

Early evaluation of Women's Health Hubs

Interim summary report

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List of abbreviations

Abbreviation	In full
CCG	Clinical Commissioning Group ¹
GPwSI	GP with a Special Interest
GUM	Genitourinary medicine
ICB	Integrated Care Board
ICS	Integrated Care System
FSRH	Faculty of Sexual and Reproductive Healthcare
LARC	Long-acting reversible contraception
PCWHF	Primary Care Women's Health Forum
PCN	Primary Care Network
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
WHHs	Women's Health Hubs
WP	Work Package

The BRACE programme

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The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

¹ During the course of the evaluation, CCGs have been abolished and replaced with Integrated Care Boards. However, the report refers to CCGs which were the commissioning bodies when identified hubs were established.

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A note on terminology

Defining Women's Health Hubs

Stakeholders have highlighted that the 'Women's Health Hub' (WHH) label is open to interpretation, and not all services of this kind refer to themselves as WHH. WHHs are not necessarily a 'place' but a 'concept' and are distinct from other hubs such as mental health and family hubs, though inevitably there are links. We are exploring the diversity in terminology in use, and perspectives regarding nomenclature, as part of our evaluation.

Using the term 'women'

While we refer to women throughout this document, we recognise that WHHs may also serve people who are transgender, non-binary, with variations in sex characteristics (VSC) or who are intersex, and we are working to ensure that our evaluation is inclusive.

A note on the report

This summary paper presents early results from an ongoing evaluation of WHHs. The findings presented in this report may be subject to change as we continue to gather survey responses and undertake in-depth qualitative evaluation with four specific hub sites and wider stakeholders.

The mapping survey remains open, and we continue to work with hub stakeholders across the UK to produce an up-to-date map. The results presented here are accurate to the best of our knowledge. However, this is a complex context and hubs are evolving continuously. We ask readers to contact us if they find that the detail presented does not accurately reflect their local hub provision.

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Executive summary

This is the interim report of an ongoing, early evaluation of Women's Health Hubs (WHHs), which began in April 2022. The aim of the evaluation is to explore the 'current state of the art', mapping the WHH landscape, studying experiences of delivering and using hub services, and defining key features and early markers of success to inform policy and practice.

The report presents early findings from an online survey of hub leaders to map the current WHH landscape across the UK. More detailed qualitative evaluation is currently underway. A final report will be published in mid-2023.

Background

- Women's sexual and reproductive health (SRH) needs are complex and vary across the life-course from menstruation to post-menopause. Currently, women's health needs are met by a variety of providers, venues and professionals.¹
- The complexity of the landscape means that provision is often not well-integrated and there are challenges in access linked to gaps in training, workforce issues, funding cuts, fragmented commissioning between the NHS and local authorities, and Covid-19.²
- Local areas and teams across the UK are establishing WHHs in response to these challenges to improve provision, experiences and outcomes for local populations, address inequalities and reduce costs. These emerging models have been highlighted as best practice and wider adoption and roll out recommended.^{3,4}
- The Government has identified the opportunity to integrate women's health services more effectively, with a more woman-centred, life course approach, reflected in the new Women's Health Strategy.⁴ The Strategy, which was published in July 2022 (after our evaluation commenced), aims to improve the health and wellbeing of women and girls in England, and encourages the expansion of WHHs and other models of one stop clinics across the country.
- In response to WHHs being identified as an important policy topic, NIHR asked the BRACE Rapid Evaluation Centre to undertake a rapid evaluation of current hub evidence and practice, to inform WHH policy, implementation, and impact measurement.

Evaluation and methods

- The evaluation will evaluate why, where and how hubs have been implemented, why different approaches have been taken, if and how inequalities have been considered, and experiences of implementation, delivery and receiving services.
- The evaluation comprises an online survey of hub leaders across the UK to map current WHH provision, interviews with regional and national stakeholders, and in-depth qualitative evaluation in four hub sites.
- The in-depth evaluation sites have been selected for maximum diversity. Site selection has been guided by the mapping survey findings, input from women and stakeholders, and a review of the literature.



- We have analysed survey responses received to-date, but the survey remains open to capture any further hubs identified. The in-depth evaluation sites, regional and national interviews are in-progress.
- The final report will be submitted to NIHR in March 2023, and will be published in mid-2023.
- Data collection so far has focused on high-level insights – at a strategic level, and mapping the landscape through identifying hub sites across the UK. There are some important groups we have yet to hear from, including front line staff and women using hub services.
- The next stage of fieldwork includes more in-depth research with a range of stakeholders in four exemplar hub sites, and interviews with regional and national level stakeholders.

Wider input has informed and supports the evaluation:

- A Women's Advisory Group was established to provide input throughout and to use the experiences of women to shape the project and influence the wider women's health sector. It comprises a diverse group of eight women of varying ages, backgrounds and with different experiences of NHS care for women's health issues. The Group has helped us to shape our study, for example, advising on effective and appropriate ways to recruit women to participate in the evaluation and highlighting the need to include women who are less likely to/not accessing hub services in the evaluation.
- A Stakeholder Advisory Group has been created, which is made up of a range of members with significant experience in the field of women's health, including clinicians, policy stakeholders and a woman with lived experience. Their input has supported and guided the evaluation, for instance, working with the team to develop and refine a working definition of WHHs and identifying key stakeholders for regional and national interviews.

Key findings and insights

- The survey analysis includes responses submitted up to 5th October 2022. The survey remains open and any additional responses will be included in the analysis for the final report. The analysis presented includes 15 responses for 14 UK hubs.
- Hubs are evolving, and many are still not operational: most defined themselves as 'currently operational with plans to expand', with others still 'in development'.
- The most common hub objectives are to reduce secondary care (hospital) use, reduce the number of appointments women have to attend for a single health issue, and to reduce waiting times.
- Most hubs define themselves as 'one-stop shops' or 'hub and spoke' models.
- The most commonly reported commissioning arrangement is co-commissioning between the local authority and the Clinical Commissioning Group (CCG) (now replaced by Integrated Care Boards (ICBs)).
- The majority reported a GP-led clinical leadership model, rather than a SRH consultant-led approach.
- Hubs provide a wide range of services. Almost all offer Long-acting reversible contraception (LARCs) for gynaecological reasons, with LARCs for contraception, consultations for menopause

and support for heavy menstrual bleeding also common. Some services were not offered at all: pelvic physiotherapy and abortion care.

- GPs with a special interest in women's health are the most frequently reported professionals working within hubs, followed by administrators and healthcare assistants.
- Almost all hubs reported offering training to health professionals (e.g. LARC and ring pessary fitting, menopause training).
- Common facilitators of implementation hubs are: strong relationships/collaborations across services and organisations; committed and experienced GPs; supportive leadership.
- Common barriers included: funding; information technology/systems; recruitment and retention; a lack of physical space.

Women's group insights

The Group shared some insights regarding hubs, which included:

- The terminology used to describe these services i.e., 'hubs' is confusing and implies a physical location with a range of services all under one roof.
- It is important that WHHs consider how to reach all communities, including ethnic minorities, those who are disadvantaged and/or under-served by existing services.
- Hubs should carefully consider how they communicate with women and that the hub 'offer' is clearly articulated.
- Linked to this, it was felt that there is a lack of clarity around what hubs are aiming to do, which services are 'in' and 'out' and where the boundaries between hubs and other services lie, and what is considered to be 'women's health'.

Key messages and implications from the findings so far, include:

- **Defining and locating hubs.**

WHH models across the UK are diverse and complex, with different services offered, and with differing stakeholder perspectives regarding the role and definition of a 'hub'. Terminology (e.g., 'one stop shop') is applied differently. We will explore assumptions about how individual models function in our ongoing empirical work. Many hubs describe ongoing development and incremental growth of models.

Implications: The diversity means that this is a complex policy and practice area. If the diversity is to continue and the nature and role of hubs is not clear, it risks confusion for women, professionals and policymakers. Top-down standardisation may hinder tailoring models to fit local needs. It is likely that a balance needs to be struck between standardisation and locally defined models. Learning is still ongoing regarding the relative benefits and limitations of different models.

- **Implementation progress and focus.**

Findings suggest that most areas do not have a WHH. While there are some well-established hubs, many are at a relatively early stage of development. Most hub leaders in our survey described plans for expansion of scope and reach. Provision is often focused on LARCs, rather than 'one stop shop' care, though there are many examples of additional services.

Implications: The current small number of hubs and early stage of development for many indicates that it will take some time for existing models to reach their full potential, and for WHHs to scale up and spread across the NHS. This early stage presents an opportunity to develop guidance, align approaches and to capture the learning from different ways of working.

- **Measurement of activity and impact.**

Approaches to the measurement of hub processes and outcomes appears to vary and is emerging. While hub leaders aim for models to reduce disparities, evidence is still emerging regarding whether this is achieved in practice.

Implications: The variation presents challenges in evidencing activity and impact, and comparing models. Our stakeholders, including our Women's Advisory Group, were clear that hubs must address inequalities in access, care and outcomes, and standardising the approach to measuring the impact on inequalities is required to evidence whether this has been achieved.

- **Implementation facilitators and barriers.**

While the survey provided high level insights regarding key barriers and facilitators experienced by hub leads, we are exploring them in depth through our hub site, regional and national interviews and documentary review, and will present detailed findings in the final evaluation report.

The findings and interpretation presented in this early report will be refined as more data is gathered and analysed as the evaluation continues.

1. Background and context

Women's sexual and reproductive health (SRH) needs are complex and vary across the life-course from menstruation to post-menopause. Currently, women's health needs are met by a patchwork of providers, venues and professionals, including primary care, gynaecology, maternity, community sexual health services and genitourinary medicine (GUM).

The complexity of the landscape means that provision is often not well-integrated and there are challenges in access linked to gaps in training, workforce issues, funding cuts, fragmented commissioning between the NHS and local authorities, and more recently due to Covid-19. There is variation in availability and quality of services across the country, with a lack of accountability or ownership in the system for women's health needs.^{2,3,5-10} Poor access can also lead to poor experiences and outcomes: there are significant inequalities in SRH, with ethnic minority groups and young people among those disproportionately impacted.^{6,10} It is likely that inequalities in service provision and access have widened as a result of the Covid-19 pandemic.²

There have been calls for a more collaborative and holistic approach to delivering women's healthcare services, in recognition of these issues.^{2,3,5,6}

Local areas and teams across the UK are establishing Women's Health Hubs (WHHs) in response to these challenges to improve provision, experiences and outcomes for local populations, address inequalities and reduce costs.

Hubs function to meet women's SRH needs by integrating care, and enabling women to be seen in the community by practitioners with appropriate skills, often within primary care, although not necessarily within their own practice/provided by their own practice team. There are a variety of services available at WHHs, for example, the provision of long-acting reversible contraception (LARC) methods including coils and implants, menopause management, and care for heavy menstrual bleeding (HMB). These emerging models have been highlighted as best practice and wider adoption and roll out recommended.^{3,11,12}

Moves toward greater integration in commissioning and delivery of SRH services mirror a wider policy direction with the Government's commitment to integrating and delivering health care across a population footprint. This is reflected in the development of Primary Care Networks (PCNs), Place Based Partnerships and Integrated Care Systems (ICSs) to integrate care across settings and improve the health of the population.^{13,14,15}

The Government has identified the opportunity to integrate women's health services more effectively, with a more woman-centred, life course approach, reflected in the recent Women's Health Strategy. The Strategy aims to improve the health and wellbeing of women and girls in England, by *"taking a life course approach, focusing on women's health policy and services throughout their lives, embedding hybrid and wrap-around services as best practice, boosting the representation of women's voices and experiences in policy-making, and at all levels of the health and care system"*^{4 p8}

The Women's Health Strategy also highlights priority areas for action, including menstrual health and gynaecological conditions, menopause, mental health and wellbeing, fertility, pregnancy, pregnancy loss and postnatal support.

It sets out a number of immediate steps that are being taken to improve women's experiences and outcomes, which relate to WHH. One such step is "*encouraging the expansion of women's health hubs around the country and other models of 'one-stop clinics', bringing essential women's services together to support women to maintain good health and create efficiencies for the NHS*".^{4 p11}

The Women's Health Strategy describes how WHH models "*provide integrated women's health services at primary and community care level, where services are centred on women's needs and reflect the life course approach, rather than being organised by individual condition or issue*".^{4 p25}

To promote best practice across the country, the Strategy committed to establishing a women's health accreditation mechanism, recognising providers and commissioners who provide services in these ways. Local commissioners and providers are strongly encouraged to consider adopting these models of care.⁴

What is a Women's Health Hub?

WHHs are understood differently by stakeholders – there is currently no agreed, shared 'definition' of what a WHH is. Hubs are not necessarily a 'place' but a 'concept' and the term is being used in different ways across health and social care services.

The Primary Care Women's Health Forum (PCWHF) is a key organisation working to promote and educate in order to encourage the development of these models. The PCWHF describes WHHs as follows:

"At the core of any Women's Health Hub framework is convenient access to a range of services for all women. Women's Health Hubs bring existing healthcare services together to provide holistic, integrated care. This care is accessible, delivered by trained healthcare professionals, supported by specialists. This results in better outcomes for patients. A Women's Health Hub is a concept, it is a service where healthcare professionals with enhanced skills bring together their expertise. It enables these healthcare professionals to offer a wide range of women's health services in an easy to access location. A Women's Health Hub is not a building, there is no need to invest in new physical space. It is not a major financial investment, it's about efficiencies of scale. It is not timewasting, it uses the right healthcare professional at the right time, in the right place to ensure a sustainable approach."

¹⁶

In the Women's Health Strategy, a vision for WHH is described "... hub models can provide management of contraception and heavy bleeding in one visit, integrate cervical screening with other aspects of women's health care, or manage menopause at the same time as contraception provision for women over 40."^{4 p26}

A working definition

Through our work with experts and women, it was evident that we needed a detailed definition for the evaluation in order to draw boundaries around what a WHH is (versus a community gynaecology service, LARC hub, or other). This builds on the definitions from the PCWHF and in the Government's Women's Health Strategy. Our working definition is as follows:

- WHHs are in the community and working at the interface between primary and secondary care and/or voluntary sector and wider.
- WHHs offer more than a single service (and include the provision of both gynaecological services and contraception) or demonstrate plans to.
- WHHs have more than one organisation involved in the design, commissioning and/or delivery of care, beyond simply referring-in.
- WHHs are co-commissioned or joint-commissioned, meaning two or more organisations are responsible for tasks such as awarding or reallocating contracts to providers (or moving towards this) and/or have evidence of integrated governance and leadership models.¹⁷

Providing both gynaecological and contraceptive services

The integration of both gynaecological and contraceptive services is a criterion for our definition of WHHs. Access to both gynaecology and contraception is challenging. A particular consideration is that LARCs, specifically interuterine devices/systems (coils) may be required for either contraceptive purposes, or for gynaecological reasons (such as heavy menstrual bleeding). Separate sexual health and gynaecology commissioning arrangements mean that services often cannot provide coils for both reasons in one setting. From a policy perspective, reducing the LARC backlog for both gynaecological and contraceptive reasons was a key impetus for the development and roll-out of WHHs and as stated in the Women's Health Strategy:

"A key aim of hub models is to improve women's access to the full range of contraceptive methods, and in particular LARC."^{4 p26}

Our discussions with hub leads during our mapping exercise suggested that the provision of both gynaecological and contraceptive services requires integration/reorganisation at a commissioning level. Where community gynaecology services are not able to provide contraceptive services, our discussions with clinical leads suggest this is due to commissioning barriers. For instance, responsibilities for commissioning different SRH issues and treatments are split across NHS England, local authorities and CCGs, making it less possible for services to adapt their offer of care.¹⁸

The evaluation

This rapid evaluation of current evidence and practice is being undertaken to inform WHH policy, implementation, and impact measurement. The study is taking place over 12 months from April 2022 to March 2023. The report presents early findings from an online survey of hub leaders to map the current WHH landscape across the UK. More detailed qualitative evaluation is currently underway. A final report will be published in mid-2023.

Evaluation aims

The overall aim of the evaluation is to explore the ‘current state of the art’, mapping the landscape, studying experiences of delivering and using hub services, and defining key features and early markers of success to inform policy and practice.

Specifically, the study will evaluate why, where and how hubs have been implemented, why different approaches have been taken, if and how inequalities have been considered, and experiences of implementation, delivery and receiving services. The evaluation will provide feedback about the successes and challenges of hubs and potential improvements, including different stakeholder group perspectives of what hubs are intended to achieve, and whether hubs are making progress towards this.

It will also gather preliminary evidence about what is known about performance, outcomes and costs and how they are/can be measured.

Evaluation questions

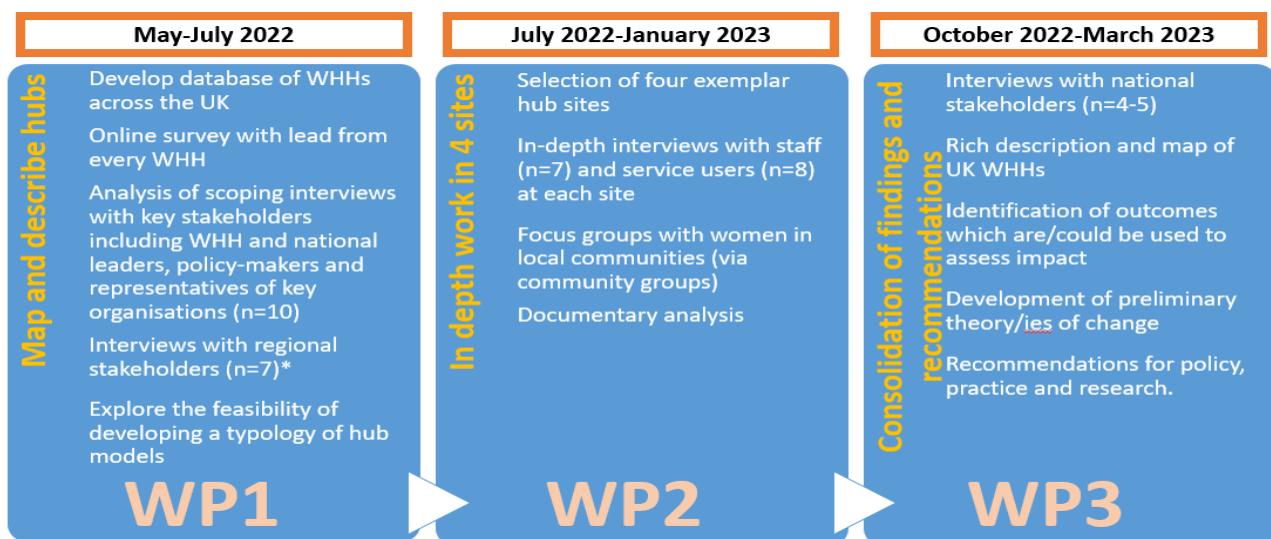
In order to address the evaluation aims, the study seeks to answer the following evaluation questions about Women’s Health Hubs:

1. What are WHHs, and is there variation in how stakeholders name and define them?
2. How many WHHs have been established/are in development across the UK, where are they, and what are their characteristics, including models of structure, commissioning and delivery?
3. Why have WHHs been implemented, and how are they intended to address health inequalities?
4. What have WHHs achieved to date? How do they achieve this?
5. What are the experiences and perspectives of staff regarding WHH setup, commissioning, funding, implementation and delivery?
6. What are the experiences and perspectives of women who have used hub services?
7. How are WHH performance, outcomes and costs measured, and how might they be measured in future?



Evaluation plan

Figure 1 Overview of evaluation plans



(WP = Work Package)

*Regional stakeholder interviews were postponed to enable discussion of hubs in the context of the Women's Health Strategy, as publication was delayed until 20th July.

Wider input to inform the evaluation design and analysis

Women's Advisory Group

A Women's Advisory Group was established to provide input throughout the evaluation and to use the experiences of women to shape the project and influence the wider women's health sector. It comprises a diverse group of eight women of varying ages, backgrounds and with different experiences of NHS care for women's health issues including smear tests, endometriosis and menopause. The Group is chaired by a woman with extensive experience of public involvement in research and evaluation. Three meetings have been held with the group so far, at key points in the project.

The input from women in our Advisory Group has helped us to shape our study, for instance:

- Highlighting the need to include women who are not accessing the hub services in the evaluation. This resulted in the addition of focus groups with women in communities where there has been low uptake of women's health hub services, in the in-depth evaluation sites.
- Advising on effective and appropriate ways to recruit women to participate in the evaluation, and suggesting a variety of routes for undertaking data collection with women using hub services, including offering online, telephone and face to face options for women to take part.

- Highlighting the importance of having flexibility in data collection and ensuring that the approach taken is appropriate, being mindful of women's differing preferences and needs.
- Emphasising that it was important that we explore women's pathways in/out/back into hubs, and how this is understood by, and communicated to women.
- Providing input into the design of evaluation tools.
- Providing guidance and perspectives regarding important criteria for selecting the hubs to be involved in in-depth evaluation.
- Reflecting on the concept of WHHs as emerging models of care.

We will continue to work closely with our Women's Advisory Group throughout the evaluation, including during the final reporting stage, using their experiences and insights to shape our work. The Group has also provided valuable insights into how the concept and policy regarding hubs may be perceived by women in the community, which are summarised later on page 28.

Stakeholder Advisory Group

To support the evaluation design and delivery, the team has established a Stakeholder Advisory Group. The Group is made up of a range of members with significant experience in the field of women's health, including clinicians, policy stakeholders and a woman with lived experience.

To date, we have met with the Stakeholder Advisory Group three times – once during the scoping phase in February and twice since the project began in April.

The input from our Stakeholder Advisory Group has helped us to shape our study, for instance:

- Working with the evaluation team to develop and refine a working definition of hubs.
- Identifying key stakeholders for regional and national interviews.
- Directing us to existing hub models and facilitating contact with leads to complete the survey.
- Developing our understanding of the women's health care context.
- Assisting with the development of a long list of criteria for exemplar site selection, and the selection of the final four sites.
- Sense-checking our early findings and interpretations.

2. Methods

The mixed methods evaluation combines quantitative and qualitative data collection from WHH models across the UK, with in-depth qualitative insights from four purposively selected exemplar hub sites in England, to provide deeply contextualised findings. This approach offers both breadth and depth in data collection and comprises three work packages as outlined on page 14.

This interim report focuses on early findings from the national survey work (WP1) conducted between May and September 2022. An online survey with key stakeholders across the UK was supplemented by desk research to build a database of hub models, and by analysis of interviews undertaken in the scoping phase of the evaluation (December 2021 to March 2022).

Work Packages 2 and 3 commenced in September 2022, and further findings will be shared in the final report, which is to be published in 2023.

Ethical approval

This study has been approved by the Research Ethics Committee at the University of Birmingham (ERN_22-0669).

Data collection: mapping survey approach

An online survey was designed to be completed by service leads in WHHs across the UK. The main purpose of the survey is to gather essential descriptive information from local areas to map the current WHH landscape. The survey was designed with input from a consultant in SRH and a health economist with expertise in public health, sexual health and women's reproductive health, and piloted with a SRH consultant.

The survey was launched in May 2022 and remains open to maximise the opportunity to capture information on as many hubs as possible throughout the evaluation period, in light of the rapidly developing landscape.

The survey was distributed by email to hub leads already known to the study team, advertisement via the PCWHF and Faculty of Sexual and Reproductive Healthcare (FSRH), via social media, and through our stakeholder group shared the survey link within their networks. Contacts were sent multiple reminders to complete the survey.

The survey was administered using the online platform SmartSurvey and took approximately 30 minutes to complete. Respondents were also given the alternative option of participating in a video/telephone call to complete the survey with a member of the evaluation team. Two hubs leads selected this option.

An initial analysis of survey responses was undertaken in July 2022 to support the selection of four hub sites in which to conduct in-depth evaluation (see page 29 for further details on criteria for exemplar site selection). A further analysis on all responses received to date was completed in October 2022 to inform this report. The analysis was conducted by exporting the data to Excel and



producing descriptive statistics for closed-text questions. The open-text questions were collated and summarised to identify the common themes. A final analysis on all survey responses is planned for December 2022.

Box 1 – Content of the mapping survey

The survey includes 68 open and closed questions

Topics include:

- Patient population covered by hub services
- Rationale for hub development
- Services provided by the hub
- Patient pathway
- Current and future objectives of the hub
- Hub commissioning and funding arrangements
- Clinical leadership and governance structure of hub
- Hub workforce
- Training provided
- Performance and monitoring data collected
- How hubs address inequalities

Other data to inform analysis: scoping interviews

In January – February 2022, interviews were conducted to scope the evaluation design. Ten key stakeholders from across England were interviewed, including leaders of WHHs, national-level leaders and policymakers, and representatives of key organisations including the PCWHF, FSRH, and RCOG.

The interviews were undertaken to gather insights, views and experiences on WHHs and to help define the scope of the evaluation, including key areas of focus. The interviews also supported the identification of relevant evidence and key stakeholders in the field.

The findings from these interviews helped to inform the evaluation design and protocol. The data from these interviews have been analysed thematically using a coding framework developed from the evaluation questions.



3. Findings from the mapping survey

The analysis that follows includes responses to the mapping survey provided up to 5th October 2022. There were 20 survey responses received, but only 15 responses are included in this analysis, covering 14 hubs across the UK (two responses received from one hub). There are an additional five survey responses that are not included in this current analysis. Two of these were not included as further follow-up is needed by the evaluation team to clarify the survey responses and will be included in the analysis for the final report. The other three responses have been excluded from analysis as it was determined that the service does not meet our definition of a WHH (e.g. focused on providing gynaecological services, with no plans to expand into contraception). In addition, 12 individuals attempted to complete the survey but reported that there is not a WHH in their area and so were unable to answer the questions. Please note that respondents did not all answer every question and this is indicated throughout the text and figures (N=).

Survey respondents were from a variety of roles, particularly GPs and SRH consultants, as well as commissioners.

As Table 1 shows, most of the hubs identified to date are located in England (N=11), and no hubs have been found in Wales.

The majority of hubs identified were described by respondents as 'currently operational with plans to expand', with several more still 'in development'. This reflects the current landscape of WHHs with the majority still on their implementation journey with plans/aspirations to further develop the nature and scope of hubs.

Table 1 Key characteristics of identified hubs

No.	Location	Nation	Hub local name	Implementation stage	Year launched	Model	Commissioning arrangement	Clinical lead
1	City and Hackney	England	Community Gynae PCN Hub	Operational with plans to expand	2016	Hub and spoke	Other	Other
2	Hampshire and Isle of Wight	England	Women's Health hub	In development	2022	Virtual	No formal commissioning arrangements	GP-led
3	Liverpool	England	Liverpool Women's Health Hubs	Operational with plans to expand	2020	Other	Co-commissioned between local authority and CCG	GP-led
4	Guildford & Waverley	England	Guildford & Waverley Community Gynaecology Service	Operational with plans to expand	2014	One stop shop	Commissioned by CCG only	GP-led
5	Manchester	England	Manchester Community Gynae Service and Level 3 Contraception service	Operational with plans to expand	2006	One stop shop	LA (Level 3) and CCG (community gynae)	SRH consultant-led
6	Aberdeen	Scotland	ROC Private Clinic	Operational with plans to expand	2021	Hub and spoke	No formal commissioning arrangements	Other
7	Tower Hamlets	England	-	In development	2022	One stop shop	Co-commissioned between local authority and CCG	Shared leadership model
8	Western trust NI	Northern Ireland	Western federation	Operational with plans to expand	2017	One stop shop	Co-commissioned between local authority and CCG	GP-led
9	Eastern Federation NI	Northern Ireland	<i>None provided</i>	Operational with plans to expand	2017	One stop shop	-	GP-led
10	City and Sandwell	England	Modality Gynaecology	Operational with plans to expand	2016	Hub and spoke	Other	GP-led
11	Hertfordshire	England	Enhanced Community Gynaecology Service/community gynae clinics	-	-	-	Commissioned by CCG only	Gynaecology consultant-led
12	Sheffield	England	Sexual Health Sheffield Hub	Operational with plans to expand	2019	Hub and spoke	Co-commissioned between local authority and CCG	GP-led
13	North Durham	England	Durham Gynae	Currently operational with plans to expand	2010	Other	Other	-
14	South Durham	England	William Brown centre WHH	In development	2022	-	-	-

Hub objectives (now and in the future)

Survey respondents identified current and future objectives for WHHs (N=12).

Figure 2 shows that WHHs have a wide variety of current objectives including reducing the use of secondary care, reducing the number of appointments needed for a problem and reducing waiting times, which were reported as current objectives by all hubs who responded to this question. This suggests that improving efficiencies (and thus experiences) for patients and for the system is a key aim for WHHs.

Five hubs identified providing new/additional women's health services as a future aspiration. In contrast, reducing unplanned pregnancy is least likely to be a current or future aspiration (three hubs selected this is not an aspiration for now or the future).

Hub models and access to healthcare professionals

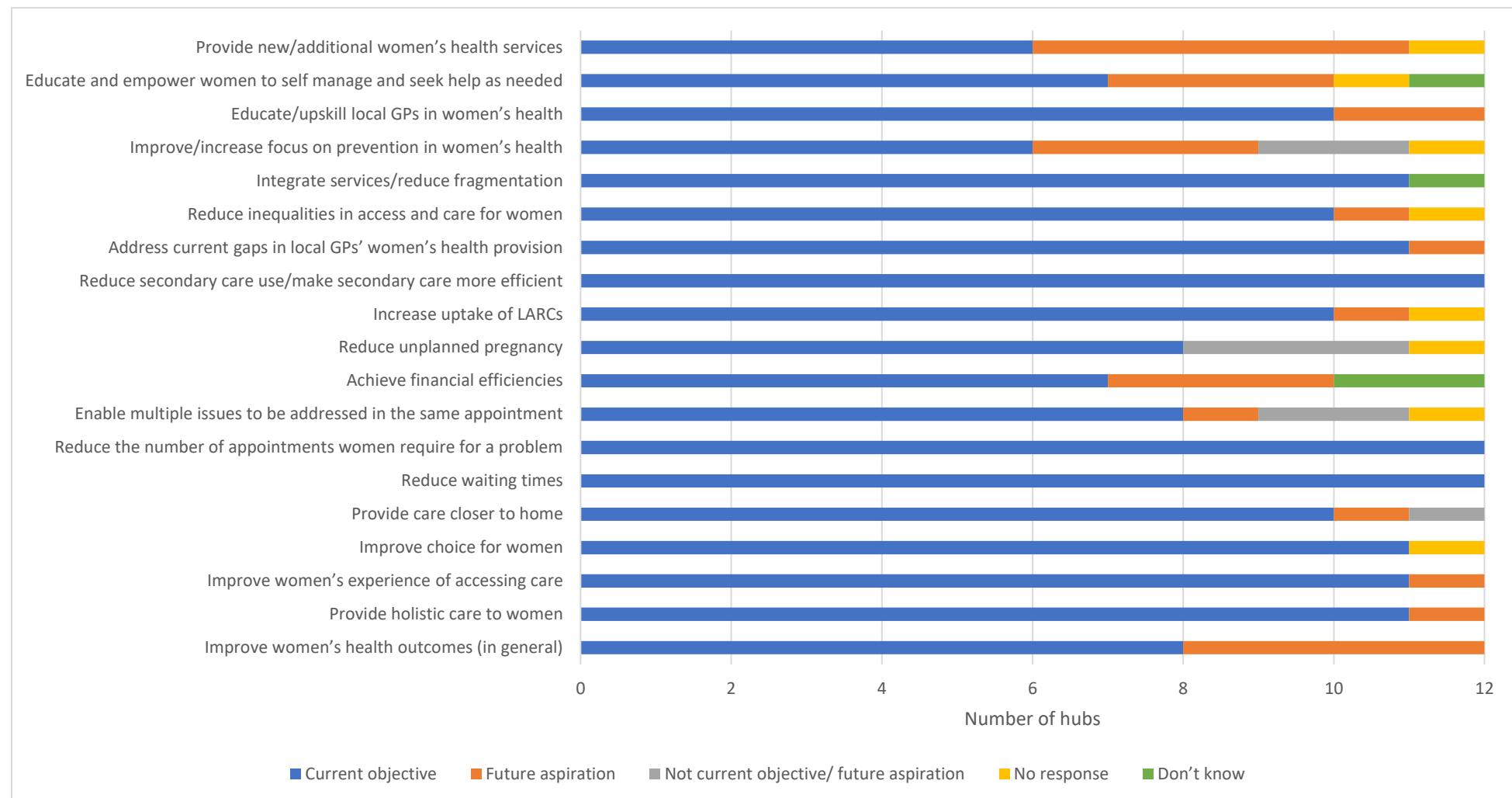
One important way to understand and describe WHHs is by their overall model of working, i.e. how they are set up and deliver care. Of the hub sites that responded (N=11), the main models identified can be described as the following:

- Five hubs are one-stop shops, where services are brought together 'under one roof' in a single location.¹⁹
- Four hubs are hub and spoke models, which operate from a central anchor/hub with one or more 'spokes' supporting the provision of care.²⁰
- One hub is a hub and spoke model with a virtual element (online events and group consultations)
- None of the hubs identified are 'pop-up' models
- One hub is still developing its overall model

This suggests that there is some diversity in what hubs look like locally, and that there isn't a single model or approach, which has been developed and implemented.

While the model is a helpful way of understanding how WHHs operate, another key consideration is whether hubs offer women an opportunity to see a range of healthcare professionals during one visit/appointment, a frequently cited aspiration for WHHs. Of those hubs which responded to the question (N=10), most (6) reported that women are unable to see more than one HCP per visit. Two of these hubs have plans to offer this in the future. Respondents were asked to describe how women are referred to the hub (N=12). Most hubs reported taking referrals from primary care (GPs, N=8) with a small number offering self-referrals (N=3).

Figure 2 Objectives of Women's Health Hubs – current and future (N=12)



Commissioning and funding

Complex and fragmented commissioning arrangements for women's health are frequently identified as obstacles to providing effective and holistic women's health care. Commissioning was reported as a barrier to local services providing both gynaecological and contraceptive care. WHHs aim to provide a more integrated and collaborative approach to delivering women's health care services, designed around a woman's needs rather than organisational, funding and commissioning structures.

Table 2 presents a breakdown of commissioning arrangements in the hubs identified in our mapping survey to date. The most common commissioning arrangements is co-commissioning between local authority and CCG (or equivalent), which helps to support hub aims to provide both gynaecological and contraceptive care.

Table 2 Commissioning arrangements in hubs (N=13)

Commissioning arrangements	Number of hubs
There are no formal commissioning arrangements in place	2
Co-commissioned or combined commissioning between local authority and CCG (or equivalent)	5
Commissioned by local authority only	0
Commissioned by CCG (or equivalent) only	4
Via NHS Trust	1
Don't know	1

Of those that responded (N=11), four hubs received additional funding for their hub service while seven hubs reported not receiving any additional money.

Clinical leadership and governance

The findings from the survey highlight a variety of models which best describe the clinical leadership in the hubs identified so far. These can be described as follows (N=12):

- Seven hubs are GP-led
- Two hubs are led by an SRH consultant
- One hub is led by a gynaecology consultant
- One hub has a shared leadership model (between GPs with special interests in women's health (GPwSI), a consultant in gynaecology and consultant in SRH).
- One hub is led by a Community gynaecology consultant

While the most commonly reported model that best describes the clinical leadership in the hubs identified so far is a GP led model, there is substantial diversity in the approach taken across the UK.

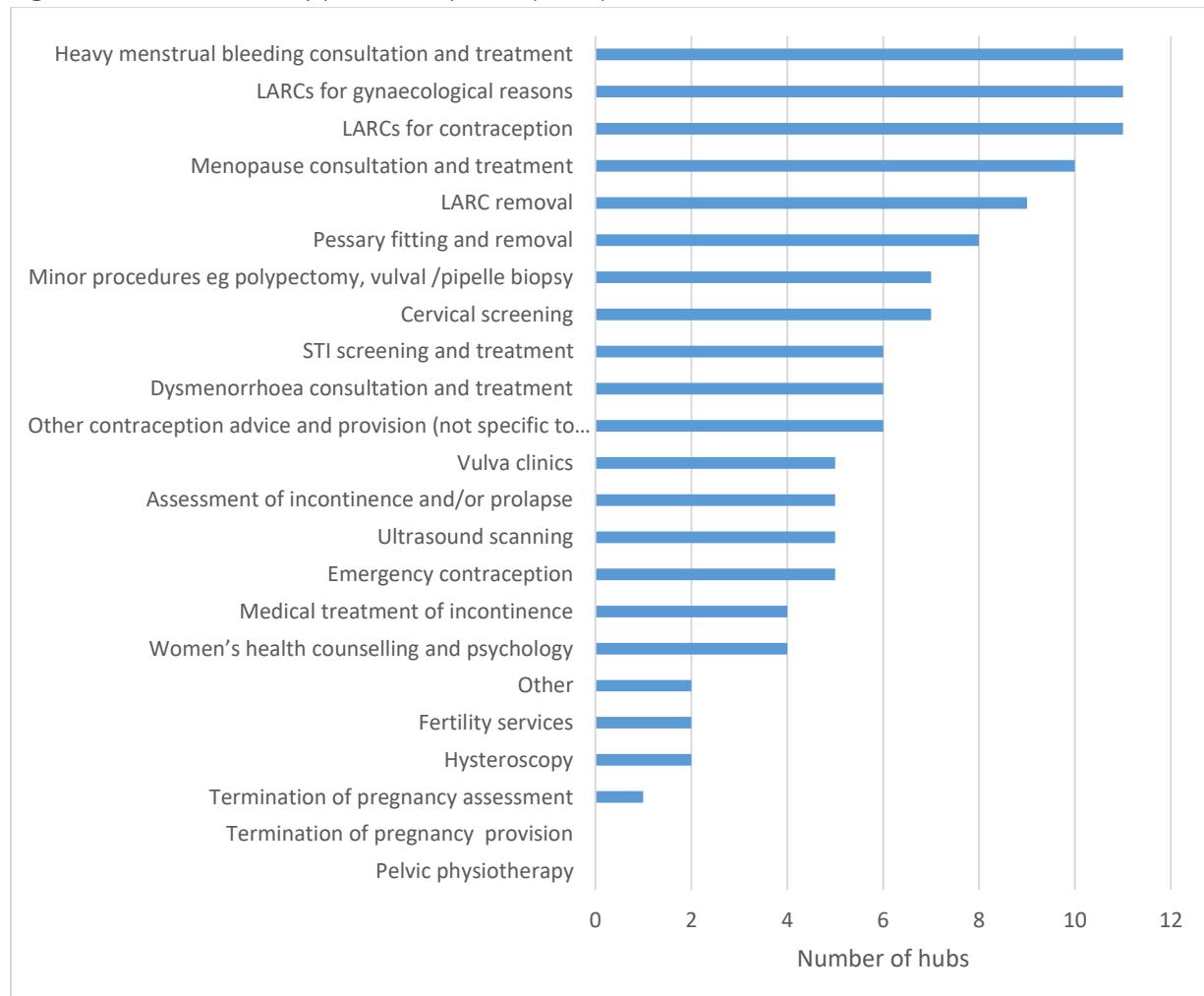
Services provided by hubs

The range of services provided by different hubs is an important consideration for the ambitions, development and implementation of WHHs across the UK. Figure 3 shows the variety of services currently offered by those hubs included in our mapping survey.

The majority of hubs reported offering LARCs for gynaecological (11) and contraceptive (11) reasons, with ten hubs reporting offering both, suggesting that it is possible to overcome the challenge of LARC provision for all reasons. Consultations for heavy menstrual bleeding and menopause are also frequently reported.

Pelvic physiotherapy and termination of pregnancy are not offered in any of the hubs currently identified.

Figure 3 Services currently provided by hubs (N=12)



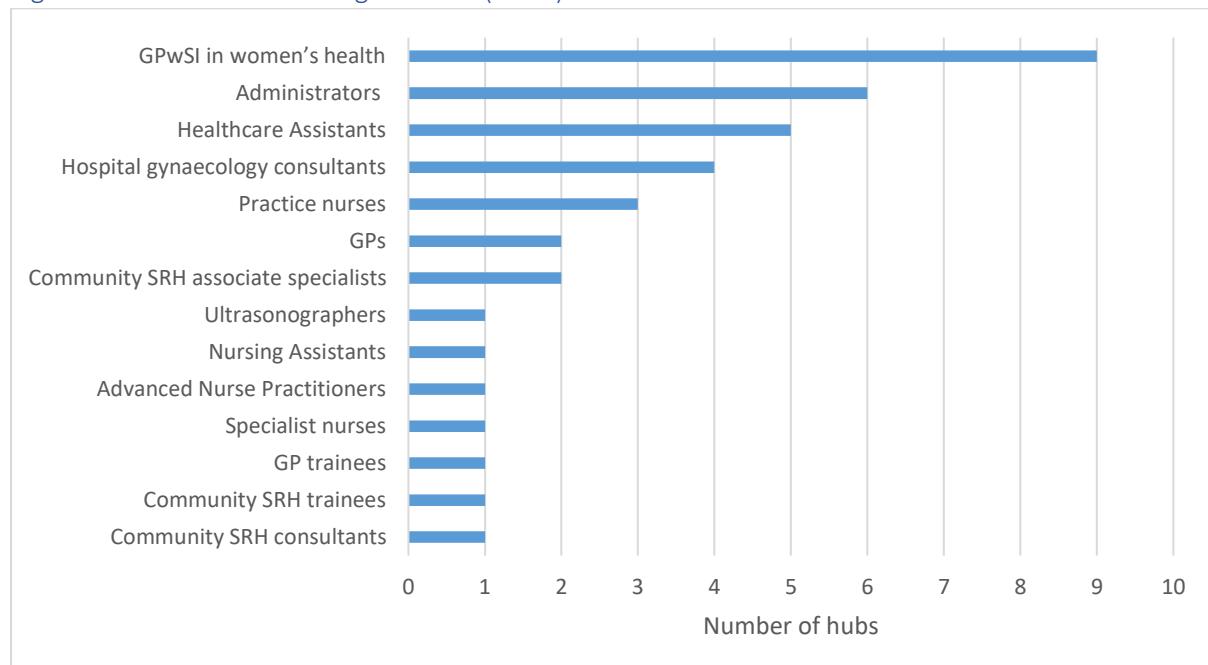
Workforce

An aspiration for WHHs is to bring professionals and services together to support women, offer a wide range of easily accessible women's health services and provide more holistic, integrated care. Workforce is a fundamental component of achieving this aim.

The survey explored which professionals work in WHHs. GPs with a special interest in women's health are the most common professionals working within hubs, followed by administrators and healthcare assistants.

Figure 4 presents the range of staff working in hubs. None of the hubs are reported as being staffed by hospital gynaecology associate specialists/trainees, GUM consultants/associate specialists/trainees, physiotherapists, physician assistants/associates, care assistants, pharmacists, counsellors or data analysts.

Figure 4 Professionals working in WHHs (N=10)



Training

While workforce is an essential component of the ambition to develop and implement WHHs, training is another key function in supporting wider implementation and sustainability of such models. The survey findings reflect that the hubs identified to date are playing a role in building capacity in the wider health system by providing training in women's healthcare.

Of the hub sites that responded to the question (N=13), only one hub reported that no training is currently being offered.

Types of training reported by sites included:

- LARC fitting
- Ring pessary fitting
- Menopause training
- GPwSI training
- Observations/shadowing opportunities for health professional training

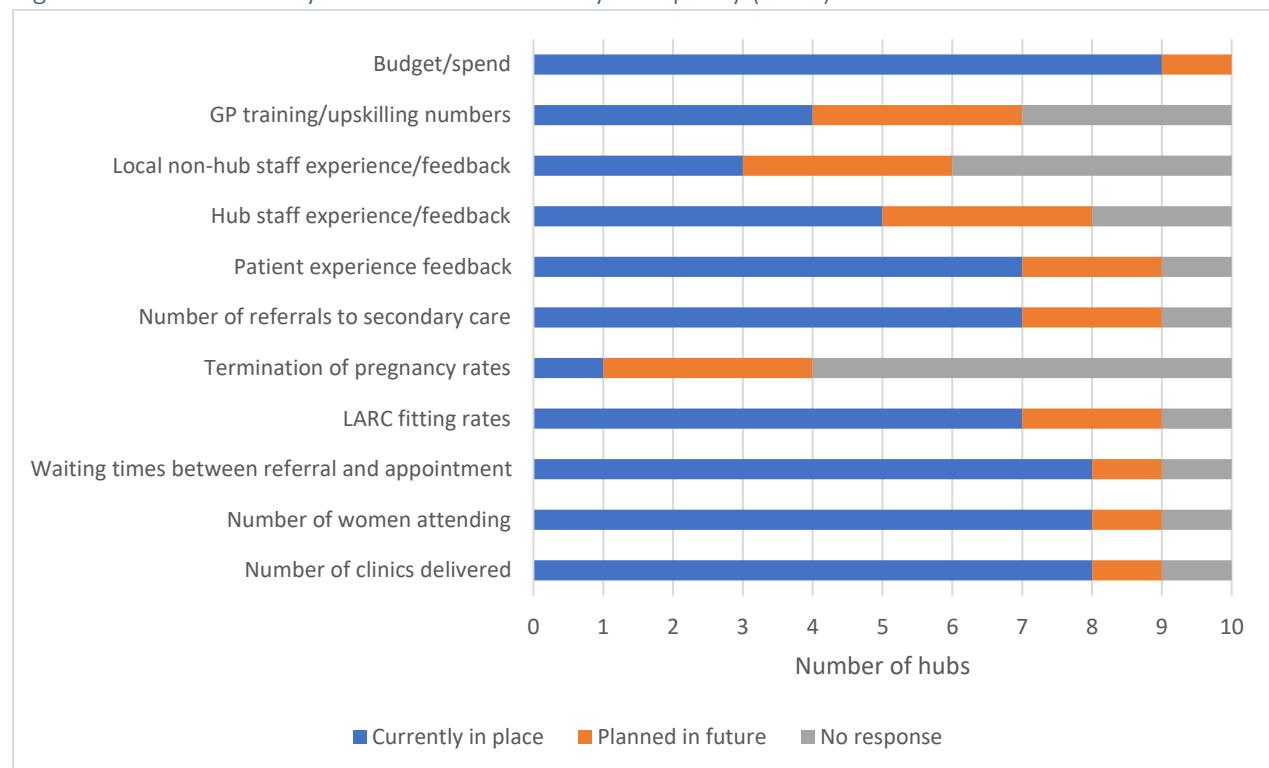
Hubs (N=9) reported that competency to work in the hub is determined primarily using training qualification evidence, with some hubs implementing annual appraisals.

Data used to monitor activity and quality (now and in the future)

In order to understand more about the data collected to monitor the performance and any early outcomes from WHHs, the survey explored the data currently collected by hubs, as well as plans for future data collection.

Ten hubs answered this question (Figure 5). Budget information is the most commonly collected data (nine out of ten hubs). Termination of pregnancy rates is least likely to be collected.

Figure 5 Data collected by hubs to monitor activity and quality (N=10)



Facilitators and barriers to hub implementation

To understand more about WHH implementation and experiences to date, survey respondents were asked to share up to three facilitators and barriers to the implementation of their hub. The most common factors are presented in Table 3.

Table 3 Common facilitators and barriers highlighted by survey respondents

Common facilitators	Common barriers
Collaborations/relationships across services and organisations (N=6)	Funding issues (e.g. lack of funding or complex/siloed funding/commissioning arrangements) (N=6)
Committed and experienced GPs (N=5)	Challenges with IT systems (particularly integrating across different IT systems) (N=4)
Supportive leadership (N=4)	Staff recruitment and/or capacity (N=4)
	Finding sufficient physical space to offer services (N=4)

Facilitators N=11 responses

Barriers N=13 responses

Cross-organisational or service relationships appear to be a key to hub implementation, supported by strong leadership and GPs who are experienced and committed to getting hubs off the ground and embedded. In contrast, practical issues, such as those related to funding and commissioning are key challenges, which mirrors wider reflections about the difficulties of funding cuts and the barriers posed by commissioning in women's health.

4. Insights from our Women's Advisory Group

As mentioned earlier, our Women's Advisory Group, has provided invaluable feedback and reflections to help to support the evaluation, and shape the design and conduct. They also shared insights regarding hubs, a brief summary of some of the emerging messages from these meetings is presented below.

- The terminology used to describe these services i.e. 'hubs' is confusing and implies a physical location with a range of services all under one roof. Women also asked questions about the inclusivity of use of the term 'women', though it was also acknowledged that using 'women' helps to distinguish the hub service from others.
- It is important that WHHs consider how to reach all communities, including ethnic minorities, those who are disadvantaged and/or under-served by existing services. There were concerns about what the outcomes might be for women who do not or cannot engage with hubs, and therefore that hubs could worsen inequalities.
- Hubs should carefully consider how they communicate with women. Clarity around the hub offer is key for women, both to ensure awareness but also understanding about what they offer and how they link with other health and care services for women. There was also a sense that more could be done to publicise the new Women's Health Strategy to women in general, and there was a perception that awareness of the Strategy was low.
- Linked to this, it was felt that there is a lack of clarity around what hubs are aiming to do, which services are 'in' and 'out' and where the boundaries between hubs and other services lie, and what is considered to be 'women's health'. Concerns were raised around whether mental health services would be included, and there was confusion regarding how maternity pathways fit with the work of hubs, as maternity care was viewed as a central part of women's healthcare.

We will continue to work closely with our Women's Advisory Group throughout the evaluation, including during the final reporting stage, using their experiences and insights to shape our work.

5. Selection of in-depth evaluation sites

The early evaluation work described in this report enabled the development of criteria for selecting exemplar hubs for in-depth work in a number of ways, for example:

- Findings from survey, in particular the heterogeneity of models highlighted the need to maximise diversity in the sites selected.
- A review of the literature on integrated care showed the importance of contextual factors, such as whether hubs are implemented in urban or rural areas.
- The views of our Women's Advisory and Stakeholder Groups helped us to develop a list of criteria and shared views on their relative importance.

A long list of over ten dimensions on which hubs could differ was developed from this early work, including size/catchment area, workforce mix, and local deprivation. To select the in-depth hub sites for evaluation, the team worked with our Stakeholder and Women's groups to prioritise the hub characteristics/dimensions and contextual features. Five priority criteria were used for the final selection of exemplar sites, the process for which took place over a number of team meetings. We selected four exemplar sites from those who completed the survey based on the following criteria, aiming for maximum variation:

- **Stage of development of hub site/whether services are up and running:** most sites are still in a stage of development as this a relatively new initiative often characterised by incremental improvements and growth. Nevertheless, hubs need to be actively offering services to patients so that data can be collected.
- **Location/geography:** this includes consideration of the nation of England, so that findings represent any regional variation, and whether hubs are in rural or urban areas. This is because literature on integrated care demonstrates unique barriers and facilitators for the success of hubs models based on rurality.
- **Clinical leadership** (i.e. GP-led or consultant-led): our early work suggests this may be a dimension on which some hub models differ, with suggestions that it could be important to investigate.
- **Commissioner** (i.e. commissioned by NHS or local authority commissioners, or joint-commissioned) and role of commissioning (extent to which the hub was developed with input from commissioners): as above, our early work suggests this may be a dimension on which some hub models differ, with suggestions that it could be important to investigate
- **Type of hub model** (i.e. hub and spoke, one-stop-shop): a key aim of the evaluation is to capture the variety of ways that hubs are structured.

Other criteria that formed the long list were used to ensure comprehensiveness in our approaches, for instance, the data collected from sites, and the ways in which we will present our findings in the final report.

6. Key messages and implications

Defining and locating hubs.

The work so far has identified the diversity and complexity of WHH models across the UK, with differing perspectives regarding the role and definition of a 'hub'. Stakeholders including women have highlighted that the term 'hub' is being used increasingly across health and social care settings, with different interpretations, and considerable scope for confusion. Some have expressed a preference for other terms, such as 'network'. Some leaders are running services which constitute a hub, but do not label them as such. Locating, mapping and defining hubs has proved more challenging than expected, with varied definitions, scope and nomenclature. While there are multiple examples of models of interest, e.g. 'one stop shops', findings so far suggest that labels are applied differently, and we will explore assumptions about how individual models function in our ongoing empirical work. Services offered also currently vary considerably, though many hubs describe ongoing development and incremental growth of models. It was rare for hubs to offer care from more than one health professional in the same visit. The role of hub services in training and capacity building in the wider system was also not consistent across the country.

It is important to note that there are other services in this space which are excluded from our definition of a WHH, such as community gynaecology and services which focus on the needs of specific groups of women. While they are not explored in-depth in our evaluation, they are an important part of the women's health service landscape.

Implications

The diversity of WHH approaches in place across England means that this is a complex policy and practice area. There is no standardisation of models, and a lack of common language or application of the term 'Women's Health Hub'. Through this evaluation we have worked to articulate a clear definition of WHH, and we will continue to collaboratively refine this as the work progresses. We will also continue work to identify additional hubs to map the landscape as accurately as possible. A key question for policy and practice is whether this diversity can and should be embraced, and to what extent some agreement and standardisation could or should be sought. If the diversity is to continue and the nature and role of hubs is not clear, it risks confusion for women, professionals and policymakers, which may impact on engagement, implementation, uptake and evaluation/monitoring. Variation may also perpetuate inequalities with different approaches in different places. However, if there is too much top-down standardisation WHH leaders may not be able to adapt their models to fit local needs, context, workforce and resources, particularly during a time of ongoing financial constraint in the NHS. It is likely that a balance needs to be struck between standardisation and locally defined models, and the learning is still ongoing regarding the relative benefits and limitations of different models. We will explore the boundaries and implications of this as the evaluation progresses. We have selected a diverse range of in-depth evaluation sites to explore and compare the diversity of models to maximise the learning.

Implementation progress and focus.

Our work so far suggests that areas with hubs in place are in the minority, and that while there are some well-established hubs, many services are at a relatively early stage of development. Most hub leaders in our survey described plans for expansion of scope and reach, for example by adding in additional services. Provision is often focused on LARCs, rather than 'one stop shop' care, though there are many examples of additional services. Some services, such as abortion care and psychosexual counselling, were not provided at the current time. Objectives around improving efficiency (e.g., reducing appointments required, reducing waiting times, reducing secondary care use) currently appear to be the most common for hubs.

Implications

The current small number of hubs and early stage of development for many indicates that it will take some time to scale up and spread WHHs across the NHS, and for existing models to reach their full potential and to offer women multiple services in the same place/visit. This presents an opportunity to develop guidance, align approaches (where appropriate), and to capture the learning from different ways of working. Hubs often have a focus of addressing a key recommendation of the Women's Health Strategy: increasing access to LARCs, with plans to expand over time. The focus on efficiency reflects general pressure on healthcare systems and desire to streamline and improve experiences of care within finite and stretched resources. This also aligns with the Women's Health Strategy's commitment around encouraging the expansion of WHH and other models, to "*create efficiencies for the NHS*".^{4 p11}

Measurement of activity and impact.

Measurement of hub processes and outcomes appears to vary between sites, with sites refining and developing their approaches. We have not assessed data quality, but it is likely that this also varies. The role of local data in driving service design also appears to differ between sites. Often data collected focuses more on outputs and activities rather than outcomes. While hub leaders aim for models to reduce disparities, evidence is still emerging regarding whether this is achieved in practice.

Implications

The variation presents challenges in evidencing activity and impact, and comparing models. Our stakeholders, including our Women's Advisory Group, were clear that hubs must address inequalities in access, care and outcomes, and standardising the approach to measuring the impact on inequalities is required to evidence whether this has been achieved in practice. We will explore the impact on inequalities in our in-depth evaluation sites.

Implementation facilitators and barriers.

While the survey provided high level insights regarding key barriers and facilitators experienced by hub leads, we are exploring them in depth through our hub site, regional and national interviews, and documentary review, and will present detailed findings in the final evaluation report.



The findings and interpretation presented in this early report will be refined as more data is gathered and analysed as the evaluation continues. An important part of our analysis will be to explore the dimensions of integration in different hub models and contexts, and compare with what is known regarding integrated care models.

Limitations and caveats

There are several limitations and caveats that should be borne in mind for this interim report:

- Many WHHs have been identified through the work to-date. However, there is no comprehensive list/database of hubs, and they are understood differently by stakeholders – there is no single, agreed definition. The term ‘hub’ may be unclear to some – implying a physical location, and the term is being used in different ways across health and social care services. Further, there is substantial variation in approaches and in perspectives regarding what hubs could/should be. As a result, it has been challenging to identify women’s health hub models across the UK, particularly, as stakeholders in local areas may not recognise their service as a hub.
- In light of the difficulty in locating these models, it is possible that other examples exist that we have not yet uncovered.
- Survey respondents from local hub sites may not be familiar with all the details of their local WHHs. In some areas, multiple hubs exist. We mitigated this risk by leaving the survey open for a long period to obtain as many responses as possible. Further we are aiming to identify numerous stakeholders in each hub site area with whom to liaise about potential hub models.
- The survey findings reported represent a snapshot in time and so reflect each hub’s development and progress at the time it was completed. It is possible that there has been changes or advances in hub sites since survey completion.
- A number of sites submitted partial responses and so for a range of questions, we are unable to report our findings as a complete dataset.

7. Next steps for the evaluation

As the report outlines, we have already learned a considerable amount about developed and emerging women's health hubs.

Data collection so far has focused on high-level insights at a strategic level, and mapping the landscape through identifying hub sites across the UK. There are many important stakeholders who are not represented in this interim output, including frontline staff working in women's health hubs and women using hub services.

In the next stage of fieldwork, we will be focusing on speaking to a range of professionals, women and community groups in four in-depth evaluation sites to ensure that we capture both breadth and depth in findings, and obtain a detailed understanding of hub implementation, experiences and achievements to inform policy and practice.

Areas that will be explored include:

- Experiences in setting up, implementing and delivering hub sites and/or working with the hub
- Service user experiences of receiving care as part of a Women's Health Hub
- If and how hubs are addressing local health inequalities, e.g. in access and outcomes
- How services are responding to the needs of different women
- How performance and outcomes are measured in the hub
- Any insights or evidence of outcomes or impacts
- Key learning to date

Overview of remaining fieldwork

This next phase of fieldwork focuses on exploring WHHs in more depth, primarily through qualitative evaluation. This work includes:

- Interviews with regional stakeholders (n=7)
- In-depth interviews with staff (n=7) and service users (n=8) at each exemplar hub site
- Focus groups with women in local communities (via community groups) (n=4)
- Documentary analysis of relevant hub documents, e.g. business cases
- Interviews with national stakeholders (n=4-5)
- Rich description and map of UK Women's Health Hubs
- Identification of outcomes which are/could be used to assess impact
- If possible, development of a preliminary theory/ies of change
- Recommendations for policy, practice and evaluation

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