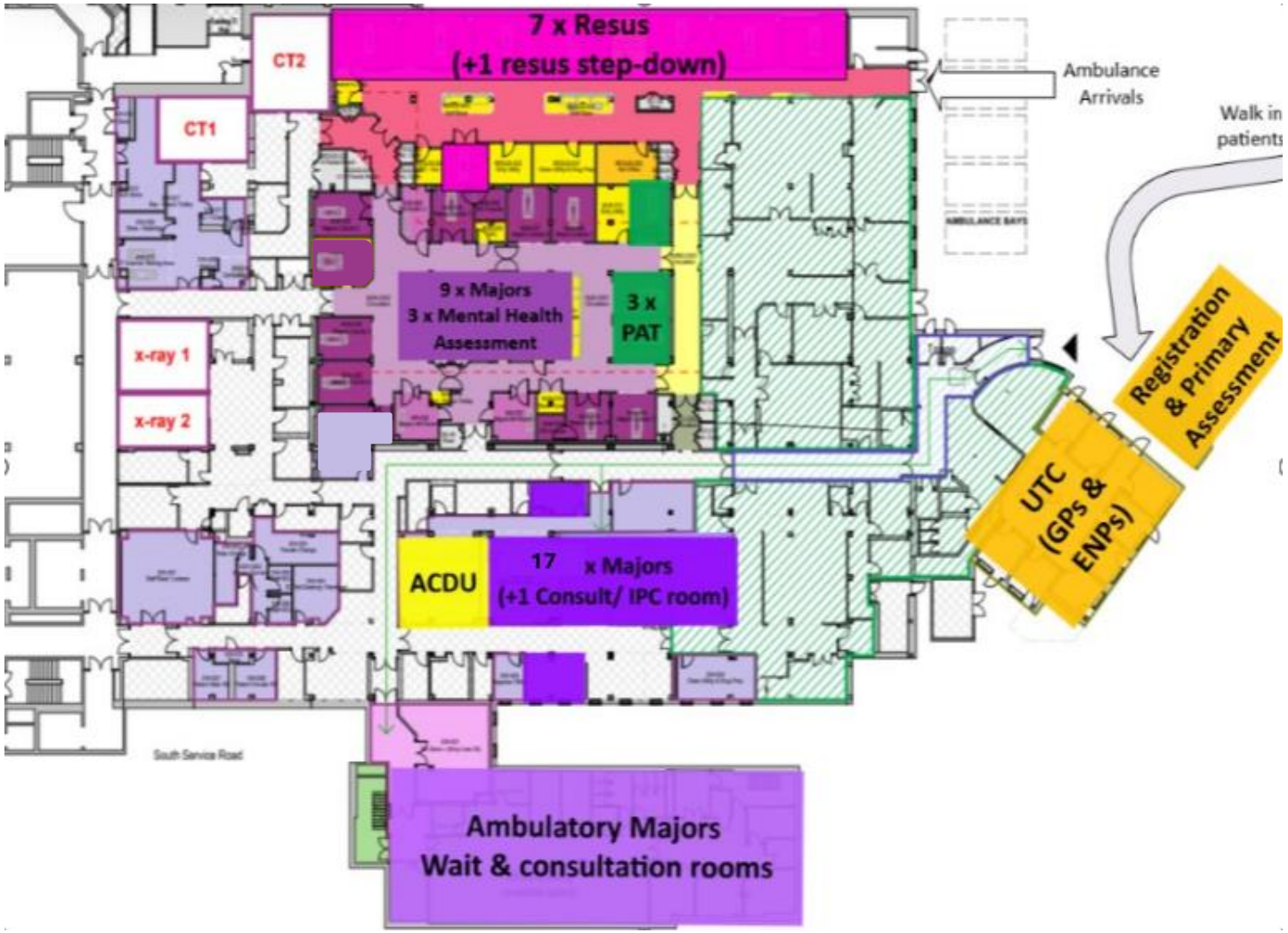
Phase 2 Risks

	Key Risks	Mitigations
1.	**Mental Health (MH) patients** – current cohorting area for medically ready patients waiting MH inpatient beds closes at the start of Phase 2 with no re-provision	- Collaborative UHSx and SPFT Task & Finish Group has improved joint working, developed common understanding and objectives - This risk cannot be resolved through operational actions alone. It requires system-level working
2.	**Patient flow challenges** – current delays to patients awaiting an acute inpatient bed creates overcrowding in the emergency department. There will be an overall reduction space in Phase 2	- Divisional Hospital Alternative Liaison Programme (HALO) focusing on attendance and admission avoidance - Trust-wide flow improvement programme - Wider system working e.g. Neighbourhood Alliance development
3.	**Larger footprint and distances between clinical areas** - impact on clinical coverage e.g. ability to observe patients and increased travel time between clinical areas	- Detailed planning with Acute Floor team and key stakeholders to understand impact on patient journeys and staff - Planning of staff deployment across the department in this phase to understand workforce impact
4.	**Logistics** - Maintaining safe separation of construction activities from public and clinical areas	- Close collaboration between the Trust and contractors to identify and mitigate risks ahead of time - Involvement of key stakeholders
5.	**Wayfinding** – risk of confusion for patients and staff	- Targeted communications before during and after each phase - Wayfinding signage to be update as service moves happen - Increased volunteer presence in the Emergency Department to support patients

Phase 3 Overview

Start: Jan 29	End: May 30

Key
Red hatch: Construction zone



What we're delivering

- New front door for both walk-in patients and ambulance arrivals
- Increased Ambulatory ED waiting room and consultation room capacity
- Improved waiting area facilities (vending, public toilets)

How we'll deliver it

- All walk-in patients will arrive to the modular building before steaming to the most appropriate clinical area
- New resus and majors north areas open
- Ambulatory ED, incl. majors chairs, to move to the decant space
- Opportunity to increase Ambulatory Clinical Decision Unit (ACDU) capacity to improve non-admitted flow

Phase 3 Risks

	Key Risks	Mitigations
1.	**Walk-in patients** – Walk in entrance will be in the physically separate from main Ambulatory ED. Need to maintain throughput of patient registration and primary assessment to avoid patient queuing and overcrowding	- Split of primary and secondary assessment functions, in line with national best practice - Review of staffing deployment at this phase to ensure timely assessment and streaming at the front door
2.	**Reduction of dedicated Patient Assessment & Triage (PAT) cubicles** – risk of delay to ambulance handover	- Increase in resus capacity will release PAT cubicle capacity - Clinical team agreement to implement mobile PAT model meaning that patients could be placed in any cubicle and triage team come to them
3.	**Ambulance entrance goes through resus –** risk to privacy and dignity of resus patients and impact on patient experience for other patients	- New resus cubicles are walled with doors, providing improved separation from circulation areas - Joint work with SECAMb to plan ambulance route
4.	**Logistics -** Maintaining safe separation of construction activities from public and clinical areas	- Joint detailed planning and risk assessment between UHSx teams and contractors to identify and mitigate risks
5.	**Wayfinding** for patients and staff	- Targeted communications before during and after each phase - Wayfinding signage to be update as service moves happen - Increased volunteer presence in the Emergency Department to support patients

Benefits for patients

Our aim is for all patients to receive excellent care from the right specialist in a modern environment that respects their privacy and safety.

- Faster clinical decisions: Dedicated SAU and AMU assessment areas provide rapid specialist review, reducing time spent in ED.
- Enhanced privacy and dignity: Modern, private cubicles and zoned waiting areas replace the current "cramped“ 1970s infrastructure.
- Specialised mental health support: Three purpose-designed cubicles in “Majors” to provide a safe environment for assessing patients in crisis.
- Improved infection control: New isolation cubicle in PAT and increased individual cubicles and new ventilation will improve infection control.
- Better trauma care: Locating “Resus”, ambulance bays, and CT scanners near each other saves life-critical seconds for major trauma.

Benefits for staff

Modernising our Acute Floor gives staff the tools and workspace they need to provide high-quality emergency care to the people we serve.

- Integrated clinical model: Bringing the ED, SAU, and AMU into an Acute Floor model enables better teamwork and resilience for UEC services.
- Essential support facilities: Staff rest areas, changing rooms, and toilets that were potentially jeopardised by previous design challenges.
- Dedicated workspace: Additional desk positions and new "hot offices" within clinical zones help to keep clinicians closer to their patients.
- Modernised tools and workflow: A total IT infrastructure overhaul ensures reliable digital services, and new drug prep and storage improve safety.
- Sustainable environment: New layouts and ventilation built to national standards provide a professional workplace "conducive to safe care“.

Summary and questions

Nigel Kee

Excellent
Care
Everywhere

We are compassionate. We are inclusive. We are respectful.

The future is bright, but requires patience and understanding

Conducting "open heart surgery" on the hospital to deliver a total overhaul of our UEC services while keeping our front door open 24 hours a day will prove challenging.

- Despite the urgency of our challenges, the constraints and complexity of the AFR programme mean *it will take time to complete* and disruption is sadly unavoidable.
- We look for your understanding and support as we deliver a long-term solution to address these long-entrenched issues that we know affect care and experience for our patients.
- AFR will deliver a new, modern ED fit for the 21st Century, but it is equally important people understand that *quicker wins and bigger improvements will be delivered in other ways...*

...as the NHS 10 Year Plan says:

“To fix the front door of the NHS, we must first fix the back door. We cannot improve emergency care in isolation; it requires a fundamental shift of care from hospital to community, and a partnership between health and social care that is seamless for the patient.”

Fit for the Future: 10-Year Health Plan - Policy Framework and Consultation.

Making the shift from hospital care to the community

The Neighbourhood Alliance: Integrated Community Teams programme

- **Reducing admissions:** The primary goal for 2026/27 is a 10% reduction in avoidable emergency admissions. This targets over-65s, care home residents, and patients at risk of falls, flu, pneumonia, or heart failure.
- **Tackling inequalities:** Alongside the core offer, teams will use local data to target other high-risk groups, such as those with mental health needs or specific long-term conditions.
- **Vaccinations and screening:** There is a phased plan to increase uptake in deprived communities by 15%. Plans on cardiovascular disease (CVD) prevention are also being developed.

Reminder: Acute Floor Reconfiguration key dates