Achieving success with the Women's Health Hub (WHH) model - Joint position of the RCOG, the RCGP, the FSRH and the BMS

1. Introduction

The overarching ambition of the Women's Health Hub (WHH) model must be to improve women's access and experiences of care by better integrating the services and support they require throughout their reproductive life course. Integrated Care Systems (ICSs) have a unique opportunity to improve the way care pathways work for women living in their footprint, determining priorities based on local need.

This position statement sets out the joint position of the Royal Colleges and specialist societies representing healthcare professionals working across primary care, secondary care and sexual and reproductive health services on how best to harness the potential of the developing WHH model. It sets out a consensus position on the definition and aims of the hub model, considers key enablers and barriers to success, and outlines considerations for women's health services that systems provide and how they can be brought into hub models.

2. Definition of the women's health hub model

Placing too strict a definition of a Women's Health Hub model on the Integrated Care Systems that will lead on their development risks reducing the potential for systems to deliver a model of care that is best suited to populated need locally, and builds effectively on existing services and community assets.

However, the interim findings from the NIHR-funded study found significant variation in existing Women's Health Hubs, many of which had little in common in the way they were commissioned and delivered, and the services they offered to women[i]. There is a risk in the definition of a women's health hub model being diluted to the point that services are able to define themselves as hubs without demonstrating how they are improving access, experience and outcomes in women's health.

The DHSC should set out a definition of the WHH model, the proposed accreditation mechanism set out in the Women's Health Strategy could then be used to recognise models that meet the definition. Accreditation could be tiered, and should consider how closely models reflect nationally agreed aims outlined by DHSC, and achieves locally established outcomes.

This is essential to ensure that the WHH model is seen by healthcare professionals and women as a meaningful recognition that their local area is prioritising the commissioning and delivery of high-quality, integrated women's health services.

The definition of the WHH model should be centred around the primary aim to improve access to, experience of and outcomes in women's health across the life course in the local population, with a strong emphasis on reducing inequalities. The

hub model should result in more women being seen in the right setting, by the right professional, at the right time. This position statement provides further detail on the key areas for consideration when outlining the definition of the women's health hub model.

3. Aims of the women's health hub model

Although ICSs will need to set aims based on local population need, shared national aims of the hub model are important to support Systems to understand and deliver the vision set out in the Women's Health Strategy for England.

Key aims of the women's health hub model should include:

- Improved access to women's healthcare, and reduced inequalities in access between different groups of women
- Improved experiences of women's healthcare, and reduced disparities in experiences of care
- Improved outcomes in women's healthcare, particularly in relation to sexual and reproductive health and gynaecological health
- Improved integration of key women's health services across the whole system (including local-authority funded services), more collaborative ways of working between primary, secondary and CSRH services with joint leadership and governance
- Improved prevention of poor health outcomes throughout women's life course, harnessing the benefits of public health, prevention and early intervention services
- Improved knowledge and self-management for women, with high-quality information provision and signposting tailored to local need
- An increase in the services women can access in the community, where women live and work
- Primary care is equipped with the skills, experience and knowledge to provide high-quality women's healthcare as the front door to the NHS
- Improved efficiency across the system, reducing the number of appointments women need to attend, increasing quality of and reducing variation in secondary care referrals
- Improved workforce satisfaction and retention across the system, and increased use of multi-disciplinary team working

4. Building on existing services

The WHH model provides an opportunity for collaborative working between primary and secondary care, alongside sexual and reproductive health services, to ensure a holistic approach to women's healthcare provision.

GP practices care and support women close to home in a holistic manner, and are responsible for meeting many of women's sexual and reproductive healthcare needs alongside all other care women and their families need. Where primary care professionals require the support of specialist services in secondary care and sexual and reproductive health, the WHH model should become an essential bridge to improve collaborative working between services, support the delivery of high-quality women's healthcare outside of specialist services and mean that women can access care from skilled and knowledgeable healthcare professionals wherever they are in the system.

In order to make sustainable improvements to women's health and harness the benefits of the WHH model, there must be a focus on equipping primary care with funding, staffing

capacity and skills and knowledge to consistently deliver high-quality women's healthcare. The WHH model is a way to build on the services already offered in primary care and increase access to specialist care closer to where women live and work, this could include developing services set up similarly to long COVID clinics[ii], where specialists from primary care (such as GPs with extended roles) and secondary care and CSRH professionals work together to better meet women's health needs.

5. Services for inclusion

Services available within the WHH model should depend on local need, and sustainable growth of hubs will rely in part on ICBs taking the time design a hub model at a pace that allows for the necessary culture change, and ensure opportunities to learn from evaluation to improve services as they develop.

There is likely to be significant variation in how the services outlined in the appendix are currently commissioned and delivered in different areas, and the set-up of existing services should be a starting point for ICBs developing a WHH model. The table of services set out in the appendix of this position statement provides a wide-ranging list of services that could be included into a hub model as it develops, outlines some considerations for provision of the service, and finally considers some of the potential benefits if delivered successfully.

ICBs should consider building services into a hub model where there is an opportunity to improve women's access to and experience of care in their local area. Regardless of whether they are commissioned or delivered as part of a hub model, ICBs should reflect on how all of the services outlined below can be better joined-up, and are simple to navigate for women and the healthcare professionals supporting them.

It is well recognised that access to high-quality information in many areas of women's health is lacking, and addressing this is a central commitment in the Women's Health Strategy for England[iii]. The WHH model has a role in addressing this issue. **All women's health hub models should be commissioned to deliver locally tailored information in a range of formats suited to their local population, as well provision of signposting and support for women to navigate the local system and understand what services are available to them and how to access these services.** Information and signposting should be provided for key areas of women's health including menstrual health and gynaecological conditions, sexual health and contraception, pre-conception health and fertility, pregnancy, pelvic floor health, and perimenopause.

6. Location and models of delivery

It is important to recognise that implementing a WHH model will not always result in the creation of a new building or physical space as the 'hub'. Instead, ICSs should think of the hub model as building upon and better integrating the existing women's health services and support across general practice, secondary care and sexual and reproductive health (SRH) services. Co-location of services on existing sites will likely play a key part in the development of the WHH model.

Governance and location of hubs should not be specified centrally and as this might stymy understanding of effective models of care in the early development of hubs, and prevent local systems from developing a service that works effectively for their local population, and within their local system. The focus should be on integration of services across primary, secondary and reproductive and sexual health services. Integration of services should focus on how delivery can span across traditional boundaries, with models of shared delivery, co-

location of services, shared clinical leadership and governance, and shared workforce. **DHSC must provide resources to support effective integration of services that looks at solutions to existing barriers to integration, including issues relating to commissioning structures, historic workforce employment arrangements, and clinical governance and leadership.**

Co-location of services as part of a hub model in order to increase the availability of services closer to the community, reduce the number of appointments women have to attend (the 'one stop shop' model), and allow healthcare professionals from different parts of the system to work more closely together should be considered where this has the potential to improve access and experience of care. Alternatively, models that better integrate existing pathways to reduce the need for multiple referrals and allow healthcare professionals to deliver care based on women's needs without being prevented from doing because of where they are in the system.

It is our joint view that hubs should be built out from existing primary care and community services - ensuring they are close women and sit within communities, building on existing skills and experience within the primary care workforce and in the community. Primary care networks should be central to the development of women's health hubs, with a recognition that GP practices offering a wider range of services within a 'hub' would improve access and experiences of care. The role of community assets and local VCSE organisations will also be important.

Women's Health Hubs should be commissioned by Integrated Care Boards and there should not be a one-size-fits-all model for modes of delivery. However, Hubs should focus on better integration of services through addressing historic fragmented commissioning of women's sexual and reproductive healthcare, introducing shared/pooled budgets or co-commissioned services across the NHS and local authority. **It remains our shared position that commissioning for all women's health services including contraception should sit under the remit of the NHS, or at a minimum there should be mandated co-commissioning of SRH services.**

The location of services should also reflect clinical guidelines on where specialist care is recommended, as well harness opportunities to integrate or co-locate services closer to the community. Where news models of care look to increase the availability of services outside of hospitals, DHSC should work with professional bodies and specialist societies around workforce competencies to ensure the high-quality provision of care.

7. Workforce roles and training

Workforce planning must be undertaken on a system-wide basis, identifying the skills and roles needed to deliver key services, and building the workforce based on skills and competencies required rather than assuming the need for particular professional groups or parts of the system to take on particular roles simply because that is the way services have historically been delivered. The WHH model is an opportunity for ICBs to review the skills and experience around women's health in the existing workforce, identify gaps and invest in the necessary training and development to equip professionals to deliver high-quality women's healthcare across the system.

It is important to recognise that there are existing workforce pressures across the health service and therefore recruitment of specialist roles (e.g. women's health physiotherapists, menopause specialists, SRH specialists) can be challenging. ICBs should set aside funding to invest in training and development of the workforce to support the delivery of the hub model. All healthcare professionals should be able to work to the top of their license, and

non-clinical roles should be considered to provide additional support and free up clinical capacity. Where the hub model sits within primary care, opportunities to make use of the Additional Roles Reimbursement Scheme (ARRS) should be taken advantage of.

In terms of clinical leadership and governance, there should not be a one-size-fits-all approach, and where possible co-leadership across primary, secondary and SRH services should be considered. **DHSC should work closely with, or consider commissioning, the RCOG, RCGP and FSRH to work in collaboration to develop a competency framework for leadership of the women's health hub model, as well as a framework for the skills and training required to work in a hub across key services that ICBs might include**. A competency framework will need to provide a balance between ensuring that professionals are able to deliver high-quality care without putting unnecessary barriers that prohibit professionals from being able to work in a hub. Competencies should be based on existing clinical best practice and training/qualifications, and also include non-clinical skills such as leadership skills and communication.

When professionals are working across primary, secondary and/or sexual and reproductive healthcare services that have differing commissioning, governance and employment structures, there needs to be due consideration of the best approach to ensure that staff are well integrated across employers and locations. **DHSC should develop resources to support ICBs with potential barriers around employment, focusing on practical solutions that enable the workforce to deliver care as part of the WHH model**, recognising the potential benefits to retention and increased skills and knowledge if professionals are encouraged to work as part of the hub model.

The WHH model has the potential to improve skills, knowledge and experience in women's healthcare across the system, particularly for primary care professionals. Models should provide opportunities for secondary care and SRH specialists to provide guidance and support, clinical oversight and supervision, training and shadowing for primary care professionals in key areas of women's health so that services can be co-delivered with the primary care workforce. Specialists will also benefit from working closely with primary care professionals and learning from the holistic, psycho-social approach to consultations that take place in general practice.

8. Measuring outcomes

Understanding the benefits and learning from the development of women's health hub models locally will be crucial in continuing to improve services and creating a fit-for-purpose model that can be adapted and rolled out nationwide. Sharing best practice through a central forum via DHSC or NHS England will be important in supporting those on the ground who are leading the development of hubs, as well as to identify and address barriers created by national policy or practice.

Measures of success must focus on whether or not women's outcomes, experiences and access have improved as a result of the introduction of a hub model. Measuring the number of hubs in existence, or how many services they deliver, will not help us to understand how the model can best improve women's healthcare. National guidance should be developed to support ICBs to develop a set of measures to evaluate the effectiveness of the WHH model they have developed. DHSC/NHSE should work with stakeholders to develop a dashboard of indicators that relate to potential services WHH models might deliver, allowing ICBs to select the most appropriate indicators for success for their local model. The consensus process developed via Public Health England (now OHID) to determine national reproductive health indicators for women's health should be used.

Appendix: Services to consider

Service	Considerations for provision
Contraception services	Improving access to contraception and contraceptive counselling should be considered as a priority for the women's health hub model. This must include improving access and reducing inequalities in access to Long Acting Reversible Contraception (LARC). Improving access to contraception has the potential to reduce unplanned pregnancies. In 2018, statistics showed that 45% of pregnancies and one third of births in England were unplanned or associated with feelings of ambivalence[iv]. Studies have also shown that unplanned pregnancies nearly doubled during lockdown[v]. Reducing unplanned pregnancies has the potential to improve pre-conception health and associated outcomes, as well as reduce costs to the health services – with the overall cost of unplanned pregnancies in England was estimated at £193m in 2010. Despite data that shows demand for LARC continues to increase, provision of LARC within SRH services and GP practices is struggling to meet demand. Reduction in funding and fragmented commissioning has resulted in services struggling to meet demand with provision not yet returning even to pre-pandemic levels[vi]. ICBs should focus on how the WHH model can be used to improve access to contraception for women, alongside a focus on reducing inequalities in access. Addressing the historic fragmentation of commissioning for contraception provision is key to improving access, and will allow healthcare professionals working across primary, secondary and sexual and reproductive health services to better meet women's holistic needs. Whether ICBs invest in a physical 'hub' to improve access to contraception services, or invest in existing service provision, in order to remove barriers in accessing contraception it is essential to address historic fragmented commissioning arrangements between the NHS and local authorities, and consider how contraception services can be co-commissioned or delivered through pooled budgets. DHSC should provide support for ICBs on approaches to co-commissioning, including a forum for sharing best practice. Improving access to a full range of contraception in general practice also requires DHSC to address current barriers to delivering LARC in primary care, in particular issues around fair fitting fees, and funding for backfill to free up primary care professionals to undergo training in LARC fitting.

	Fragmented commissioning arrangements also mean that women are required to visit different parts of the system depending on why they require contraception[vii]. This means, for example, women cannot access LARC fitting for heavy menstrual bleeding in SRH services who are funded to deliver LARC for contraceptive purposes only. This prevents healthcare professionals from delivering the best care for women where they are, and increases numbers of unnecessary appointments. WHH Models should ensure that wherever women are in the system, they can access contraception for all purposes. ICBs should also consider commissioning post-natal contraception into the maternity pathway, and how this can be integrated into a WHH model.
Medical and conservative management of menstrual health and gynaecological conditions	In line with NICE guidelines, the WHH model provides the opportunity to offer a service which acts as a bridge between primary and secondary care for the management of gynaecological conditions and menstrual health. This should focus on identifying where more care traditionally delivered in secondary care could be moved into community settings or co-located within primary care or SRH services. Much medical and conservative management of menstrual health and gynaecological conditions already takes place in primary care. ICBs should consider how the WHH model could provide a bridge between primary and secondary care management and integrate or co-locate additional services outside of secondary care. Improving access to medical and conservative management of menstrual health and gynaecological conditions outside of secondary care has the potential to reduce long waits for secondary care gynaecology services, and reduce the variation in care women receive before a secondary care referral. Ensuring access to contraception for all purposes is key in ensuring the WHH model can effectively deliver this services.

Menopause care	The majority of menopause care and treatment takes place in primary care, unless there are circumstances where a referral is needed to a menopause specialist. As part of the design of WHH models, ICBs should consider how to improve access to menopause specialists for women, and to improve provision of specialist advice for primary care professionals to ensure high-quality referrals. Improving access to menopause specialists could include consideration of co-locating specialists in primary care settings or develop simple referral pathways to a service outside of secondary care. ICBs should also consider how menopause specialists working in primary and secondary care can support ongoing training and education to ensure best practice in menopause care is delivered across the system. This should be based upon ensuring systems deliver menopause care in line with NICE guidelines, as well as the following: • RCGP, RCOG and the BMS joint position on menopause • BMS, SfE, RCOG, FSRH, FPM and RPS menopause practice standards
Pelvic floor health services	Symptoms of pelvic floor dysfunction (including urinary and anal incontinence and prolapse) are common and can have a huge impact on women's quality of life as well as a significant economic cost. The WHH model provides an opportunity to improve access to services promoting prevention and early intervention to improve women's access to conservative management of pelvic floor dysfunction throughout the life course. ICBs should consider provision for women around pelvic floor health when developing a WHH model, focusing on improving women's access to women's health physiotherapy and fitting of pessaries. This could include co-locating professionals in GP practices or alongside other hub services and upskilling primary care professionals as appropriate. The RCOG position statement on pelvic floor health outlines recommendations to improve pelvic floor health.

	There is an opportunity for linking in perinatal pelvic floor services where they currently exist and as they roll out nationwide[viii].
Abortion care services	ICBs should consider how existing service provision for abortion care services can be integrated into WHH model pathways to ensure that women can access high-quality abortion care. Provision should be based on the joint national service specification for NHS abortion care services. In particular, ensuring that contraception is integrated into the abortion care pathway to reduce the risk of future unplanned pregnancies should be prioritised[ix].
Fertility and pre-conception health support and information	ICBs should consider how the WHH model can improve women's access to support and information on fertility, including ensuring all women have access to NHS-funded fertility services that meet NICE guidelines. ICBs should provide information on all of the fertility services available to women in their local area, to improve transparency in the availability of fertility care, and reduce geographic variation in provision. ICBs should consider how the WHH model can improve pre-conception health advice for women, including better integrating services to support women with pre-conception health including local authority-funded programmes such as smoking cessation. ICBs should also consider how to improve pre-conception counselling for higher risk women.
Sexual health services	ICBs should consider the provision of sexual health testing and advice/support around sexual health for women and girls and how this fits within the WHH model. ICBs where rates of sexual health screening uptake are low should consider how integrating or co-locating services could improve take up of sexual health screening.
Breast screening	Where ICBs choose to set up a WHH in a physical building or co-located with existing services, they may wish to consider how breast screening services could be integrated into this model of care.
Dexa scanning	Where ICBs choose to set up a WHH in a physical building or co-located with existing services, they may wish to consider how Dexa scanning and support and advice on bone health and its relationship to reproductive

	life stages could be offered as part of a holistic, one-stop shop for women's health.
Diagnostics and outpatient procedures	Where ICBs choose to set up a WHH model in a physical building or co-located with existing services, they should consider whether there are parts of their existing gynaecology service that could be delivered in the community, closer to where women live and work. This could include diagnostics (possibly aligned with CDCs) and gynaecology outpatient procedures as appropriate. It is important to note the importance of always ensuring choice for women requiring outpatient gynaecology procedures around where and how they undergo treatment.
Social prescribing and care navigating	ICBs developing WHH models should consider the role of non-clinical roles such as social prescribers and care navigators in providing joined-up, holistic care for women.
Domestic abuse services	ICBS should consider how the WHH model they are developing can be effectively integrated with domestic abuse services, and how it can contribute to the health system response to reducing violence against women and girls. WHH set up in a physical building or co-located with existing services could consider provision of a safe space for women experiencing domestic abuse.
Drug and alcohol support services	ICBs should consider how the WHH model they are developing can be effectively integrated with drug and alcohol support services.
Local-authority funded public health programmes for smoking and obesity reduction	ICBs should consider how women's health outcomes in their area could benefit from improved access to local-authority funded public health programmes such as smoking cessation and weight management. Where appropriate, funding could be pooled to improve women's access to these services and tailor the services to the local population of women.
Cervical screening	The cervical screening programme is delivered by GPs and some sexual health services. ICBs should consider how the WHH model could reduce the barriers currently faced by gynaecology services which mean they cannot deliver opportunistic smears alongside other gynaecology

	appointments. This would increase uptake of cervical screening. ICBs should also consider whether colposcopy services could be delivered within a WHH model, moving services closer to where women live and work.
Antenatal and postnatal health services	ICBs should consider co-location of antenatal and postnatal health services such as midwifery-led antenatal clinics, maternal mental health support and breastfeeding support as part of the WHH model. This should primarily focus on moving services closer to where women live and work.

[i] Early evaluation of Women's Health Hubs Interim summary report, BRACE, 2022
[ii] Enhanced service specification: Long COVID 2021/22, NHS England, 2021
[iii] Women's Health Strategy for England, DHSC, 2022
[iv] Health matters: reproductive health and pregnancy planning, Public Health England, 2018.
[v] Disrupted prevention: condom and contraception access and use among young adults during the initial months of the COVID-19 pandemic. An online survey, Ruth Lewis et al, BMJ, 2020
[vi] FSRH Statement on latest UKHSA and OHID Sexual and Reproductive Health profile statistics, FSRH, 2023
[vii] Holistic Integrated Commissioning of Sexual and Reproductive Healthcare: AoMRC, RCOG, FSRH, RCGP, RCM, RCN, RCPath, RCPCH and FPH position, 2019
[viii] NHS pelvic health clinics to help tens of thousands of women across the country, NHS England, 2021
[ix] the Hatfield Vision, FSRH, 2022