Women's Health Hubs: a rapid mixed-methods evaluation

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Published September 2024
DOI 10.3310/JYFT5036

Scientific summary

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Health and Social Care Delivery Research 2024; Vol. 12: No. 30
DOI: 10.3310/JYFT5036

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Background

Sexual and reproductive health covers a range of needs and conditions, including contraception, pregnancy and abortion, sexually transmitted infections (STIs), psychosexual services (e.g. counselling for sexual dysfunction), and gynaecological health (e.g. peri-menopause, menopause and menstrual problems) [All-Party Parliamentary Group on Sexual and Reproductive Health. Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the *COVID*-19 Pandemic (Internet). 2020. www.fsrh.org/documents/womens-lives-womens-rights-full-report/ (accessed 24 October 2023)]. Women's sexual and reproductive health needs are complex and vary across the life course, and they are met by a variety of providers, venues and professionals. In England, challenges in access, workforce, funding and fragmented commissioning impact on women's health service provision.

In response to these challenges, local teams across the UK established Women's Health Hubs (WHHs) to improve provision, experiences and outcomes. WHHs aimed to integrate women's health services more effectively, with a more woman-centred, life-course approach. These emerging models were highlighted as best practice and wider adoption was subsequently recommended as a part of England's Women's Health Strategy in 2022. However, there was no agreed definition of a WHH in clinical and policy communities. Hubs were described as not necessarily a 'place', but a 'concept', and the term was being used differently across services and organisations.

In response to WHHs being identified as an important policy topic, in 2022, the National Institute for Health and Care Research (NIHR) asked the BRACE Rapid Evaluation Centre to undertake a rapid evaluation of current hub evidence and practice.

Objectives

The aim of this evaluation was to explore the 'current state of the art' of WHHs, 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. The evaluation explored the following questions:

1. What are WHHs, and is there variation in how stakeholders name and define them?
2. How many WHHs have been established or 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 WHHs achieve this?
5. What are the experiences and perspectives of staff regarding WHH set-up, commissioning, funding, implementation and delivery?
6. What are the experiences and perspectives of women who have used hub services?
7. How are WHHs' performance, outcomes and costs measured, and how might they be measured in future?

Methods

This was a mixed-methods evaluation, combining quantitative and qualitative data collection, with data collected at local, regional and national levels. This approach offered both breadth and depth in data collection. The evaluation comprised three work packages (WPs):

1. Mapping the current landscape and context for WHHs, including an online survey of leads from hubs across the UK and interviews with regional stakeholders.

2. Detailed research in four purposively selected exemplar hub sites in England, including interviews with staff and service users, focus groups in local communities and documentary analysis.
3. Bringing together and consolidating findings from WPs 1 and 2 to generate evidence on WHH models, including interviews with national stakeholders.

The mapping in WP1 was UK-wide, but the remainder of the work focused on WHHs in England. The England focus was decided collaboratively with a multidisciplinary Stakeholder Group, due to the particularly complex commissioning context in English health and social care systems.

In total, interviews with 85 people were conducted: 40 WHH and wider staff, 7 regional stakeholders, 6 national stakeholders and 32 women. Four focus groups were undertaken with women in the local communities served by exemplar hubs. Ten initial scoping interviews undertaken to inform protocol design were included in the analysis.

Results

There were diverse approaches to implementing WHHs across England, with no standard or 'typical' model, and a lack of common language and terminology to describe hubs. A hub can be interpreted as a physical place, but also as a virtual platform (e.g. to triage or offer educational events for women), which can be difficult to understand for some stakeholders, including some women. In collaboration with our evaluation Stakeholder Group, and based on our findings across WPs, we developed a working definition of a WHH that represents a set of common features that were recognised within the community of practitioners as typifying a hub approach:

- Women's Health Hubs are based in the community and work at the interface between primary and secondary care and/or voluntary sector and wider.
- Women's Health Hubs offer more than a single service (and include the provision of both gynaecological services and contraception) or demonstrate plans to do so.
- Women's Health Hubs have more than one organisation involved in the process of service delivery, including in design, commissioning and/or provision of care, beyond simply referring in.

This definition should be considered alongside the need for hub design to be tailored to local contexts, needs and resources. As a result, we have not specified which model(s) should be used to implement hubs, which role(s) should lead design/delivery or other details about how the hub is established and resourced. While this offers flexibility to local areas to design a service that meets local needs, there is a risk of creating confusion for women, healthcare professionals and policy-makers regarding what a hub is and should do. This may impact on engagement by these groups and on hub implementation. The heterogeneity in hub models can also hinder evaluation, monitoring and comparison of hub impact.

The working definition we have developed can be refined over time in response to evolving evidence and practice. A clear definition can support policy and decision-makers to better understand which models work best for women, including those from groups with greater needs, and which are most effective (including cost-effective). Further refinement of the definition could include standardisation of terminology, for example, to confirm the number and type of services that constitute a 'one-stop shop', and whether the 'spoke' aspect of a 'hub-and-spoke' model must be a physical location or could be virtual. Clear definitions of a hub may also avoid simple rebadging of local services as hubs in response to policy initiatives, without meaningful transformation of care pathways.

We identified 17 active WHHs across the UK. This means that most women did not have access to a hub at the time of data collection. Most of the hubs we identified were continuing to evolve and had plans in place to expand their offer and/or geographical reach. Hubs were introduced to meet a range of aims, primarily intending to improve healthcare access, quality and experience. Hub leaders were committed to reducing

inequalities and many were implementing strategies to do so but approaches and evidence were still evolving. Hub services were often described as filling the intermediary space between standard primary care and specialist secondary care, although this boundary varied across hubs. Hubs were predominantly clinically led by GPs with a special interest in women's health, although some were led by other professionals. Often, leadership was not well defined, with unspecified responsibilities and accountabilities, and a blurring of leadership, management and governance boundaries. While many hubs were reported as being one-stop shops, it was rare for them to offer multiple services at the same time and those that did were often opportunistic rather than a planned service offer (e.g. offering a smear test at the same time as fitting a coil). Most hubs operated from multiple venues, often in primary care or community settings. The professionals working to deliver services within hubs varied, and there was no consistent approach to staffing, with different costs associated with the roles deployed.

A range of commissioning approaches were in place, often involving collaboration between multiple organisations. Given the challenges in securing funding and overcoming commissioning barriers, hub leaders had developed a range of creative approaches to accessing resources for implementation and delivery. However, these innovative local workarounds may not be suitable for long-term, sustainable scale-up and spread of WHHs. Some hubs had been unable to expand their clinical offer due to pre-existing commissioning barriers. Challenges included moving funding or activity from secondary care gynaecology to WHHs and identifying a long-term solution to enable offer of long-acting reversible contraception (LARC) for both gynaecological and contraceptive reasons in a hub. Resolving these challenges was often described as critical to successful implementation of hubs. In addition to financial resources, some hubs had secured additional expertise and capacity to support implementation, including from other areas of the health system, local authorities and pharmaceutical companies.

Development of metrics and the measurement of hub outcomes was evolving and varied between hubs, making comprehensive assessment and comparison difficult. Some hubs had used local data to measure and model population need to inform hub design, and to estimate hub costs and benefits. Available data to quantify hub activity and impact so far were limited, but where reported it indicated that hubs had provided care for many hundreds of women in England. It also indicated that hubs have the potential to reduce waiting times and referral to secondary care gynaecology and increase LARC uptake. Evidence of impact on inequalities was still emerging. Women who participated in the evaluation reported having a positive experience of accessing their local hub and the care they received. However, women using the hub and other local women in the community were generally not familiar with the term 'women's health hub' or did not know that they had received care from a hub, though they welcomed the hub concept. Women also described some challenges in accessing hub services, including difficulties making a GP appointment in order to be referred to the hub.

A minority of hubs reported involving women in the design and development of the service. There is scope for greater involvement of women with a range of backgrounds and experiences in WHH development at both a national and local level to ensure that they meet the needs of all women and address inequalities.

A number of factors facilitated the implementation and delivery of WHHs. This included leaders (both clinical and non-clinical) who were committed to the hub vision and worked collaboratively across organisational and sector boundaries to design and set up the service. Sufficient workforce capacity and wider policy and strategic support were also important. Implementation challenges included identification of funding and other resources (e.g. facilities equipment, physical space), stakeholder engagement (including allaying concerns regarding negative impacts on other parts of the system), competing priorities and pressures in the healthcare system, and IT issues. The fragmentation of English commissioning arrangements for gynaecology and contraception was a frequently reported barrier. We identified examples of hubs that had overcome some of these barriers to integrate care for women in their area.

The creation of Integrated Care Boards (ICBs) in 2022 was seen as a potential route to scale-up hubs nationally. The lack of an ICB leader with responsibility for women's health (with the exception of

maternity) was noted as a challenge. The many competing priorities for ICBs were highlighted as limiting capacity to focus on women's health. Subsequent to the completion of our evaluation in 2023, additional national funding was announced linked to the Women's Health Strategy, to support the setting up of a WHH in each ICB in England, along with the appointment of a Women's Health Champion in every ICB.

Hubs had largely been developed bottom up by local professionals, designed to meet the specific needs of the local population. Participants often reflected that a top-down approach to implementing hubs may limit the flexibility to adapt to local needs, context, leadership, workforce and resources. A middle ground between a bottom-up and top-down approach may be required to balance standardisation across hubs (e.g. to have a shared vision and definition) with flexibility to align with local context.

Hub establishment was still in the early stages, and it will take time to scale the approach up across the NHS and to ensure long-term sustainability of services, and localities were all at different starting points. The small number of highly diverse hub models in place at the time of this evaluation and varied approaches to measurement meant that it was challenging to assess impact. However, it highlights the opportunity to develop resources to support local systems to design and establish hubs, agree on core definitions and model components, standardise approaches (where appropriate), capture learning/data and test assumptions of different ways of working. Implementation efforts should include exploring and understanding any unintended consequences, a common occurrence when introducing complex changes into health systems. Agreeing some aspects of standardisation (where appropriate), sharing learning and measuring outcomes and impact data can facilitate future and ongoing implementation and evaluation of WHHs, and allow exploration of the relative benefits of different models. This learning can inform further scale-up of and development of WHHs.

Conclusions

At the start of this evaluation, WHHs were a set of innovative service models spread across the UK, and at the end of the evaluation, they were an explicitly stated policy objective for the Department of Health and Social Care (DHSC). Our findings identified that the few existing WHHs are diverse, and continuously evolving, with many at an early stage of development or delivery, with some employing innovative approaches such as virtual group consultations. The launch of the Women's Health Strategy, and the associated funding to support hub implementation announced in March 2023, provides an opportunity to expedite the spread of these models. However, the heterogeneity in models and contexts, and the complexity of women's health care, means that rapid scale-up may be challenging, and substantial commissioning barriers must be overcome. Our findings suggest that implementing models informed by local needs and resources will be necessary, and requires input from women, particularly those who are least well served by current services. We do not yet have clear evidence for the system-level impact or costs of WHHs, and the gathering of consistent data to test assumptions, and measure and learn from WHH achievements, including impacts on inequalities, will enable evaluation of further scale-up. WHHs have the potential to transform women's access to care, and there is a large community of experts striving to improve women's health care. The Women's Health Strategy for England provides a further catalyst to national-level change, alongside the emerging system-level approaches to health improvement driven by ICBs, and wider population interest in women's health.

Funding

This award was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research (NIHR award ref: NIHR135589) and is published in full in *Health and Social Care Delivery Research;* Vol. 12, No. 30. See the NIHR Funding and Awards website for further award information.

Health and Social Care Delivery Research

ISSN 2755-0079 (Online)

A list of Journals Library editors can be found on the NIHR Journals Library website

Health and Social Care Delivery Research (HSDR) was launched in 2013 and is indexed by Europe PMC, DOAJ, INAHTA, Ulrichsweb™ (ProQuest LLC, Ann Arbor, MI, USA), NCBI Bookshelf, Scopus and MEDLINE.

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: journals.library@nihr.ac.uk

This journal was previously published as *Health Services and Delivery Research* (Volumes 1–9); ISSN 2050-4349 (print), ISSN 2050-4357 (online)

The full HSDR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr.

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This article

The research reported here is the product of an HSDR Rapid Service Evaluation Team, contracted to undertake real time evaluations of innovations and development in health and care services, which will generate evidence of national relevance. Other evaluations by the HSDR Rapid Service Evaluation Teams are available in the HSDR journal.

The research reported in this issue of the journal was funded by the HSDR programme or one of its preceding programmes as award number NIHR135589. The contractual start date was in April 2022. The draft manuscript began editorial review in April 2023 and was accepted for publication in November 2023. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HSDR editors and production house have tried to ensure the accuracy of the authors' manuscript and would like to thank the reviewers for their constructive comments on the draft document. However, they do not accept liability for damages or losses arising from material published in this article.

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