



Women's Health Hub Toolkit Resource

Growing the workforce for
Women's Health Hubs (WHHs)
and other community
women's health services

*A multidisciplinary approach
to developing a sustainable
service*

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When developing Women's Health Hubs (WHHs), it is important to assess the demand for a service, how the service will meet that demand and to consider workforce development and retention. Financial viability and long-term sustainability are also key factors to long-term success.

What is the need?

The first consideration is to review the needs of the local population, to ensure that a potential service can match the demand. Both a lack of available skilled staff and an absence of demand can create challenges; the former will create frustration and delay for patients, whereas the latter can lead to a financially unviable service.

What are the funding arrangements?

It is crucial to consider how a service will be funded. This includes a strong business case (considering real life events such as DNAs and unfilled appointments), and long-term sustainability (including contractual arrangements and commissioning). Non-recurrent funds can lead to unrealistic expectations, operational distractions and disappointment for both staff and patients.

Who will deliver the service?

You may already know of clinicians who have the necessary skills or are keen to be trained. It is important to include training needs as part of your project development plan, as well as a review of currently available staff and their capacity for increased hours, or adjustments to current job plans.

How will you train and equip your staff?

The lack of available or affordable training is often cited as a barrier to delivering women's health services¹. There are various routes through which healthcare professionals can be trained for various skills. For example, when training colleagues to deliver intrauterine devices and subdermal implants, options include training via local Community Sexual and Reproductive Health Services or via pharmaceutical contracts, where registered trainers with the College of Sexual and Reproductive Health (CoSRH) can bring training out to local practices.

What are the costs of training? Consider the cost to both the individual and the organisation.

Costs for training vary depending on the skill or qualification. Costs might include the cost of a course, the cost of membership fees (e.g. membership of the CoSRH) and the cost of single or recurrent use equipment required for delivery of that service (for example a gynaecology couch or fitting packs for intrauterine devices). It is also important to consider any individual loss of earnings if a professional does the training in their own time, and the cost to a practice or larger organisation if paid leave is given for training. Many areas raise the issue of backfill (the cost of covering sessions missed during training). These are all important considerations when developing a business case.

What non-clinical roles do you need?

Non-clinical individuals such as administrators or care-coordinators are invaluable when it comes to project planning, day-to-day administration and the communication that is required to set up a hub.

Administrative duties might include:

- Managing the booking system. This could include making appointments and maximising the clinic's potential and financial viability by phoning patients on a waiting list to avoid empty slots.
- Minimising missed appointments through patient engagement (sending out appointment reminders etc).
- Communication with local practices to ensure engagement with and utilisation of the service.
- Promotion of the service to patients (e.g. distributing promotional materials, working with practices to identify groups of patients who would benefit from the service etc).
- Standardised ordering of consumables (consumables could be bought in bulk for the network service to secure discounts).
- Supporting practices in verifying procedures performed against payments made, and ensuring that the payments cover the cost of the services etc.
- Audit performance of the service and breakdown of referrals.
- Provide administrative support for quality improvement activities such as audit and significant event analysis.
- Collate monthly performance figures and report these back to the relevant organisation/body.

What clinical roles do you need?

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Provision of specialist skills (such as fitting intrauterine devices and subdermal implants) can often be delivered by a multi-disciplinary team. With the growing list of allied professionals working in primary care, and the many ARRS (Additional Roles Reimbursement Scheme) roles, it is important to ensure that the right role is matched to the right task. ARRS roles are usually cost-neutral to practices, which means they help maintain financial viability of a service. However, it is important that clinical skills and responsibilities sit with the appropriately trained person and that the cost of any supervision needed is included in the business case. A healthcare professional who has a lower top-line salary may actually be more expensive if frequent supervision is required.

Using a multidisciplinary team approach has many benefits, including improved workforce sustainability, provision of professional development and teaching opportunities for HCPs and strengthened financial viability. This set up often builds a shared vision and can enhance team dynamics and staff morale. In recent years the CoSRH has recognised some additional health care professionals as suitable for training in LARC procedures².

The most commonly used staff in a WHH are as follows:

GPs and other doctors

Pros:

- Wide range of skills and knowledge, including on co-morbidities not directly related to women's health.
- Can be trained in various procedures and skills.
- All doctors are prescribers.
- Able to deal with more complex queries and supervise other staff.

Cons

- Top-line salary is more.

Nurses and nurse practitioners

Pros:

- Broad range of knowledge in the nursing field.
- Can be trained in various procedures.
- May already be able to prescribe or be able to train whilst in post.

Cons:

- May not be able to prescribe or want to acquire this skill.
- Depth of knowledge may vary depending on experience and training.

Nursing Associates

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Pros:

- Part of ARRS scheme and therefore may be fully reimbursed and very cost-effective.
- Can follow Patient Specific Directives (PSDs).
- Can assist with procedures.
- Can progress to a registered nurse (and beyond) whilst in post.

Cons:

- Not able to work independently or to prescribe.
- Can only work to PSDs, not PGDs (patient group directives).

Health Care Assistants

Pros:

Cheaper top-line salary.

- Can assist with minor procedures.
- Can act as a chaperone and give simple health related advice.

Cons:

- Cannot make clinical decisions or prescribe.

Depending on the nature of the service, other staff may be employed. This could include health and wellbeing coaches, social prescribing link workers, physiotherapists and clinical pharmacists. Many pharmacists are now able to prescribe, but confidence in prescribing may vary depending on the clinical area. Physician's assistants will not be discussed in this review due to the current uncertainty related to the Leng review. The term physician's associate is now obsolete within the NHS.

Clinical governance, upskilling and keeping up to date

All staff must have the relevant training for the roles they do and need time to keep their skills up to date. Hubs should have good relationships with local secondary care services and community sexual and reproductive health services. Referral pathways, access to acute and urgent services and pathology labs are also important. Consideration should be given to how results will be reviewed and actioned. Local educational meetings, Fitter Forums, Advice and Guidance services and support networks can be useful for reviewing cases and complex queries.

Suggested training

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This list is not exhaustive, and it is important to consider what competencies are required for the services that you will be providing.

- *Ring pessaries*: Pelvic Obstetric & Gynaecological Physiotherapy (POGD)³ or locally agreed training routes.
- *Contraception*: CoSRH, university-based courses, Essentials for Primary Care course, PCWHS.
- *Intrauterine device and subdermal implant training*: CoSRH.
- *Sexual health*: Sexually Transmitted Infection Foundation (STIF).
- *Hysteroscopy*: British Society for Gynaecological Endoscopy (BSGE) accreditation or locally agreed training.
- *Colposcopy*: British Society for Colposcopy and Cervical Pathology.
- *Cervical polyp removal*: local accreditation.
- *Cytology*: Local training courses which result in being registered as a cytology taker on local system.
- *Menopause*: PCWHS/CoSRH courses for basic skills. PPMC certificate and advanced training from British Menopause Society.
- *Ultrasonography*: CoSRH, local university courses.
- *Diploma in GPSI gynaecology*: Bradford University.

Resources (accessed 29th Sept 2025)

- [CoSRH website](#).
- RCN. [CPD and searching for courses](#).
- NHS England, March 2025. [Changes to the GP contract in 2025/26](#).

References (accessed 29th Sept 2025)

- 1) PCWHS. [Workforce Needs Assessment to deliver patient access, provision and sustainability of Long-Acting Reversible Contraception \(LARC\) in primary care](#). Sept 2021.
- 2) CoSRH. [CoSRH Qualifications](#).
- 3) POGP. [Best Practice in the Use of Vaginal Pessaries](#).

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