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CARE-NET POLICY BRIEF



Understanding Acute Respiratory Infection Hubs

Acute Respiratory Infection (ARI) Hubs were set up across England in winter 2022/2023 to help deal with higher-than-expected demand on emergency healthcare services from people with respiratory infections like colds, flu and COVID-19. This study was carried out to understand how ARI Hubs have been set up and run, what outcomes they are expected to achieve and whether it would be possible to carry out a more in-depth study of their effectiveness and value for money in the future.

How was this study conducted?

This study ran from May 2025 to June 2026 and used a variety of methods:



A review of prior local evaluation studies.



A survey covering 35 of the 42 regional health bodies (Integrated Care Boards, or ICBs) in England.



23 interviews with 38 National Health Service (NHS) staff at national, regional and local levels.



3 focus groups with 28 members of the public.



A workshop with around 20 NHS staff and 3 public representatives.

What did this study find?

Set-up and funding: From the survey and interviews, we found that almost all ICBs (41 of 42) ran ARI Hubs in winter 2022/2023, when centralised funding was provided by NHS England. By winter 2025/2026, only 12 ICBs still ran them. The main reason for this drop was the lack of funding from NHS England after the initial winter, requiring ICBs to fund ARI Hubs from their own budgets in the following years.

Organisation: Among the 12 ICBs still running hubs in winter 2025/2026, there were 74 hub systems operating across 27 local areas. Three delivery models were used: 'at-scale' (services provided from one or a few sites in the area); 'distributed' (services provided from all or most General Practitioner [GP] surgeries in an area); and 'co-located' (services based near an emergency department or urgent treatment centre).

Locations: Most hubs (73%) were in the North of England and tended to be in areas with higher population density, greater respiratory disease burden and greater deprivation.

Operations: Hubs were operated by primary-care organisations and staffed mainly by GPs, though some used Advanced Nurse Practitioners, which allowed for more appointments to be delivered within a fixed budget. Clinicians who delivered ARI Hub appointments were often temporary staff, who were picking up additional shifts on top of their regular employment. Most hubs treated all ages, but children made up a large proportion of patients. Opening days and times varied and included usual business hours, evenings and/or weekends.

Referrals: Most patients were sent to ARI Hubs by their own GP surgery. Referrals from NHS 111 were less common because many hubs were not registered on the system that allows this, partly due to late decisions about whether to fund ARI Hubs each winter, and technical difficulties. Unlike emergency departments and urgent treatment centres, patients could not refer themselves to ARI Hubs.

Infection control: Although reducing the spread of respiratory infections was a key goal for ARI Hubs, most hubs were not separating potentially infectious ARI patients from other patients because they operated in existing clinical spaces that did not have separate entrances or waiting areas.

Point of Care Testing (PoCT): Testing patients in ARI Hubs (for example, to guide antibiotic prescribing) was rarely used due to cost, space and time constraints. Only one ARI Hub system used it, and they reported that it helped to reduce antibiotic prescribing.

Evidence of impact:

- Existing local evaluations reported high appointment use, low missed-appointment rates and few patients needing subsequent emergency care, suggesting that the right patients were being seen by hubs.

However, strong evidence showing that hubs reduced demand on emergency healthcare services was lacking. Participants in our study also held mixed views on whether this was achieved in practice.

- Local evaluations reported that patients were highly satisfied with their ARI Hub experience, valuing prompt access and flexible appointment times. However, some of those involved in our study believed that some patients found travelling to unfamiliar sites inconvenient.
- Local evaluations estimated the number of avoided emergency-department attendances and resultant cost savings by asking patients whether they would have otherwise gone to an emergency department if the ARI Hub hadn't existed, but this method has significant limitations. Participants in our study had conflicting views on whether hubs represented good value for money or whether this should even be one of their goals.

Feasibility of a future impact study: An in-depth impact study will be challenging to conduct, but possible. This future study will compare local areas with ARI Hubs against those without a hub during winter 2025/2026, looking primarily at the impact of ARI Hub services on how many people visited the emergency department for respiratory infections.

Why do these findings matter?



Health inequalities: ARI Hubs tended to be situated in more deprived areas with greater need, which may be positive. However, some high-need areas had no hub services, and barriers persisted for rural populations and underserved communities.



Policy alignment: In theory, ARI Hubs supported the ambition to shift care from hospitals into communities, but whether hubs were the best use of limited resources for achieving this remains unclear.



Trade-offs for decision makers: Investing in ARI Hubs meant not investing elsewhere. Without strong evidence of system-wide impacts for the ARI Hub model, justifying continued spending was difficult. People involved in our study were also concerned that extra primary-care appointments might have simply attracted additional demand for service rather than reducing pressures on emergency healthcare services.



Practical recommendations: This study suggests that decision makers should make funding decisions earlier to allow proper set-up; strengthen ways for patients to access ARI Hubs (especially from NHS 111); design services flexibly so they can easily scale up or down, depending on demand; consider integrating hubs with other respiratory services; and ensure hubs are accessible and appropriate for children, who are frequent users.

Conclusions

In summary, ARI Hubs across England varied in how they delivered services, but they appeared to provide extra primary-care capacity in winter and received positive feedback from patients. Evidence that ARI Hubs reduced pressures on emergency healthcare services was limited, but this will be addressed in a future impact study. Future planning for ARI Hub delivery should focus on improving patient access to ARI Hubs, the ability to scale up and scale down services as needed, and earlier decision making around funding.

CARE-NET

The Cambridge and RAND Europe National Evaluation Team

CARE-NET is a collaboration between THIS Institute (The Healthcare Improvement Studies Institute) at the University of Cambridge and RAND Europe. CARE-NET is one of three teams in England selected to generate long term, robust and broad national evaluations of health and social care innovations.

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