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Setting up a Women's Health Hub in Hackney

A CASE STUDY

This case study explores how primary care in collaboration with community gynaecology adapted services to meet the needs of patients and address a gap in women's health provision in the London Borough of Hackney.

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SITUATION | **SOLUTION** | **SUCCESS**

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LOCATION: HACKNEY, EAST LONDON

SERVICE: WOMEN'S HEALTH HUB

Background

In City and Hackney, both Clinical Commissioning Group (CCG) and Local Authority (LA) commissioned services have been provided across an area with coterminous boundaries which is served by a single secondary care provider, the Homerton Hospital, offering gynaecology and specialist sexual and reproductive health services. In primary care there are eight Primary Care Networks made up of 40 practices. Of these, 17 currently offer long-acting reversible contraception (LARC) services (three implants only; 11 intrauterine contraception, and three offering both).

In addition, there has been a long-standing (more than 10 years) but small consultant-led Community Gynaecology service, led by the sexual and reproductive health service at Homerton, which traditionally saw around 300 women per year via a single weekly clinic. This service was created for women with needs such as menopause, irregular bleeding, polycystic ovarian syndrome (PCOS), and fitting of LARC for non-contraceptive reasons – that could easily be managed in the community. As it had always been a CCG-commissioned service, provision of LARC was not formally provided unless for non-contraceptive reasons, in spite of the fact that it was the same staff providing both services. In practice, patients occasionally did fall into the 'wrong' service, but this was a small part of the workload and therefore did not create any commissioning headaches.

The challenge

When Homerton Hospital underwent an internal restructure (around three years ago), the management structures for SRH services and women's health services became separated and the original community gynaecology service was merged with secondary care gynaecology. There was a recognition that community gynaecology in this existing form was just a satellite gynaecology service rather than something that provided true community-level care.

The service was an anomaly – not integrated with either main gynaecology or the sexual health service - and would almost certainly have collapsed at this point, were it not for the developing relationship between the lead Community Gynaecology Consultant from Homerton, the CCG and local primary care providers.

The CCG had been keen to try to reduce secondary care referrals and had proposed a tiered service so that more gynae would be managed in primary care. In addition, there was a secondary care gynae transformation programme set up which provided the opportunity to propose a greater role for community gynaecology. An audit by secondary care had shown that there were a small number of patients (but almost certainly an underestimated number) who didn't need to come to hospital care. The idea of expanding Community Gynaecology was socialised with the CCG commissioners through these meetings and was in line with their view of a greater role for primary care and of course improving efficiencies.

Primary care in collaboration with community gynaecology had seen a gap and a way that the existing service could be adapted so that it was still semi-specialist, but that it sat more closely to primary care and therefore better met these needs as well as those of the patients.

As part of a co-design process between the CCG and community and then a re-contracting process, the service was initially expanded and then redesigned to continue provision within the existing standalone site – 'lead hub' – but alongside this a 'pilot hub' was also set up to provide for the PCN population footprint. This new service was intended to fulfil the principles of providing a service that was closer to home for patients, separate from the hospital gynaecology service, that better supported women's health provision by general practice. It took a tri-partite approach that included direct service provision, support and development for primary care practitioners and population engagement and information provision. The direct service provision has remained only one part of a more embedded approach.

Professional education and population engagement interventions have been developed since set up, which have included large menopause and fertility engagement events, virtual group consultations and the start of the development of a women's health GP training scheme.

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Overview of activity

The pilot 'hub/s' were set up within a single PCN with five practices. The concept was discussed with the PCN steering group and the PCN development and clinical leads. Two practices put themselves forward to host a monthly clinic where the other practices would be able to refer their patients for community gynaecology care. These practices were then excluded from the existing main hub community gynaecology service which continued to serve referrals from all the other Hackney practices.

The business case was initially developed in collaboration with the CCG, primary care neighbourhoods programme, GPs – network and clinical leads – as well as Homerton Gynaecology. There was some early hesitancy from secondary care, especially because it was deemed that women who may need to be referred would not be and women would receive a suboptimal service. Having governance procedures in place with the secondary care gynaecologists and good relationships with both primary and secondary care was central.

The business case was initially very small and funded largely as proof of concept. It quickly became apparent that the funding was not sufficient at this stage, and the service was set up with a lot of goodwill and very little properly allocated capacity. Essential to the set-up phase was a very proactive NHS management trainee at Homerton who located the PCN and practices from where the service was to be delivered. There was early recognition that many of the practicalities were not ironed out in advance. Issues such as IT, consumables and restocking, prescribing and ordering specimens were addressed as the model evolved. This stage was necessary to form the basis of a well-costed business case so that by the time it reached the various groups needed for approval, the pilot hub was well-known and well-liked by key people, including the clinical leads within primary care and the neighbourhoods programme.

This new service was set up to fulfil the principles of providing a service that was closer to home for patients, separate from the hospital gynaecology service, that better supported women's health provision

Key stakeholders

The stakeholder landscape is complex and in order to maintain good communication with the right people it was important to keep abreast of all the new structures as they developed to make sure that the model was socialised widely. In retrospect, the most important early stakeholder engagement work was with the lead clinical GPs (the work was championed by the clinician who drove the meetings and ultimately, the business case development) and the CCG commissioners. Once it was established that the model was consistent with the strategic direction of travel – particularly in providing more integrated care and also reducing unnecessary referrals into secondary care - it gained traction as a model. At the same time there was work underway in other long-term conditions (LTC), which was using community gynaecology as a testbed for other LTC interventions in the community.

The local authority and public health departments have been aware from the outset, but only as the model has become embedded have they become involved directly as a partner. Within the newer and expanded pilot model we are looking to include a LARC training clinic where interpractice referrals will be offered, and a training clinic provided weekly in one of the host practices. The cross-charging agreements with the CCG have yet to be fully worked out. Although this will primarily be a contraception clinic, it is envisaged that it will be a more holistic procedures clinic that will include gynae minor procedures - and ultimately will not need to distinguish between contraception and non-contraception in the patients that are booked.

Financial viability

It is important that the pilot is robustly evaluated to inform a further business case for spreading and sustaining the model if effective. This will include an economic evaluation in order to consider whether transferring wholesale to a system of primary, intermediate and secondary care is economically viable.

IT considerations

There are a number of IT issues that are still being worked out. The main issues are patient booking, specimen ordering, prescribing and letters generation. At the moment, the secondary care systems are used for booking and generating letters. However, these do not work within general practice for the prescribing and specimens issues. This is a much wider issue for the integration agenda and the community gynaecology project is being used as an exemplar to try to get some of these issues on the table.

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Training

The training goal is to bring as many primary care staff as possible to a level where there is a consistent provision of care regardless of point of access. The PCN hub model will provide an intermediate level of care that is currently delivered via the specialist services, but each PCN will ultimately have such a service. It is envisaged that this would be led by a GP or specialist nurse who would be supported through the main community gynae hub, which would also be the centre for training. Currently these plans are in the formative stages.

Monitoring of project outcomes

An evaluation has been designed based on the sexual health evaluation toolkit produced by Public Health England ((PHE), now the UK Health Security Agency (UKHSA)). A set of metrics is also being developed through which the Hub can be evaluated. (Find out more about evaluation here.) A project manager will come into post and also oversee this piece of work over the next year, which will feed directly into the new business case.

Key successes

- Stakeholders buy-in
- Bringing LA and CCG organically onto the same page
- Increased provision of out-of-hospital care
- Patient engagement and virtual group consultations increasing the reach and improving efficiency
- Serving patients proactively and equitably
- Working with voluntary sector and PCN new roles such as social prescribers and Health and Wellbeing practitioners to try to meet the needs of those least well served.

Lessons learned

- There is a need for project management support
- Funding is inadequate
- Socialising the idea widely with all is essential
- IT, estates, and workforce are key operational issues

Current challenge/s

- Chicken and egg situation: The new service needs funding but first needs to show proof of concept. This takes more work than is likely to be funded at the outset
- There is a need to rely a lot on the goodwill of people working in different but related areas
- Everyone is exhausted from the demands of the recent Covid pandemic
- The big backlog in patients – but this is also a key lever
- Lots of change in structures – but again, this can work to our advantage.

Next steps

- Mobilise the new business case, extended to 25% of resident population (funding has been approved by the CCG to provide this)
- Integrate LA services
- Recruit a project manager, half-time GP for co-delivery, and nursing support.

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