Our AMU receives 66% of its referrals directly from the community, bypassing the Emergency Department (ED) allowing initial secondary care assessment by physicians trained/training in Acute Medicine. Local capacity was exhausted daily by the increasing referrals & the unpredictable arrival times and we struggled to recognise patients suitable for management out with the AMU in sufficient time to make good use of facilities within the hospital. A change in our practise was needed to improve our local efficiency, capacity & patient experience.

In 2009 we started a step-wise evolution of our local model of acute care with early senior decision making then increasing overall capacity & finally diversity of the assessment areas. This had the effect of increasing direct AMU discharges and reducing the numbers awaiting a bed on arrival to zero in a comparative time period without effect on our readmission rate.

Our pathway gets care right for the patient first time and makes the most efficient and effective use of the secondary care facilities as well as our own local capacity.

Phase 1 Early Senior Decision Making: creating the right medical model

After identifying significant barriers to providing this early input we made the following changes to practise:

**Step 1:** Employed a consultant team to provide ongoing senior review during the working day. Initially a midday round, then real-time assessment of new patients at key points of the presentation providing senior input and decision-making earlier in the day & assisting flow through the system; enhanced further with the appointment of dedicated Acute Physicians.

**Step 2:** Re-assignment of middle grade medical staff to the role of first assessor for all patients where possible not just the sickest. More consultants meant middle grades were able to rapidly enhance their skills to recognise and manage patients at both extremes of health allowing rapid care and identification of the most unstable and quick recognition of those appropriate for ambulatory care or discharge.

Phase 2 Streamlining Patients to Pathways of Care: creating the right environment to support our model

**Step 1:** Creation of an ambulatory area embedded within the AMU Data collected on referrals & discharges identified our current & potential scope for this. We changed our ethos to “Assess to admit—not admit to assess”

**Step 2:** Increased overall AMU capacity to reflect our daily average referrals.

Categorisation of patient care into 3 distinct groups to target assessment:

Group 1: stable & safe to be managed in the ambulatory area
Group 2: requiring rapid initial assessment of stability & presenting complaint to determine if suitable for ambulatory area
Group 3: unstable or frailty requiring immediate access to a level 0 or above bed

**Step 3:** Increased capacity & diversity of ambulatory assessment space to reflect these groups

Physical adaption of the AMU area designed & led by the Acute Physicians: an assessment bay of 6 beds, 4 monitored reclining chairs, 4 clinic rooms all separated to reduce noise & activity.

Despite a significant increase in volume of referrals since 2011 & loss of seasonal variation 2012 we were able to demonstrate effective increase in direct discharges & reduction in patients waiting for an assessment space or bed on arrival to the unit.