Royal College of Physicians

How to plan new hospitals to improve patient pathways and staff wellbeing

Executive summary

Hospitals are far more than just a building. As the Health Foundation has outlined, as a central part of the NHS they are powerful 'anchor institutions' in their community 'that can positively influence the social, economic and environmental factors that help create good health in the first place'. They do not exist in isolation from either the communities they are based in or the wider health and social care system they are part of. The Royal College of Physicians (RCP) believes that the most important consideration when designing and planning new hospitals is how can we improve the experience and outcomes for patients.

This report is structured around the following three themes:

1. How to design hospital services around the needs of patients rather than the 'system'
2. How to ensure that patients receive better, quicker services from hospitals
3. How to improve staff wellbeing in hospitals to enable better workforce retention and delivery of services

It focuses primarily on how better patient pathways should be built into the functioning of new hospitals, signposting many examples of good practice. Part of this aim is dependent on a shift in mindset to design services around the needs of patients rather than the 'system'. The pandemic has provided lessons here. For example, the use of remote outpatient appointments was rare before March 2019, despite widespread patient dissatisfaction with the traditional model of outpatients.[1]

The significant shift to remote appointments, although not without challenges, has undoubtedly made accessing healthcare simpler for most patients and shows the way forward.

Improving patient pathways also means learning the lessons from the quality improvement work that takes place in hospitals, in order to implement very practical changes that we know lead to better patient care. There are many improvements that can be built into the functioning of new hospitals, such as co-locating acute admission units and delivering more effective ward rounds.

The third aspect of ensuring that new hospitals function effectively is improving staff wellbeing to enable better workforce retention and delivery of services. We need to think here about both the macro and micro levels – from tackling workforce shortages so that staff feel less stressed, to ensuring there is somewhere for them to hang their coat up.

Methodology

This publication draws on a number of resources that have been produced by the RCP and the wider health and care sector, as well as reflecting the findings of and conversations with our physician members – the vast majority of whom work in hospitals. We point to many examples of good practice, and encourage people to follow the references to understand the full detail.

One important resource we have referenced is our 2017 report *Delivering the future hospital*.[2] This contains an overview of the improvement journeys, outcomes and learning from eight development sites. We also cite a number of important findings from the clinically led NHS England Getting It Right In Emergency Care initiative, which is part of the wider Getting It Right First Time (GIRFT) programme to reduce unwarranted variations in care.[3] Those designing hospitals should pay close attention to the specialty reports produced as part of the GIRFT programme, as these provide important lessons on how to incorporate improved pathways into new hospital design.[4]

1 How to design hospital services around the needs of patients rather than the system

Co-design services with patients

Person-centred care is the holy grail of healthcare delivery. Ensuring that patients and carers are at the centre of healthcare design and delivery is something we all want, but the challenge has always been how to do this in a practical and meaningful way. The RCP's Future Hospital Programme worked intensively with eight development sites to develop and deliver models of person-centred care.[5]

The key lessons learnt were:

- **The need for patients to have an active and valued voice in decision making**
  At the north-west Surrey site, patients played an important role in the implementation and management of the newly formed Patient Advisory Group.[6] This group contributed to the development of the Bedser Hub; a bespoke, single-site healthcare facility.

- **Patients can directly coordinate change**
  Patients and carers are aware, first hand, of the changes needed to improve patient care and are often well placed to coordinate change. In the North West Paediatric Allergy Network team, the local patient representative led the development of the new patient zone of the network's website.[7] Similarly, the patient representative and linked RCP Patient and Carer Network member at Mid Yorkshire Hospitals were central to the production of a new patient information leaflet after identifying, from patient experience interviews, a lack of understanding by patients of who was responsible for their care.[8]

- **The need to create the mechanisms for patient/clinical dialogue**
  Effective patient and carer involvement in co-designing services will not happen without proper structures in place. When designing services, hospitals should identify a member of the clinical team to act as a main point of contact for patient representatives; ideally, this should be the project lead. Hospitals should also appoint at least two patient representatives to each clinical team and foster mutual support and cross-cover.

Support digitally enabled change and communication

Continue to reform outpatients

Achieving significant change that helps patients can often be slow due to little more than inertia. The sluggish progress (until the pandemic) to reform outpatients is a prime example. In the RCP's 2018 report *Outpatients: the future*,[1] we highlighted how the system did not work well for patients, with one in five appointments in England, and one in four in Wales, cancelled or reported as DNA (did not attend) – the majority of cancellations by hospitals.

Members of the RCP's Patient and Carer Network had expressed frustration with 'the heavy reliance on traditional face-to-face consultations, which are often rushed with little opportunity for questions or discussion', and the fact that reaching a diagnosis and treatment plan required 'several hospital visits, over several weeks … prolonging uncertainty and wasting time'.[1]

This changed almost overnight when the UK faced COVID-19, with outpatient appointments replaced by remote appointments – most by telephone and some by video. And although this has presented access problems for some patients, and some appointments will always need to be done face to face, the shift was overall a positive one for patients. A report by National Voices found that 'for many people, remote consultations can offer a convenient option for speaking to their healthcare professional. They appreciate quicker and more efficient access, not having to travel, less time taken out of their day and an ability to fit the appointment in around their lives. Most people felt they received adequate care and more people than not said they would be happy with consultations being held remotely in future'.[9]

Clinicians have also generally welcomed the change. Our member survey in April 2021 found that physicians want to continue delivering a much greater proportion of their appointments remotely in future.[10] A majority (55%) say that at least a quarter of their outpatient appointments should be virtual, and more than a third (35%) think that at least 35% of their outpatient appointments should be virtual. Making sure staff have the right equipment and guidance is still a challenge that needs to be addressed though by hospitals – 41% say they do not have everything they need to deliver good remote care.

Patient-initiated follow-up

Another development is patient-initiated follow-up (PIFU), which is relevant to several of the recommendations from our outpatients report.[1] Patients should be involved in selecting appointment times, outpatient appointments should be flexible and minimise disruption to patients' lives, and individuals should be supported to be co-owners of their health.

PIFU is part of the NHS outpatients transformation requirements. It should, where possible, replace routine appointments, with benefits to both patients and clinicians.

Remote monitoring

Benefits for patients can also be realised through greater use of remote monitoring, where technology is used to allow patients to submit personalised data. These data can be used to reassure and support patients to achieve health goals through self-management (eg step counters for cardiac rehabilitation) and allow data transfer back to clinical teams for interpretation and 'clinical monitoring from a distance' (eg implantable cardiac devices can collect and transmit cardiac data through a compatible network accessible by clinicians).

Portals used for data sharing can alert clinical teams to potential clinical problems, triggering more formal review, and patients can submit queries electronically via the portal. They have also been shown to reduce healthcare use – for example emergency attendances – compared with standard face-to-face follow-up. Care delivered in this manner can replace routine face-to-face follow-up appointments with ones triggered by patient need.

Shared electronic patient records

To create a more seamless experience for patients across the health and care system, we need to design systems where clinicians can access patient information more easily. This will help to avoid patients having to explain the same information to staff in different parts of the system, and clinicians will more easily be able to diagnose conditions and care for patients.

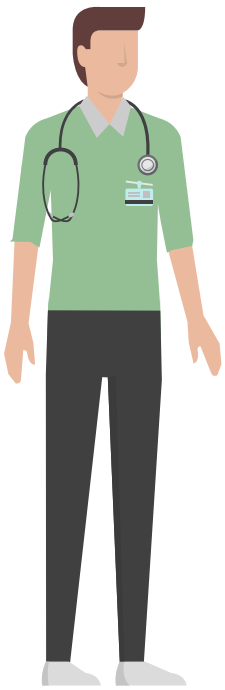
Greater Manchester provides a good example of what can be achieved, having accelerated the development of its single care record system for almost 3 million people in the region.[11] Up until March 2020, each of the 10 localities in Greater Manchester could only access patient records from their own area. The Greater Manchester (GM) Care Record joins up health and care data from across Greater Manchester.

The project was already planned before the pandemic, but when the control of patient information (COPI) notice[12] was introduced in response to COVID-19, it mandated that NHS organisations shared data as part of the COVID-19 response. This helped to unlock some of the information governance barriers, although the clinicians involved reported that they still had to negotiate with over 500 data controllers.

Now 99% of patients in Greater Manchester are covered by the GM Care Record, and the usage statistics are very high.

'The Greater Manchester Care Record has had a huge impact. For example, now I can see the GP records for a patient who lives in Wigan, which was impossible before. As a consultant in a big tertiary centre it makes a huge difference. Most patients wouldn't think that would be such a transformative thing, but it is. Clinical decision making is simpler as we now have up-to-date information on test results, care plans, medications and social care support.'

Binita Kane, consultant respiratory physician, Manchester University Foundation Trust



Break down the divisions in care delivery

The way that healthcare services are delivered can often reflect the organisational structures within the healthcare system, rather than patient need – especially the barriers between primary, secondary and social care and between specialties in hospitals.

Integrated health and social care teams and virtual integrated clinics

Making greater use of integrated health and social care teams is one answer. For example, in South Devon and Torbay, care for frail older people was improved through an integrated care pathway that included mental health and GP services. Having integrated health and social care teams meant that patients had faster access to services.[13] Previously, getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but all of these services could be accessed through a single call.

Virtual integrated clinics can also help to break down the divisions in care delivery.[3] They allow results and reports to be sent to GPs quickly, reducing length of stay. Patients often need a quick specialty opinion rather than being seen in clinic. The use of a baton phone when covering emergency admissions can facilitate a quick clinic response and expedite discharge.

Designing in 'one-stop visits' to the functioning of new hospitals will also help to improve the patient experience, where multiple tests and scans are done on the same day to reduce the number of hospital visits needed.

The role of integrated care systems (ICSs)

As England moves towards having statutory ICSs responsible for designing and delivering many services in their region, this presents a fantastic opportunity to ensure that services are better designed around the needs of patients.

It is vital that ICSs learn the lessons from good practice in other areas and are able to share information easily. An example of integration done well at a local level comes from Cardiff and Vale's Frequent Emergency Attender Service.[14]

A multidisciplinary panel of 28 organisations (including housing, police, social services and older people's charities, among others) meets monthly to discuss patients attending A&E more than four times a month. Information sharing is often the key. All participants stay for the whole session, and the wide range of perspectives generates unexpected insights.

The original fear was that the organisations were already overworked and the service would create extra pressures, but it became clear that those attending usually already knew the patients involved and so the service simply joined up their responses. Since the beginning of the project, 160 patient plans have been drawn up, and this has led to 84% of these patients no longer attending A&E frequently. The project has resulted in reduced cost, reduced length of stay and fewer attendances – and patients say that they feel empowered in a way they haven't in the past.

‘Engineering’ better service design

This section sets out what more person-centred hospital services should look like, but the question of how to get there is crucial. The report *Engineering better care* by the Royal Academy of Engineering, the RCP and the Academy of Medical Sciences is instructive in outlining what a systems approach to designing services and continuous improvement should entail.[15] The application of this systems approach will enable services to be better designed around the needs of patients, staff and communities.

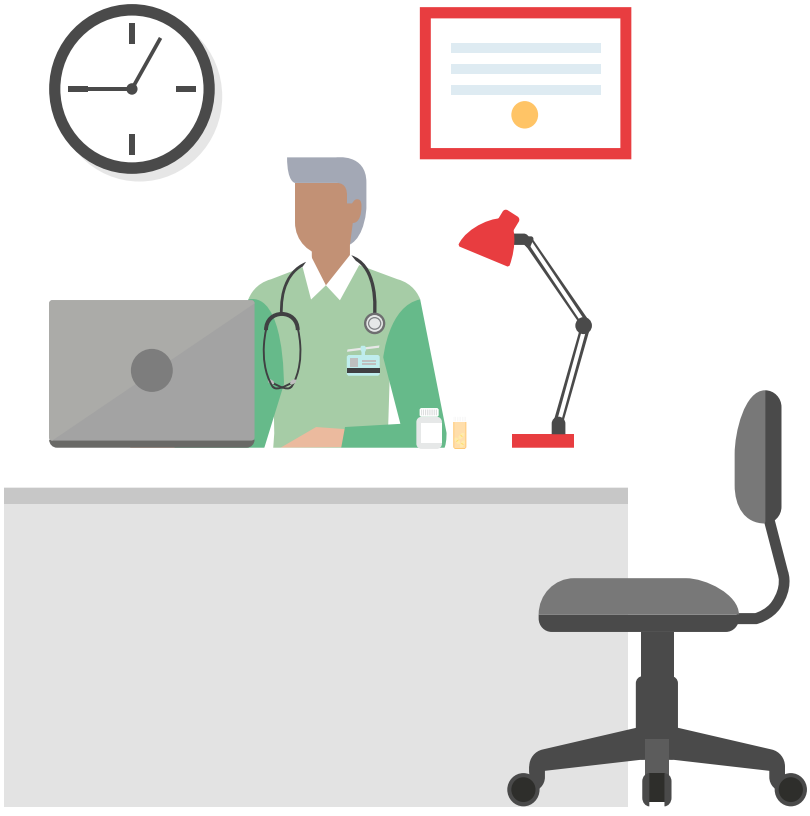
The report explains that the design of healthcare services can benefit from the rigour of the engineering approach to systems.[15] Its four key findings in relation to how to implement a systems approach to healthcare design and improvement are:

1 **Systems being centred on people** – an effective systems approach is centred on people, their needs, their capabilities and ultimately their role in understanding, designing, delivering and maintaining success

2 **Iteration before implementation** – the behaviour of complex systems is not easily understood and improvement is most often the result of successive iterations targeted at maximising the chance of success prior to implementation

3 **Design as an exploratory process** – improvement results from a creative process that seeks not only to explore the real need, but also to evaluate a range of possible solutions to select the best option

4 **Risk management as a proactive process** – the identification of possible opportunities for and threats to a system before they arise is more likely to lead to the delivery of robust and adaptable systems



2 How to ensure patients receive better, quicker services from hospitals

Quality improvement work points the way to many practical changes in physical and service design that should be embedded in new hospitals to ensure patients receive the right care and are discharged quickly.

Improve the admissions process

'Assess to admit' model

As outlined in NHS England's GIRFT emergency care report,[3] all acute medical units (AMUs) should be developed on an 'assess to admit' basis and not 'admit to assess'.

The design of AMUs with chaired areas can help to suggest that it is an assessment unit and not necessarily a prelude to admission. There may be a central assessment area within the AMU to identify the severity of illness in referred patients and thus their correct pathway. This may be to an enhanced care area in the AMU, which facilitates step up/down of patients and starts treatment quickly.

There should also be an ambulatory care area that can take patients from the assessment area, from A&E and directly from community practitioners. Up to 30% of acute medical referrals can be managed via ambulatory care. This is often preferable for patients and reduces the pressures on inpatient beds. There are consequent reductions in bed occupancy rates that assist in the delivery of the A&E 4-hour standard.

Separating inpatient and outpatient flows

The Royal Papworth Hospital that opened in 2019 provides an excellent template for improving the patient pathway by separating inpatient and outpatient flows.[16] This helps to maintain the dignity of patients while also supporting effective infection prevention and control, which is vital as the NHS plans how to manage further COVID-19 waves and future pandemics.

At the Royal Papworth site in Cambridge, the layout of the hospital is much simplified compared with the traditional hospital. The first two floors contain the outpatient wing, operating theatres and offices, while patient bedrooms are kept separate on upper floors.

The improved layout and patient pathways have meant that, for example, the 5-minute journey time from ambulance to treatment at the old Papworth Hospital has been reduced to just 90 seconds.

Co-locating acute admission units

One lesson from the RCP's Future Hospital Programme was that co-locating acute admission units delivered significant benefits to patients and the system – by having all new admissions in one area, transfers of care were much simpler.[2]

The example of Worthing Hospital, a medium-sized district general hospital, is instructive.[2] Worthing combined an AMU with a surgical assessment unit, and co-located them with an acute frailty unit. The importance of rapid access to the 'right person' helped to deliver improvements to patient experience, in parallel with improved clinical effectiveness. As soon as the ambulatory care area opened, it became clear that many patients previously admitted under surgical teams could be seen and cared for in the ambulatory setting. The key outcome from this project to co-locate acute admission units was decreased length of stay, particularly for surgical patients, alongside no increase in mortality or readmission rate.

More innovative thinking is also needed in terms of co-location when it comes to grouping clinicians in hospitals physically according to disease. For example, locating gastroenterologists close to colorectal surgeons can help to improve the efficiency of patient pathways and patients' experience.

Improve the discharge process

'Discharge to assess' model

When patients are discharged late in the day, a cohort of morning patients for admission develops with no empty beds to accommodate them. As GIRFT has outlined, 'discharge to assess' type models can enable quicker discharge of patients with more complex conditions. In Medway, a discharge to assess model was created in just 8 weeks, with a single point of access for all discharge coordination.[2] A communications and marketing plan was rolled out using 'Home First' branding on banners and posters across the hospital. Delayed transfer of care rates dropped by 25 % in 3 months, and both patients and staff reported positive experiences.

Proactive rehabilitation

GIRFT has again shown that a proactive rehabilitation package, where patients are returned to the appropriate place of care more rapidly, can support independence, rehabilitation and speedier recovery.[3]

The involvement of relevant allied health professionals (AHPs) in the assessment of patients as close to the time of their arrival as possible is important. In Stoke, a weekly AHP multidisciplinary team (MDT) meeting is held to discuss all patients within the 16-bedded respiratory high-dependency unit. It is recommended that a more in-depth discussion for complex patients with protracted length of stay should occur in all higher-dependency areas to facilitate discharge planning in hospitals.

Implementing better ways of working

Hot/cold split-site model

Physically separating elective and non-elective surgical activity has the potential to improve the quality and efficiency of care. For example, since 2017 Gloucestershire Hospitals NHS Foundation Trust has split its trauma and orthopaedic services across its two hospital sites, which are 9 miles apart in Gloucester and Cheltenham.[3]

Cheltenham was designated the main cold (elective orthopaedic) site and Gloucester the hot (trauma) site. Prior to this separation of services, the A&E department across the two hospital sites was failing all constitutional standards. Trauma services were upgraded and improved at Gloucester and senior decision makers now review all trauma admissions on a daily basis, and are available within 30 minutes of being called to see or offer guidance to trauma patients. Since its inception, the breaches in the A&E 4-hour waiting target attributable to trauma and orthopaedics have fallen from over eight to one or two per week. This has resulted in a significant reduction in trauma admission and overall usage of trauma beds, while ensuring that patients requiring admission are seen quickly and admitted. There has been significant improvement in elective performance at Cheltenham; it performed 19% more lower limb joint replacement surgery after reconfiguration.

Better staffing models and team working

Effective staffing models are needed to ensure the capacity is there at times of increased workload and patient flow is maintained. Ambulatory care needs staffing 7 days a week with therapists as well as pharmacists, as do the wards, including with access to imaging and pathology services. This will help to ensure effective timely discharge. Junior doctors will also be needed on the wards 7 days a week, with consultant input, to facilitate timely investigation and discharge. This will make effective use of all the beds and represents an investment to save.

Developing effective services and new processes is also dependent on having a well-constructed MDT – involving hospital clinicians and managers, patient representatives, GPs, commissioners, nursing staff, community clinicians and, importantly, a data analyst and project manager.[2]

Improving ward rounds

Ward rounds are the focal point for MDTs in hospitals undertaking assessments and care planning with their patients. The delivery of ward rounds is, however, often constrained by the competing priorities of clinical staff, with workforce gaps, inadequate planning, unwarranted variation in practice and an absence of training in the skills required to deliver complex MDT care all being contributing factors.

To improve ward rounds and therefore reduce errors in care, longer hospital stays and readmissions, the RCP has outlined how ward rounds should be better structured, patients involved and opportunities for learning prioritised.[17]

Ward rounds best practice: the principles

Scheduling

- Schedule ward rounds, board round and associated activities to prevent conflicts.
- Include before, during and after ward round activities in the schedule.
- Scheduling should maximise patient flow. Shift times may need to be adjusted to accommodate this.
- The ward round lead should ensure the round adheres to the agreed schedule.
- Ward rounds should not last more than 120–150 minutes, or have agreed breaks, to prevent cognitive fatigue.
- Dialogue scripts can help to correctly pace ward rounds.
- Agree mechanisms to prevent unnecessary interruptions.
- Include the review of possible outliers or boarders in the schedule.

Before the ward round

- Structured information from shift handovers should be available.
- Results of investigations should be available and prepared.
- Ensure patient questions and concerns are gathered.
- Board round or huddle to prioritise patients and highlight issues from the whole team.
- Undertake individual professional reviews to inform multidisciplinary bedside review.
- Put in place arrangements for patients with translation needs or other communication difficulties.

Communicating with patients, relatives, and carers

In advance of the ward round

- Healthcare professionals should ensure that patients have a clear understanding of the purpose of the ward round, when it is likely to take place and what is likely to happen.
- Anyone identified by the patient as being important to them who is present at the time of the ward round should also be included in the conversation and communication.
- Wards should have an explanatory leaflet to give to patients and those identified as being important to them that includes details of ward rounds.
- Arrangements should be made for patients with translation needs of or other communication difficulties.

During the ward round

- Begin by assigning roles and setting expectation of learning.
- Confirm diagnosis and problems.
- Address patients' questions and concerns.
- Review patients' progress against plan.
- Confirm or revise escalation plans.
- Check safety measures, including medication review.
- Summarise a revised plan, goals and actions with the team.
- Progress actions during ward round when possible.
- Teach and learn.
- Revise plan with patient.
- Communicate and document the review and plan, assigning key actions.

Communicating with patients, relatives, and carers

During the ward round

- At least one healthcare professional, preferably the person leading the round, should be at eye level with the patient.
- While healthcare professionals may be sharing more complex information between the team, they should ensure that the patient and any relatives or carers present have understood the situation and have been able to ask questions before moving on to the next patient.
- The patient should be left with a short note explaining the outcome of the ward round, providing the information most important to patients.
- The information should be available to people identified by the patient as important to them and with whom they want to share information.

Documentation and clinical records

- Clear documentation of diagnosis, problems, assessments, goals, progress and plans is essential.
- Structured records help to organise documentation to act as prompts to ensure that no important component is missed.
- Checklists are helpful when incorporated into structured records and should be used for key safety risks.
- Information recorded at the ward round should make clear the thinking around the clinical decisions, and include clinical criteria for discharge.
- Records form the basis for clinical coding, clinical audit and for the production of the discharge summaries, and should be structured to aid this.
- Clearly documenting discussion with patients, families and colleagues is a high priority.
- A written summary for patients and relatives is encouraged.

After the ward round

- Debrief the team to discuss the ward round and for learning points.
- Multidisciplinary team board round should confirm plans, actions and prioritisation.
- Continue to update the patient on progress.
- White boards should be updated with progress and goals.
- Afternoon huddle to check progress and people who can be discharged before that day and the next day. Includes weekend handover plans on a Friday.

Ward rounds best practice: the principles

Multidisciplinary teams

- Agree principles, standards, functions and structure for local ward teamworking.
- Clarify each team member's role.
- Include each tier of decision-makers as per the RCP's *Safe medical staffing*[3].
- Agree methods and times of communication.
- Keep membership of the ward's multidisciplinary team consistent wherever possible.
- Ensure opportunities for team education and development.
- Regularly review team performance.

Education, training and learning

- Education and learning should take place across professions on the ward round.
- Simulation of ward rounds should be used to train staff in important skills.
- Learning points should be summarised at the end of ward rounds with opportunities for further learning.
- Patients should be informed that teaching and learning are part of ward rounds and consent requested when appropriate.

Physical environment

- The area around the ward round should be quiet to ensure clear, undisturbed thinking and communication.
- Key equipment must be available and maintained.
- Confidentiality must be considered in all communications.
- Privacy and dignity must be maintained.
- Space for confidential phone calls and uninterrupted record keeping is necessary.
- A private room for sensitive communication must be available.
- Planned physical changes to the ward must consider the effect on ward rounds.

Quality management, research and innovation

- It is essential to plan how ward rounds are delivered and supported.
- Quality measures should routinely be collected that relate to ward rounds, including staff and patient experience.
- Ward rounds should be included in ward accreditation schemes.
- Improvement programmes for ward rounds are required for units, as well as on a hospital-wide basis.
- Research and innovation should include new roles and maximising the benefits of new technology.

Other settings

- Admission unit ward rounds include more detailed assessment of new patients on the round.
- 'Rolling ward rounds' are appropriate on admission units.
- Friday ward rounds should be led by the senior staff, take longer, and include clear, documented plans for the weekend.
- Weekend ward rounds target those who most need review, informed by board rounds.
- 'Outliers' should be minimised but should not be disadvantaged. Continuity of team and timing will help.
- Senior handover should occur if consultant responsibility rotates.
- Specialty rounds should involve the ward-based team.

Using technology

The basics

- Adequate hardware must be available on the ward for all tasks requiring computer records, particularly at peak times.
- Staff must be trained in the use of hardware and software – using single sign on if there are multiple systems.
- Accessible secure WiFi for mobile devices.

Maximise the benefits

- Computerised records and information systems should be used to maximise availability of information for decision-making, and remote communication.
- Connectivity of individual systems with agreed methods of use will increase efficiency.
- Computers on wheels, mobile or bedside devices should be used when possible to increase visibility and decision making with patients.

Minimise the risk

- Vigilance is required around the accuracy of electronic records.
- Methods of electronic recording should be agreed and tested that reduce recording times.
- Bedside computer etiquette should be used so that the use of technology does not detract from human interactions.

3 How to improve staff wellbeing in hospitals to enable better workforce retention and delivery of services

The final aspect of enabling that the UK's new hospitals function well to improve patient outcomes is to ensure that they have enough staff, and those staff are supported to perform to their full potential.

Increase the workforce

Workforce shortages hampered the NHS's ability to provide care during the pandemic and placed additional pressure on staff – prior to the pandemic, the RCP's 2019 census showed that 43% of advertised consultant posts in England and Wales were unfilled due to a lack of suitable applicants.[18]

At the same time, clinical demand is rising. The Office for National Statistics predicts that by 2040 there will be over 17 million UK residents aged 65 years and over, meaning that the cohort of people potentially requiring geriatric care will make up 24% of the total population. These are challenges that we know are coming and must prepare for now by increasing the number of people training as doctors, nurses and other health and care professionals.

If the UK's new hospitals are to be able to meet demand in 2040, we need to be training more doctors now. Currently there is a cap on the number of medical school places in England. In August 2020, the government lifted that cap as part of its pandemic response. The lifting of the cap should be maintained and a larger, ongoing increase planned for, leading to an eventual doubling of places in England over the next decade from 7,500 to 15,000.

Doubling the number of medical school places will cost £1.85bn annually.[19] This is not an insignificant cost, but it is less than a third of what hospitals spent in 2019/20 on agency and bank staff. Our 2019 census found that on average, locums account for around 10% of consultants in UK hospitals, with 4% of trusts having 30–40% locums. Although locums play an important short-term role, reliance on them is not a long-term solution. Investing in expanding the medical workforce would represent a long-term saving in locum costs and prepare for the increased patient demand that we know is coming.

Expanding the medical workforce will also likely improve retention of the staff we already have. The GMC report *Caring for doctors, caring for patients* sets out a triad of 'belonging, autonomy, and competence'.[20] Feeling part of a supportive team, having the responsibility to make decisions and feeling competent in your role are key to improving workforce retention and wellbeing. Doctors' need for competence is most likely to be met when their workloads are not excessive and they have the time to dedicate to the clinical problem in front of them. Feeling competent is rewarding in any role, and doctors are no different. Increasing the workforce will reduce clinical workloads, in turn reducing stress and increasing job satisfaction by freeing up time for non-clinical work such as research or teaching.

Enable professional development and a learning environment

An important way of retaining the workforce is to do more to enable greater room for professional development, away from direct clinical duties.

Building in protected time in job plans for these activities – whether quality improvement, service redesign or research – is crucial. An RCP member survey from 2020 found that 57% of respondents wanted to be more involved in clinical research and two-thirds (67%) said that having dedicated time for research would make them more likely to apply for a role.[21]

Developing the leaders of the future is vital in ensuring that future hospitals deliver the highest quality of treatment and care for patients. The RCP's Chief Registrar Programme, established in 2016, aims to do this by providing protected time for doctors in training to gain experience in leadership and quality improvement while remaining in clinical practice.[22]

The RCP and Health Education England's flexible portfolio training programme is another initiative aimed at supporting non-clinical professional development alongside clinical training.[23] The programme provides protected time away from clinical medicine to pursue a minimum of 1 year on a related non-clinical pathway – either clinical informatics, medical education, research or quality improvement.

Thinking more broadly, if hospitals are to be effective learning environments for staff (and patients), we need to pay close attention to the physical and cultural environment. Simulation suites, clinical areas with sufficient space for staff, and coordinated time to enable this will all help staff to learn across professions.

Ward rounds are a good example of where a cultural environment of cross-team learning can be encouraged. The RCP's *Modern ward rounds* report illustrates how this can be done with, for example, 'reverse ward rounds', where trainees take the role of leading the round and feeding back.[17]

There are many other ways in which hospitals can facilitate learning environments. The RCP report *Never too busy to learn – a pandemic response* provides a number of improvements that can be made, including huddles, Schwartz rounds and peer mentoring schemes.[24]

Enabling hospitals to be learning environments for patients too is important, so that they are able to self-manage more confidently where appropriate. For example, as part of the RCP's Future Hospital Programme, in the North West Paediatric Allergy Network group dietetic sessions were developed for infants with cow's milk allergy, where between five and ten families came together with a dietitian and health visitor. This not only empowered families/carers to work together to manage their infants' milk allergy, but also promoted tolerance and thus resolution of the disease in the quickest time, improving the family's overall quality of life, and reducing the workload of the dietitian and cost of replacement milk formulas to the NHS.[25] Our 2018 outpatients report also emphasises the learning role that group sessions play for patients, helping to 'develop patient confidence in self-management and introduce them to a potential peer support network'.[1]

Ensure a greater focus on staff morale and wellbeing

More flexible working patterns

23 % of NHS consultants now work less than full time according to the RCP's 2019 census,[18] with this figure tending to grow year on year as both male and female doctors seek a better work–life balance.

This desire for a more manageable working life was also evident when we surveyed RCP members in April 2021, when the second COVID-19 wave was ending.[10] Over a fifth (21 %) of respondents wanted to work less in future, while a third (33 %) wanted to work the same number of programmed activities more flexibly.

When planning how future hospitals function, the question of offering working patterns that help to attract and retain staff should be an important consideration for trusts and ICSs.

Getting the 'small things' right

RCP members report that there are many seemingly minor things that have a large impact on their sense of wellbeing at work. Examples of common frustrations are not having somewhere private to make phone calls, having various IT applications within a hospital which all require separate sign-ins, and even not having a cloakroom to store a jacket or coat. These problems can and should all be considered and designed out when planning new hospitals.

The pandemic again points the way forward to some extent. An RCP member survey found that during the first wave, 46 % reported that team working had improved, with 'support from their employer' being cited as an important factor.[10] Qualitative feedback shows that this was down to not only being offered more flexible working patterns, but also simpler things like hot meals being available and free parking.

Recognising the wellbeing of staff as a care quality indicator

Individual initiatives to improve wellbeing are very welcome, such as the government's announcement in February 2021 of 40 new mental health and wellbeing hubs for healthcare staff traumatised by COVID-19.[26]

But more system-wide incentives for hospitals to improve staff wellbeing are also needed. The RCP believes that one way of doing this will be for the wellbeing of physicians and other clinicians to be recognised as a care quality indicator for all health systems.[27] Improving the working lives of clinicians can optimise the performance of health systems, improve patient experience, drive population health and reduce costs.

Conclusion

The government's commitment to build 40 new hospitals by 2030 is a fantastic opportunity to improve the care that patients experience, as well as improving staff wellbeing and thus retention and the delivery of services.

Building better patient pathways into the functioning of hospitals does not require radically new ideas, but rather the implementation of what we already know from the huge amount of quality improvement work undertaken by clinicians and other NHS staff, and pioneering efforts to design and document patient-centred services.

The starting point has to be the mindset that hospital services must be designed around the needs of patients rather than what has traditionally been done or is easiest for the system. Co-designing services with patients, enabling greater use of digital technology and breaking down the divisions in care delivery are all crucial here. This shift also needs to be underpinned by a systems approach, akin to engineering, which will also help to deliver continued improvement to hospital services over time.

This should then lead to the practical changes needed in physical and service redesign to improve patient pathways with better and quicker services. These have been well evidenced by the GIRFT programme, and can be built into the admissions and discharge processes, for example.

The other aspect of planning new hospitals that can't be ignored is ensuring that the workforce is in place to deliver these improved hospital services. That is, to a large extent, a question of pure numbers – we are not training enough staff at present to fill posts in current hospitals, so expanding the number of places in medical schools is an urgent priority. Workforce shortages have knock-on effects on the morale and wellbeing of existing staff. Greater efforts to enable professional development and a focus on getting the 'small things' right and designing out common frustrations will also improve morale and make the new hospital programme a success.

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