Women's Health Hubs – study protocol

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Note on terminology

Defining Women's Health Hubs

Stakeholders have highlighted that the 'Women's Health Hub' label is open to interpretation, and not all services of this kind refer to themselves as Women's Health Hubs. Women's Health Hubs are not necessarily a 'place' but a 'concept' and are distinct from other hubs such as mental health and family hubs, though inevitably there are links. We will explore the diversity in terminology in use, and perspectives regarding nomenclature, as part of our evaluation.

Who are Women's Health Hub for?

Our public contributors highlighted the importance of defining which women hubs are intended to serve, for example, are they targeted at younger women, or post-menopausal women. Our initial scoping work has suggested that there is a broad vision to serve all women's reproductive health needs throughout the life-course, though there is some variation in populations served according to local context and need. Our evaluation will explore how populations are defined and served across the Women's Health Hub landscape.

Using the term 'women'

The imminent Women's Health Strategy aims "*to improve the health of all women, irrespective of whether they have undergone gender reassignment or are transgender*." (Department of Health and Social Care, 2021a, pg 3). While we refer to women throughout this document, we recognise that Women's Health Hubs may also serve people who are transgender, non-binary, with variations in sex characteristics (VSC) or who are intersex, and we will work to ensure that our evaluation is inclusive.

Protocol summary

Introduction

Women's sexual and reproductive health needs are complex and vary across the life course. These health needs are currently met by a range of providers, professionals and venues, including primary care (general practice), gynaecology, maternity, community sexual health services, and genitourinary medicine. The complexity of the landscape often means that provision is not well-integrated, and there are inequalities in accessing services as well as in sexual and reproductive health outcomes (All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020; House of Commons Health and Social Care Committee, 2019). Funding cuts, workforce issues and gaps in training provision, Covid-19 and fragmented commissioning between the NHS and local authorities are contributing to increasing challenges in service access (Royal College of Obstetrics and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020; Department of Health and Social Care, 2021a).

In recognition of these issues in delivering services, local teams across the UK have responded by establishing Women's Health Hubs to improve provision, experience and outcomes for their population, and to address inequalities, at the same time as seeking to use healthcare resources more efficiently. Hubs function to meet the integrated needs of women's reproductive health care together in one place by enabling women to be seen in the community by a practitioner with appropriate skills, usually within primary care although not necessarily within their own practice/provided by their own practice team. Though Women's Health Hub models are new and emerging, they have been highlighted as good practice (Faculty of Sexual and Reproductive Healthcare, 2019; Primary Care Women's Health Forum, 2021b), with wider roll-out of hubs recommended (Royal College of Obstetrics and Gynaecologists, 2019). Women's Health Hub models may also feature in the upcoming Women's Health Strategy, expected in 2022 (Department of Health and Social Care, 2021a). Early insights, for example from the Primary Care Women's Health Forum (2021a, b) suggest there are a range of service models and local contexts into which the approach has been introduced with a variety of services available for example, the provision of long-acting reversible contraception (LARC), menopause management and pessary fitting.

However, there is a paucity of research to date on these different hub models, and through their scoping research, the research team identified gaps in knowledge including where, why and how Women's Health Hubs have been set up and implemented, aims, and experiences of implementation and delivery, including those of service users. An evaluation of the current Women's Health Hub landscape would bring together and generate evidence around what the models currently look like, insights from commissioning, implementation, delivery, successes and challenges, and potential improvements.

Research design and methodology

To inform our study design and the development of this protocol, the research team undertook scoping work to better understand the current context and landscape of Women's Health Hubs. We conducted a rapid scan of relevant policy and evidence, undertook interviews with 10 key informants, and established a Stakeholder Advisory Group with whom we held a workshop to share findings from the scoping work and refine our study focus and research questions. The scoping work included a brief exploration of which geographical areas are currently implementing Women's Health Hubs, what the evaluation should prioritise, and how best to collect data from stakeholders.

Aims

The overall aim of this evaluation of Women's Health Hubs is to explore the 'current state of the art', 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..
Specifically, the study will evaluate why, where and how hubs have been implemented, why different approaches have been taken, if and how inequalities have been considered, and experiences of implementation, delivery and receiving services. The evaluation will provide feedback about the successes and challenges of hubs and potential improvements, including different stakeholder group perspectives of what hubs are intended to achieve, and whether hubs are making progress towards this.

It will also gather preliminary evidence about what is known about performance, outcomes and costs and how they are/can be measured.

Evaluation questions

In order to address these aims, the study seeks to answer the following evaluation questions:

1. What are Women's Health Hubs, and is there variation in how stakeholders name and define them?
2. How many Women's Health Hubs have been established/are in development across the UK, where are they, and what are their characteristics, including models of structure, commissioning and delivery?
3. Why have Women's Health Hubs been implemented, and how are they intended to address health inequalities?
4. What have Women's Health Hubs achieved to date? How do Women's Health Hubs achieve this?
5. What are the experiences and perspectives of staff regarding Women's Health Hub setup, commissioning, funding, implementation and delivery?
6. What are the experiences and perspectives of women who have used hub services?
7. How are Women's Health Hub performance, outcomes and costs measured, and how might they be measured in future?

Our evaluation will comprise of three work packages:

Work Package 1: *Mapping the current landscape and context for Women's Health Hubs***.** Work will include: consolidating evidence from the evaluation scoping phase (key informant interviews and published evidence), and gathering additional information to inform a database of UK Women's Health Hubs, which will be refined throughout the evaluation; undertaking an online survey of leads from each UK Women's Health Hub (e.g. lead commissioners, hub providers); conducting interviews with regional stakeholders (aiming to speak to one per NHS England and NHS Improvement region), which may include, for example, NHS England and NHS Improvement, ICS leads and Regional Directors for Public Health; and if possible, developing a working typology of hub models, to inform sampling of four exemplar hub sites to be included in our in-depth research (Work package 2).

Work Package 2: *In-depth work with four exemplar hub sites in England***.** The work will involve: selection of exemplar hub sites; set up and familiarisation with sites; qualitative interviews with staff

working in or with hubs; qualitative interviews with service users; analysis of key documentation and refinement of the working typology of hub models.

Work Package 3: *Consolidating evidence and developing recommendations.* One of the purposes of this rapid evaluation is to generate and share learning across the system to support local adaptation and equitable rollout of Women's Health Hubs. Work Package 3 will bring together the findings from Work Packages 1 and 2 to generate evidence and provide recommendations for policy, practice and research. The work to support this will include: interviews with 4-5 national stakeholders; production of a rich description and map of UK Women's Health Hubs, including achievements, impact on inequalities, stakeholder experiences, and barriers/facilitators to implementation; identification of outcomes which are/could be used to assess impact; development of a theory of change (if possible) and development of recommendations for policy, practice and research.

Involving women

The scoping work undertaken to inform the design of the study included rapid consultation with three women with lived experience of NHS women's health services (note not Women's Health Hubs) who shared their views about the concept of Women's Health Hubs and where the evaluation should focus.

We will also establish a Women's Advisory Group to provide input throughout our evaluation and draw on their experiences to shape the evaluation and influence the wider women's health sector. For example, the group will be asked to review relevant research tools and outputs, advise on effective ways to reach women to take part, including ethnic minorities, those who are disadvantaged and the seldom heard, comment on emerging findings and share ideas around how best to frame and disseminate the research findings for the public and professionals.

Outputs and dissemination

We anticipate disseminating the findings of this evaluation project in a number of ways, including:

- A final report submitted to the National Institute for Health Research, Health and Social Care Delivery Research programme (NIHR HSDR) to be published in the NIHR Journals Library.
- An interim output, in the form of a set of presentation slides, to share preliminary evaluation findings with our Stakeholder and Women's Advisory Groups, NIHR HS&DR, the BRACE Steering Group and BRACE Health and Care Panel[1].
- A short summary report in digital format, supported by professionally produced infographics, highlighting the overall findings of the rapid evaluation, which may be of particular interest to the women's sexual and reproductive health field, NHS and local authority communities.
- A slide-pack summarising high-level findings for each of the four hub sites involved in the in-depth research. We will also offer each of our four sites the opportunity to attend a local workshop event to share and reflect on their findings.
- Papers published in high quality, peer-reviewed, academic journals.
- Presentations at conferences, seminars, workshops and meetings.

[1] The Health and Care Panel is made up of 50 members (diverse representation from system and organisational leaders; middle and operational clinical and general managers; frontline clinicians and other practitioner groups) who act as a source of advice from the health and care sector, and a sounding board in relation to the choice, design, delivery and dissemination.

- Sharing findings more widely on social media platforms, such as Twitter.
- Disseminating findings through BRACE networks, including to key bodies and stakeholders, such as the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare, National Voices, the Primary Care Women's Health Forum and the Royal College of GPs.

Throughout our dissemination activities, we will draw on the expertise and assistance of BRACE/UoB/RAND partners, our Stakeholder and Women's Advisory Groups, the BRACE Health and Care panel and steering group members who are involved with the project and the BRACE Centre.

Timescale

The study will take place over a period of 12 months from April 2022 until March 2023.

Funding

BRACE is funded by the NIHR Health Services and Delivery Research (HS&DR) Programme (HSDR16/138/31).

Background and rationale

Introduction

Women's sexual and reproductive health needs are complex and vary across the life course, from menstruation to menopause. These health needs are currently met by a range of providers, professionals and venues, including primary care (general practice), gynaecology, maternity, community sexual health services, and genitourinary medicine.

The complexity of the landscape often means that provision is not well-integrated, and there are inequalities in accessing services (e.g. All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020), which disproportionately affect certain groups. For example, women with physical or learning disabilities can face barriers in accessing cervical screening or contraception (Department of Health and Social Care, 2021a). Across the country, there is variation in the quality and availability of sexual and reproductive healthcare services with a lack of ownership and accountability in the system for women's healthcare needs (Royal College of Obstetrics and Gynaecologists, 2019; House of Commons Health and Social Care Committee, 2019; Public Health England, 2017; Ismail and Wylde, 2021; Department of Health and Social Care, 2021a).

Poor access can lead to poor experiences and outcomes. There are significant inequalities in sexual and reproductive health, with young people and ethnic minority groups among those disproportionately impacted (House of Commons Health and Social Care Committee, 2019; Public Health England, 2021). Further, women can have negative experiences of sexual and reproductive healthcare, with difficulty accessing appointments (including long waiting times), variation in professional expertise at the first point of access, and requiring multiple appointments with different providers, wasting time and resources (Royal College of Obstetrics and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020; House of Commons Health and Social Care Committee, 2019). Women are *"being left without clear direction of where to access the support and services they need*" (Bayer, 2019, pg 3) navigating a disjointed system, as care is not structured around their needs (Ibid; Primary Care Women's Health Forum, 2021a).

A range of factors are contributing to increasing challenges in service access, including funding cuts, workforce issues and gaps in training provision, pressures on primary care, the Covid-19 pandemic and subsequent backlogs, and fragmented commissioning between the NHS and local authorities (Royal College of Obstetrics and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020; House of Commons Health and Social Care Committee, 2019; Public Health England, 2017; Department of Health and Social Care, 2021a; NHS Digital, 2020). Further, it is likely that long-standing inequalities in service access and provision for women from disadvantaged and minority groups have widened as a result of Covid-19 (All Party Parliamentary Group on Sexual and Reproductive Health, 2020).

In recognition of these issues, there have been increasing calls for a more collaborative, holistic and integrated approach to delivering women's healthcare services, designed around women's needs, and which redresses the balance of care received (Royal College of Obstetrics and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020; House of Commons Health and Social Care Committee, 2019; Department of Health and Social Care, 2021a).

Local teams across the UK have responded to the challenges in delivering services by establishing Women's Health Hubs to improve provision, experience and outcomes for their population, to address inequalities, and reduce costs. Hubs function to meet the integrated needs of women's

reproductive health care together in one place by enabling women to be seen in the community by a practitioner with appropriate skills, usually within primary care although not necessarily within their own practice/provided by their own practice team. These emerging models have been highlighted as best practice (Faculty of Sexual and Reproductive Healthcare, 2019; Primary Care Women's Health Forum, 2021b), with wider rollout recommended (Royal College of Obstetrics and Gynaecologists, 2019). There appears to be wider support from women for changes in how their healthcare services are delivered. For example, in a UK-wide Royal College of Obstetrics and Gynaecology women's survey, almost half of participants supported the idea that one-stop women's health clinics and/or drop-in facilities would improve access (Royal College of Obstetrics and Gynaecologists, 2019).

The Primary Care Women's Health Forum has drawn together the expertise from hub leaders across England, and in September 2021 launched a Women's Health Hub toolkit, to support other health systems to implement them (Primary Care Women's Health Forum, 2021b). The work of the Primary Care Women's Health Forum evidences significant learning in these early hubs, but also a wide range of service models and local contexts. A variety of examples have been identified during the scoping work for this project – for examples, please see Appendix 1.

Box 1 Definitions of Women's Health Hubs

There is currently no agreed, shared 'definition' of what a Women's Health Hub is, though the Primary Care Women's Health Forum describes hubs as follows:

"Women's Health Hubs bring together existing services to provide holistic, integrated, accessible care delivered by appropriately trained clinicians with the support of specialists, resulting in better outcomes for patients."

Primary Care Women's Health Forum (2021b)

"*At the core of any Women's Health Hub framework is convenient access to a range of services for all women. Women's Health Hubs bring existing healthcare services together to provide holistic, integrated care. This care is accessible, delivered by trained healthcare professionals, supported by specialists. This results in better outcomes for patients. A Women's Health Hub is a concept, it is a service where healthcare professionals with enhanced skills bring together their expertise. It enables these healthcare professionals to offer a wide range of women's health services in an easy to access location. A Women's Health Hub is not a building, there is no need to invest in new physical space. It is not a major financial investment, it's about efficiencies of scale. It is not timewasting, it uses the right healthcare professional at the right time, in the right place to ensure a sustainable approach."*

Primary Care Women's Health Forum (2021c)

Women's Health Hub models may also feature in the upcoming Women's Health Strategy , which is expected in 2022 (Department of Health and Social Care, 2021a). In its vision for the upcoming Women's Health Strategy, the Department of Health and Social Care (2021a) identified a range of themes as well as priority areas for targeted action. One theme, healthcare policies and services, documented an ambition for women to be able to access services that meet their reproductive health needs across the life-course, with improved experiences of services and reproductive health outcomes, and for all women to have equitable access and experiences (Ibid). The vision also highlighted calls from some for "*more joined-up and holistic provision through women's health clinics or hubs"* (Department of Health and Social Care, 2021a, pg 10). Further, menstrual health, gynaecological conditions, and menopause are some aspects of health pinpointed for specific action

with, for example, an ambition for every woman and girl to be able to access the right information, diagnosis and support for menstrual health and gynaecological conditions (Ibid).

While Women's Health Hubs are emerging, establishing models of care which are more integrated, joined-up and closer to home is far from new. For example, in 2006, the Department of Health launched 'Care Closer to Home' demonstration sites to define appropriate models of care that could be used across the country. The sites were in six specialities, one of which was gynaecology; all sites attempted to reduce the need for repeated visits, improve access and address the need for integrated and/or one-stop services (Department of Health, 2007). In 2008, Integrated Care Pilots were launched to explore different ways of integrating care, with an aim of care being provided closer to service users (RAND Europe and Ernst and Young, 2012). Another more recent example is the introduction of the New Care Model Vanguard sites, which aimed to use pilots to develop new models of care for the health and care system that could be rolled out more widely (NHS England, 2016).

Moves toward greater integration in commissioning and delivery of sexual and reproductive health services mirror a wider direction of travel in policy with the government's commitment to integrating and delivering care across a population footprint (NHS, 2019; Department of Health and Social Care, 2021b; 2022). This is reflected in the development of primary care networks (PCNs), place-based partnerships (PBPs) and integrated care systems (ICSs) to integrate care across organisations and settings and improve population health. PCNs and ICSs provide opportunities for supporting the development and implementation of Women's Health Hubs across the country (Royal College of Obstetrics and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020).

Specific 'hub' models are also increasingly mentioned in NHS policy across a variety of contexts. Following the 2016 National Maternity Review and NHS Long Term Plan community maternity hubs and dedicated perinatal mental health hubs are being set up across England (NHS, 2019; NHS England, 2021). NHS and social care hubs have been implemented to keep patients well and out of hospital (NHS England, n.d.), family hubs have been championed as a place for parents and carers to access services (HM Government, 2021) and community Diagnostic Hubs are being introduced to improve access to rapid diagnosis for conditions including cancer and heart disease (NHS England, 2020).

Why is this research important/needed now?

The NIHR BRACE Rapid Evaluation Centre has agreed with its funders to undertake a rapid evaluation of current evidence and practice, which will inform Women's Health Hub policy, implementation, and impact measurement. Research into Women's Health Hubs is needed for a number of reasons.

Firstly, the Women's Health Hub models are new and emerging, with examples of hubs in planning or set up around the country, and wider roll-out of hubs recommended. However, there is a paucity of research to date on these different hub models - their aims, where, why and how they have been implemented and experiences of implementation and delivery, including service user experiences. An evaluation of the current 'state of art' of Women's Health Hubs would bring together and generate evidence regarding the design of hub models, how they are being implemented, successes, challenges and potential improvements. There is a desire to scale up this approach, and the evaluation will contribute to building the evidence base, and generate and share learning across the system to support local adaptation and equitable rollout. It is likely that the findings will be transferrable to other contexts implementing place-based, patient-centred, integrated models of

care, aligning with the national policy direction of more joined-up working through ICSs, PBPs and PCNs.

As noted above, there is a desire to scale up this model and as such, assessing the deliverability and impact of Women's Health Hub models on outcomes, inequalities and system costs is key. A study is required to first map and understand the current Women's Health Hub landscape, including the range of models in place, and current and potential ways of measuring impact..

The evaluation findings may also be used to support the direction of national policy and service specifications for reproductive healthcare delivery, with the government committing to improvements in women's health through an upcoming strategy as described above. There is strong support for the evaluation from policy teams in the Department of Health and Social Care, and interest in Women's Health Hubs from policy makers, national organisations, including the Primary Care Women's Health Forum, and leaders in hub models, making it an important focus for evaluation (e.g. Royal College of Obstetricians and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020).

Finally, this research is needed now because women's sexual and reproductive health provision is often not well integrated, with challenges in access and poor experiences for women, which have been exacerbated by the Covid-19 pandemic (Department of Health and Social Care, 2021a; Royal College of Obstetricians and Gynaecologists, 2019; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020). Women's Health Hubs have been established by local teams in response to these challenges, aiming to improve access and experience, as well as reduce duplication and costs. The findings of this evaluation can help to inform policy and guidance regarding the development of local integrated models of reproductive healthcare in ICSs and PCNs.

Preliminary scoping research

As part of the orientation and planning and protocol development process, we have undertaken preliminary scoping research. The team has identified and collated relevant published and grey literature to locate existing Women's Health Hubs, understand the context and inform our study design and research questions. Searches of peer-reviewed and grey literature were undertaken, and key stakeholders identified by the Department of Health and Social Care policy team were also asked to share relevant evidence - for example, a series of case studies describing emerging Women's Health Hub models. Additional sources were identified through citation searching.

We conducted interviews with ten key stakeholders, including leaders of Women's Health Hubs, national-level leaders and policymakers, and representatives of key organisations including the Primary Care Women's Health Forum, Faculty of Sexual and Reproductive Healthcare, and Royal College of Obstetricians and Gynaecologists, to 1) gather their insights, views and experiences on Women's Health Hubs; and 2) help define the scope of the evaluation, including key areas of focus. The interviews also supported the identification of relevant evidence and key stakeholders in the field.

During the scoping process, the team established a Stakeholder Advisory Group to support the evaluation. The research team will hold a minimum of three workshops with this group to inform and support study design and delivery. Members of the Stakeholder Advisory Group include: local hub leaders, commissioners, experts in women's health, and a woman with lived experience. More details on the Stakeholder Advisory Group can be found on page 29.

A stakeholder workshop was undertaken online on 22nd February 2022 to share findings from the scoping work, and to refine the study focus and research questions. A set of slides summarising the key findings from the scoping work was shared with attendees before the workshop. Discussions included the types of questions the evaluation should address, priority areas of focus, and the scope and practicalities of undertaking the research. The workshop helped to clarify current thinking regarding the concept of Women's Health Hubs and to locate examples. Please see Appendix 2 for a table summarising findings from this workshop. Notes taken during the workshop were used to further develop and refine the study design and protocol. Further workshops will be held as and when required, for example, to share and seek input regarding emerging findings.

A brief summary of some of the emerging key themes and messages from the scoping research can be found in Table 1. Appendix 1 contains more information on hub models identified so far, including locations and services offered.

The team also held a project scoping/design group with three women with lived experience of NHS women's health services (note not Women's Health Hubs). We asked participants about the issues and themes they think we should explore in the evaluation. We also enquired about the best ways to ensure the research reaches a broad range of women, and about the practicalities of collecting data. Table 2 summarises the themes and messages from this workshop.

The scoping work highlighted a paucity of current evidence on Women's Health Hub models and revealed gaps in the evidence base. Gaps include, for example: how Women's Health Hubs are understood; how many hubs are in existence or development, and where; key characteristics of hub models; how and why different approaches to implementing hub models have been taken; staff experiences of working in and with hubs; how models are intended to meet women's needs and address inequalities; and how they are experienced by women, including in relation to access and outcomes.

Table 1. Summary of key themes and messages from scoping interviews, evidence and stakeholder workshop

Defining and mapping hubs: • There is a lack of evidence/gaps in understanding around what is meant by a Women's Health Hub, models, implementation, experiences and outcomes. • Hubs are not necessarily a 'place' but a 'concept'. • Women's Health Hubs are understood differently by stakeholders – there is no single, agreed definition. The term 'hub' may be confusing to some – implying a physical location, and the term is being used in different ways across health and social care services. • There is substantial variation in approaches and in perspectives about what hubs could/should be. • Women's Health Hubs offer more than standard care. • To be seen as a Woman's Health Hub, there should be more than one provider/practice involved in the delivery. • There is no comprehensive list/database of Women's Health Hubs, though a range of examples of 'hub-like' approaches have been identified – it is possible that other services exist that we have not yet uncovered.
Rationale for hubs: • There is some commonality in drivers/objectives for establishing Women's Health Hub models but there are differences in priorities. • There is a desire and need to improve women's access to and experiences of sexual and reproductive care and address inequalities. • Fragmented sexual and reproductive health commissioning causes barriers to accessing and providing care. • Women's Health Hubs are often responsive to local women's needs and are driven by passionate local stakeholders. • Covid-19 has created further challenges around women's access to services, and has likely widened inequalities.
Models: • The Women's Health Hub landscape is complex and divergent with a range of models (e.g. in terms of services, aims, workforce approaches etc.) identified. • Integration at some level is a central concept though the nature of this integration (e.g. what is being integrated and how) is not the same across all models. • A co-commissioned approach is often a goal, though this is challenging to achieve in practice. • There is variation across a range of dimensions, including: the clinical 'offer'/scope (e.g. LARCs, gynaecology clinics), organisational forms (e.g. hub and spoke), leadership, workforce, training, leadership.
Implementation: • Hubs are all at different stages of planning/implementation – this suggests that hubs are evolving i.e. no model is 'finished'. • An approach wherein local areas 'start small' and build on this appears to be a necessary and good route to implementing hub models. • Flexibility is also important for establishing Women's Health Hubs, one size does not fit all. • Primary care networks (PCNs), place-based partnerships (PBPs) and integrated care systems (ICSs) can be seen as vehicles/mechanisms for supporting the implementation of Women's Health Hub approaches. • England has a particular set of contextual features, which will be relevant to hub development e.g. commissioning challenges, establishing PCNs and ICSs. • There appears to be a range of factors affecting how models are implemented and why particular models/approaches have been used. For example, the availability of funding/resources/facilities, local relationships and local workforce skills and capacity.
Measuring impact: • There are a wide range of potential measures (e.g. experience, cost, health) to explore. • Many possible measures are not routinely or consistently collected/collated/analysed. • Capturing impacts will be important for building support and encouraging uptake, and ensuring the hubs can be sustainable over the longer term.
Evaluating hubs: • Part of the work of the evaluation should be to define Women's Health Hubs – drawing a boundary will be important. • Women are at the centre of these models and the evaluation should include their experiences. • Access and equity/inequality should be key themes to explore. • The current landscape is complex – mapping the current 'state of art' across the UK will be helpful. • Integration should be a key consideration for selecting sites to be involved in in-depth research; models that have just been 'lifted and shifted' from one location to another should be excluded. • Ensuring diversity in aspects of care offered by hubs included in the in-depth research would be valuable. • It would be helpful to explore workforce (clinical and non-clinical) issues and experiences e.g. skills, recruitment, retention, training, leadership, multi-disciplinary team working. • Commissioning should be a feature throughout the evaluation, though not the sole focus.

Table 2. Summary of key themes and messages from online project design group with women with lived experience

The terminology used to describe these services i.e. as 'hubs' is confusing and implies a physical location with services all under one roof, this should be carefully considered to ensure clarity when communicating with women. It may be that a way of putting boundaries around what hubs are would be to focus on a key set of principles e.g. putting women first.
There appears to be much focus on integration, but it is vital that this is thought about in relation to being responsive to women and their needs and improving communication between teams– not simply the physical relocation of staff and services.
A life-course approach is important for Women's Health Hubs - ensuring that women are supported from puberty through to menopause and beyond, including a focus on education.
Speaking to women with lived experience of different factors, such as through a Women's Advisory Group, will help to ensure this work is done sensitively, appropriately and captures issues that are important to different women.
There is considerable variation in the experiences and needs of women across the life course. It is key that the evaluation takes this into consideration, both in terms of recruiting women to be part of the Women's Advisory Group but also when undertaking interviews with women who have received services via a hub.
Women often don't talk about women's health issues with others and there is still a sense of stigma and embarrassment associated with these issues. For some women, there is also a wider cultural context that can impact on the ways in which they interact with women's health services. Further, women may have experienced sexual abuse or violence, which needs to be carefully considered. When recruiting for the Women's Advisory Group, the team should think sensitively about who is asked to be involved, consider these factors and how we engage with different women to try to ensure those who are seldom heard have a chance to be involved.
Linked to the above, it will be important for the evaluation to try and capture how services are being made accessible, and respond to, a diverse group of women who may have very different backgrounds, experiences and life contexts, including trauma.
When recruiting women to take part in interviews about their experiences of hub services, it is key that the evaluation team present themselves as independent and not linked to the services in any way. As women's health issues/services can be a sensitive area for discussion, connecting with women will be important as will ensuring that women feel involved and have the opportunity to receive feedback from the study.
An iterative, flexible, locally appropriate approach to recruiting women for interviews would be helpful, where the team reflect on the local context, who has taken part in interviews and adapt recruitment methods, as appropriate, to try and reach a diverse group of women, including ethnic minorities, those who are disadvantaged and the seldom heard. Working with local community groups and charities could support with this.

In the subsequent sections, we detail how we will address some of these gaps in current evidence, our methodological approach, and the outputs we expect to produce as a result of this evaluation.

Plan for this evaluation

Aims and objectives

The overall aim of this rapid evaluation of Women's Health Hubs is to explore the 'current state of the art', mapping the landscape, stakeholder experiences, and defining key features, outcomes and early markers of success, to inform policy and practice..

Specifically, to achieve this, the evaluation will define Women's Health Hubs and explore why, where and how hubs have been implemented, why different approaches have been taken, and experiences of implementation, delivery and service use. The evaluation will provide feedback about the successes and challenges of the service and potential improvements, including different stakeholder group perspectives of what hubs are intended to achieve, whether hubs are making progress towards this and what could be learned for the future evolution of hub delivery.

Given the divergence identified in the current landscape through the scoping research, a rapid study to define, map and understand current approaches is necessary. Our work will also gather preliminary evidence about what is known about performance, outcomes and costs and how they are/can be measured, to offer preliminary insights into impact

Evaluation questions

In order to address these aims, the study seeks to answer the following evaluation questions:

1. What are Women's Health Hubs, and is there variation in how stakeholders name and define them?
2. How many Women's Health Hubs have been established/are in development across the UK, where are they, and what are their characteristics, including models of structure, commissioning and delivery?
3. Why have Women's Health Hubs been implemented, and how are they intended to address health inequalities?
4. What have Women's Health Hubs achieved to date? How do Women's Health Hubs achieve this?
5. What are the experiences and perspectives of staff regarding Women's Health Hub setup, commissioning, implementation and delivery?
6. What are the experiences and perspectives of women who have used hub services?
7. How are Women's Health Hub performance, outcomes and costs measured, and how might they be measured in future?

Research design

A key purpose of the study is to provide a detailed description of different hub models in place, how they are being implemented to date, and how successfully from the perspective of those tasked with implementation.

This calls for a research approach which is formative and learning-oriented, with regular and timely feedback of findings to research funders, national and local decision-makers, local participants (e.g. exemplar hubs, local authorities, providers, CCGs) and wider national stakeholders. This study will produce substantive findings and learning about Women's Health Hubs as this model emerges.

We propose a mixed-methods evaluation, combining quantitative and qualitative data from a survey of Women's Health Hub models identified in the United Kingdom, with in-depth qualitative insights from four purposively selected exemplar hub sites in England, to provide deeply contextualised findings. This approach will offer both breadth and depth in data collection. Our evaluation will be comprised of three distinct work packages (WP) detailed in Table 3 below.

Table 3: Summary of work packages and how research questions will be addressed

Work Package	Overview of methods	Description	Research Questions
WP 1	• Consolidating and gathering information to inform a database of Women's Health Hub models • Online survey with key stakeholders: a lead in each UK Women's Health Hub, identified in our database • Analysis of interviews with national stakeholders undertaken during the scoping phase • Interviews with regional stakeholders • Development of an initial working typology of hub models, if possible	Mapping of the current landscape and context for Women's Health Hubs, providing a description of different hub characteristics and models in place	RQs 1-3, 7
WP 2	• Selection of exemplar hub sites • In-depth interviews with hub professionals and staff in the wider health system • In-depth interviews with service users • Documentary analysis	In-depth work with four exemplar hub sites to understand more about why and how hubs have been funded, commissioned and implemented, experiences of hub delivery (including women's experience), measurement of performance and outcomes and successes and challenges.	RQs 1-7
WP 3	• Interviews with national stakeholders • Production of a rich description and map of UK Women's Health Hubs • Identification of outcomes which are/could be used to assess impact • If possible, development of a theory of change • Development of recommendations for policy, practice and research.	Bringing together and consolidating findings from Work Packages 1 and 2 to generate evidence on Women's Health Hub models and provide recommendations for policy, practice and research.	RQ 1,7

Methodology

The methods used in each of the evaluation work packages are described below. Work Packages 1-3 all include working with a Women's Advisory Group (please see page 29 for more details).

Work Package 1: Mapping the current landscape and context for Women's Health Hubs

Database of Women's Health Hubs in the UK

We will use the findings from our pre-evaluation scoping work as the foundation for a database of UK Women's Health Hubs, which will be refined throughout the evaluation. To date, we have identified at least 20 examples of service provision which could be described as Women's Health Hubs, but anticipate that there are additional hubs which were not uncovered during our scoping work. To identify any additional hub models to add to the database, we will disseminate requests for information about current and planned hubs via the Primary Care Women's Health Forum, Faculty of Sexual and Reproductive Healthcare and our Stakeholder Advisory Group. Through this work we will identify and seek contact details for leads in each UK Women's Health Hub.

Online survey of hub leads

We will then undertake an online survey with key stakeholders in each UK hub (e.g. lead commissioners, hub providers). The main purpose of the survey will be to gather essential descriptive information from local areas to map the current Women's Health Hub landscape. The survey will include details about hub design and set-up, services delivered, population covered by the hub, how long it has been established, staffing/team compositions, and commissioning and delivery models. The survey will also capture information about the resources required to set up and deliver services in the local hubs including some understanding of the costs and funding arrangements. The survey will consist of a mix of closed questions alongside a number of open questions to enable participants to share more details, where required. The survey will be developed with input from policy, clinical and commissioning stakeholders.

We will send an invitation to participate to a lead stakeholder (e.g. local commissioners, hub providers) in every UK Women's Health Hub in our database. The invitation will contain a link to a web-based survey, and we will also send out at least two email reminders to maximise response rates. The survey will be administered using appropriate survey software, which has been approved for use. The survey will be sent out with a short covering email explaining the purpose of the research, how the findings will be used and how long the survey will take to complete (approximately 30 minutes). We will also offer participants the option of completing the survey over the telephone with one of the evaluation team.

Data from the completed surveys will be stored securely using password-protected spreadsheets to which only the researchers will have access. The survey data will be analysed by the team. We will use the responses to the online survey to refine the database of Women's Health Hub models around the country, to produce a descriptive summary and map of hub models currently in place, and, if possible, to develop a working typology of hub models. This will support the selection of four exemplar hubs for in-depth research (please see WP 2 for more details).

Interviews with national and regional stakeholders

The scoping work which informed the design of this evaluation included interviews with ten national key informants from across England. These interviews included individuals identified as experts leading and contributing to the development of Women's Health Hub policy and practice across the country, with roles in commissioning, clinical care and service leadership, policymaking, advocacy, education and training. Participants were drawn from organisations including the Department of Health and Social Care, Primary Care Women's Health Forum, Faculty of Sexual and Reproductive Healthcarelocal authority, NHS primary and community care, and hospital trusts. Interviews were conducted in January and February 2022. Interviews explored definitions, aims and context for hubs, location and models currently in place, existing evidence, policy and evaluations, indicators of success, and plans for scale up. The data from these interviews will be analysed in-depth as part of Work Package 1, with the addition of regional stakeholder interviews, described below.

We will also interview regional stakeholders, aiming to speak to one key stakeholder in each of the seven NHS England and NHS Improvement regions, to further understand the wider landscape in which Women's Health Hubs are situated. The key stakeholder in each area will likely vary according to local context but may include, for example, Regional Directors of Public Health, Health and Wellbeing chairs and NHS leads (such as from ICSs and NHS England and NHS Improvement).

These interviews will explore the current context for the development and early progress of the Women's Health Hubs including challenges in provision of women's sexual and reproductive healthcare, as well as offer formative insights into how they relate to (or not) other key regional/place-based developments such as ICSs.

Work Package 2: In-depth work with exemplar hub sites

Selection of exemplar hubs

Four exemplar hubs will be selected for investigation, with documentary analysis and qualitative research undertaken in each to provide in-depth insights into hub set-up, development, delivery models and progress. This in-depth research will focus on England, rather than across the United Kingdom: there are a particular set of features unique to the current English context, including commissioning challenges and the establishment of PCNs and ICSs, which will be important to explore during the in-depth work. Further, given the current diversity in the landscape, it was deemed important by the study team and some wider stakeholders to focus efforts on one nation to build contextual knowledge. This will enable a more comparative approach that would not be possible if models from the devolved nations were included, which differ substantially in terms of, health policy, structure and commissioning. However, learning from the devolved nations will be of importance to the evaluation and incorporated as appropriate.

In order to select case study hub sites, the team will use information obtained during the scoping review, from regional interviews, online survey findings, the hub database, and desk research (below). We will also work with the Stakeholder Advisory Group to sense-check the list of potential hubs for inclusion.

The team will undertake desk research to gather any additional information required regarding the identified hubs. For example, the deprivation of the area in which the hub is located will be

determined using Office for Health Improvement and Disparities 'Fingertips' (www.fingertips.phe.org.uk) data.

Exemplar hub sites will be selected to ensure the generation of learning and a diversity of different types of hubs to enable a range of models, experiences and insights to be captured. Such variables might include:

- **Geography:** urban and rural areas, a mix of exemplar hubs from across England
- **Commissioning model:** a mix in terms of how the exemplar hub services have been commissioned e.g. co-commissioned between a local authority and CCG, commissioned by local authority or CCG only, no formal commissioning arrangements in place, and any relevant agreements with regard to funding and resourcing arrangements
- **Delivery model:** a mix in terms of size of population covered by exemplar hubs, team composition e.g. primary and secondary care staff etc., which organization has led/driven hub establishment e.g. primary care, local authority, sexual and reproductive health services
- **Range of services:** a mix in terms of services (and range) offered by the hubs e.g. long-acting reversible contraception, heavy menstrual bleeding management, menopause management
- **Demography:** a mix in terms of socio-economic characteristics, ethnic diversity etc.

Set up and familiarisation with exemplar hub sites

The team have already begun building relationships with various stakeholders involved in developing women's hubs in a range of local areas - some of these areas may be invited to take part in the in-depth research. A member of the research team will be allocated to each hub site to ensure consistency, build relationships and for ease of contact. We will also ask each hub site to identify a lead contact. We will have regular and clear communication with these stakeholders to aid the collection of the deeply contextualised research data and where necessary, others we build networks with (e.g. hub staff).

Researchers will make contact with local identified leads and set up times to meet with them (face to face or virtually, depending on local site preference) and any other key people involved in local design, set up and implementation. The purpose of these meetings will be to:

- Explain the research process, timings and what input/support will be required locally (e.g. brokering access to informants for the qualitative research)
- Build a deeper understanding of the local context, plans and implementation so far
- Identify key documents for the team to review as part of the familiarisation process
- Begin to identify key local stakeholders to invite to approach to take part in an interview
- Develop good working relationships with exemplar hub sites, agreeing lines of communication and clarifying expectations.

Qualitative interviews with hub professionals and service users

In each hub site, we will aim to conduct qualitative semi-structured interviews with up to 4 staff involved in hub commissioning, development and/or delivery, up to 3 staff working within the local health system and up to 8 women with experience of local hub services. In total, this means that up to 28 interviews with staff and 32 interviews with women using hub services, as shown in table 4.

The aim of the interviews with staff involved in hub commissioning and delivery (e.g. GPs, nurses, sexual and reproductive health consultants, commissioners, administrators) will be to understand their experiences of setting up and implementing their Women's Health Hubs and delivering services, how and why particular approaches have been taken (including how models are intended to meet local needs and address inequalities), insights into their impacts e.g. on women and the wider health system and what has worked well and less well. This will include considerations of resourcing and funding arrangements.

For interviews with wider staff, the aim will be to understand their experiences of working within the local health system linked to the Women's Health Hub, for example, to explore their views on the hubs, how they are working (including referral processes), links with the local system and any impacts on their work and experiences of delivering care to women.

In interviews with service users, we will explore their experiences of Women's Health Hubs, including accessibility and efficiency of, and engagement and satisfaction with services, views regarding whether the hub has made a difference to the care they received, and any recommendations for future improvements. The study team have experience conducting research with service users, and we will ensure our approach is tailored accordingly to ensure participants feel comfortable throughout the interview.

Table 4 Number of interviews from each stakeholder group and case study site

Stakeholder groups	**Number from each case study site**	**Total number of interviews across the evaluation**
Staff involved in hub commissioning, development and/or delivery	Up to 4	Up to 16
Staff working within the local health system (e.g. hospital gynaecologists, referring GPs, practice managers, pharmacists, senior leaders with overarching ownership of hubs)	Up to 3	Up to 12
Women service users	Up to 8	Up to 32
Total	Up to 15 per site	Up to 60 in total

<u>Recruitment and consent</u>

For staff, a purposive approach to sampling will be undertaken, wherein participants will be sampled strategically with the research questions and local hub context in mind (Ritchie and Lewis, 2003). Participants will be recruited through the links made with hub sites and hub leads, who will be asked to support recruitment. In light of the expected diversity between exemplar sites, we would expect the staff group to include:

- Key stakeholders who have driven local development of the exemplar hub model
- Commissioners and providers
- Staff from local hubs and other linked organisations, e.g. hospital consultants, referring GPs
- Managers and strategic leads
- Voluntary sector organisations

Potential participants will be approached by email or telephone and provided with an information sheet which includes general information about the evaluation, the purpose of the research and what participation would entail.

For service users, those who have had experience receiving services via a Women's Health Hub will be eligible for inclusion. The approach taken to recruit women service users will be context-dependent and determined in close collaboration with local hub leads/delivery staff to ensure that it is appropriate and best suited to local context and needs. One approach may be for the research lead to attend a hub location on an agreed date and for women attending appointments to be invited to take part in an interview with the research lead following their appointment, but the team will work with local stakeholders to determine the most suitable approach. This method has been used in previous evaluations and was found to be particularly helpful for engaging women who may not ordinarily respond to a request to take part in research. We will also consider offering the option of focus groups to women, where appropriate. Whichever method is chosen, all service users will be provided with an information sheet explaining the evaluation and informed that taking part in interviews is completely voluntary.

The approaches offered will also be informed in consultation with, and by feedback from, our Women's Advisory Group (please see page 29) to help to ensure a wide range of women are invited to participate in the evaluation.

Prior to commencing the interview, interviewees will have the opportunity to ask questions about the study and/or wider BRACE related work. All participants will be required to sign a consent form before participating in the interview, which will include asking whether they consent to the recording and verbatim transcription of the interview.

Interview conduct and analysis

Interviews with staff will be between 45 minutes and 1 hour and will be conducted either face to face, by telephone or online using a video conferencing platform such as MS Teams or Zoom. The option of group interviews (e.g. with members of their team) will also be offered if preferred, potentially 'piggy backing' onto existing meetings, to maximise convenience.

Interviews with service users will be up to 30 minutes. The location will be dependent on the chosen recruitment approach, decided in collaboration with local hub leads/delivery staff. All service users will be offered a £10 shopping voucher for taking part, in recognition of their time.

The study team have experience conducting research for projects on sensitive topics and/or with service users, and we will ensure our approach is tailored accordingly to ensure participants feel comfortable throughout the interviews.

Topic guides will be developed for the interviews, one for staff and another for service users. These will be reviewed by at least one member of our Women's Advisory Group. The themes and questions covered in the topic guides will be informed by the scoping work we have conducted, design work with women and insights from the Stakeholder Advisory Group. Examples of topics to be covered include:

- What a Women's Health Hub is understood to be
- What the local model looks like, key characteristics including commissioning approach, services offered, scope, size, groups of women prioritised
- Why hub sites were set up and implemented, including the role of inequalities

- Views about what the hub is intended to achieve
- Experiences in setting up and implementing hub sites
- Services and sectors involved in set-up and delivery
- Experiences in delivering hub services and/or working with the hub
- Experiences of commissioning local services in this way
- What has worked well and less well
- Service user experiences of receiving care as part of a Women's Health Hub and the extent to which hubs have improved access and satisfaction
- Staff views on whether the Women's Health Hubs offer a better service for women
- Views about whether the hub has achieved its intended aims
- If and how hubs are addressing local health inequalities e.g. in access and outcomes
- How services are responding to the needs of different women
- How performance and outcomes are measured in the hub
- Any insights or evidence of outcomes or impacts
- Key learning to date

With consent, all interviews will be audio-recorded and transcribed verbatim for analysis. Transcripts will be anonymised and kept in compliance with the General Data Protection Regulation (GDPR) 2018 and Data Protection Act 2018.

Data will be analysed thematically and comparatively, using a team-based approach and guided by the principles of the framework method (Gale et al 2013). Following familiarisation with the data, initial exemplar transcripts from each case study will be coded independently by two researchers. Initial codes will be reviewed and organised into categories, to develop a working analytical framework. The framework will then be applied to the remainder of the data, and codes and categories will be continuously refined. Coded data will then be summarised and charted into matrices, to enable within - and cross-hub comparison, and to develop analytical themes. A combined deductive and inductive approach will be adopted, guided by the research questions while allowing for exploration of unanticipated concepts identified in the data. We will specifically explore the nature of service integration in the four hub sites, and the role of local context in shaping hub design, implementation, delivery, and women's experiences.

Documentary analysis

Both at the initial familiarisation meeting with the identified hub lead, and following interviews with hub stakeholders, we will ask stakeholders whether they can identify any documents (not containing sensitive information) that could be shared with the team to help build a picture of the local context, hub set-up, implementation, commissioning and decision-making, costs, outcomes, challenges and successes, and other aims. This will include a review of any quantitative data or metrics that be collected (or made available) locally. Information will be extracted from source documents using a structured Excel extraction template.

Typology

Drawing on this case study work, we will refine the initial typology of Women's Health Hubs developed in WP1, to understand divergences. This will be a key output, pulling together and mapping what is known about these models e.g. their areas of focus, aim, commissioning and

delivery structures, team composition etc. and, describing the underlying programme theory of each case study hub.

Work Package 3: Consolidating evidence and developing recommendations

One of the purposes of this rapid evaluation is to generate and share learning across the system to support local adaptation and equitable rollout of Women's Health Hubs. It is also likely that the findings will be transferrable to other contexts implementing place-based, patient-centred, integrated models of care, aligning with the national policy direction of more joined-up working through ICSs, PBPs and PCNs.Work Package 3 will bring together the findings from Work Packages 1 and 2 to generate evidence around what the models currently look like, insights from commissioning, implementation, delivery, successes and challenges, and potential improvements. This will address the need to map and explore hub implementation, incorporating and analysing the substantial heterogeneity in definition, design and implementation of hubs. Work Package 3 objectives are:

- Interview key stakeholders involved in this field at a national and/or policy level to explore the current national policy and practice contexts for the development of Women's Health Hubs as the evaluation nears its end, at a time when the Women's Health Strategy and Sexual Health Strategy are likely to have been published, to capture changes and insights since the initial scoping interviews. 4-5 interviews will be carried out with representatives at a national level, for example, policy stakeholders and those from key organisations in this field e.g. the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare, the Office for Health Improvement and Disparities and the Primary Care Women's Health Forum.
- Produce a rich description and map of Women's Health Hubs across the UK, and their achievements to-date, including what is known about their impact on health inequalities, stakeholder experiences, and barriers and facilitators to implementation.
- Identify outcomes (interim and longer-term) which are currently, and/or could be measured to assess the impact of Women's Health Hubs, and exploring how this might be achieved e.g. through the availability and use of routine national and local data, or via primary data collection. For example, in terms of routine data, data available on Public Health England's Fingertips portal (www.fingertips.phe.org.uk) on LARC prescription and abortion rates, at the county-level. This will include understanding what information is being collected by local hub sites and approaches to collect data that is not routinely available so that the cost-effectiveness and added value of emerging Women's Health Hubs could be robustly assessed. This will incorporate considerations relating to equity and longer-term sustainability.
- If possible, develop a theory of change for the concept of Women's Health Hubs. A theory of change would specify the desired outcomes, and describe the activities and mechanisms by which these outcomes are expected to be achieved and the contextual conditions which may be integral to success. Given the diversity and complexity of these emerging models, it is likely that developing a single theory of change will not be possible. This work will be undertaken in collaboration with key local and national stakeholders in this field.
- Develop recommendations for policy and practice, to support the commissioning, design, implementation and delivery of Women's Health Hubs.
- Develop recommendations for future research and evaluation.

Project timetable

The study will take place over approximately 12 months (April 2022 to March 2023) with dissemination taking place post March 2023. This is assuming timely access to the exemplar hubs in which we are undertaking more in-depth research, obtaining necessary ethical and governance approvals, as well as identifying and completing data collection with key stakeholders. Table 5 overleaf shows the overall study timeline and the key milestones for the project.

Table 5. Project timetable

	Mar 22	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Submit protocol to NIHR													
Secure ethical approvals													
Consolidate and gather additional information for hub database, including reanalysis of scoping interviews													
Design, launch and analyse online survey													
Qualitative interviews with regional stakeholders													
Develop working typology, if possible													
Select and approach exemplar hub sites, secure any local approvals (as necessary)													
Initial meetings with exemplar hub sites and documentary analysis													
Qualitative interviews with stakeholders at exemplar hub sites													
Identifying outcomes (interim and longer-term) which are currently, and/or could be measured to assess the impact of Women's Health Hubs and exploring the possibility of developing a theory of change													
Draft and share interim slide-pack of findings													
Qualitative interviews with national stakeholders													
Data analysis and synthesis, including refining typology													
Draft and submit final report													

Expected outputs and dissemination

The study findings will be written up and shared widely in a number of formats, both written and verbal. The final report to NIHR will be submitted in March 2023 and published in the NIHR Journals Library (HS&DR Programme), as well as other high-quality, peer-reviewed academic journals. Dissemination will take place after March 2023.

The main routes for dissemination will be:

- A final report submitted to the National Institute for Health Research, Health and Social Care Delivery Research programme (NIHR HSDR) to be published in the NIHR Journals Library.
- An interim report, in the form of a set of presentation slides, to share preliminary evaluation findings with our Stakeholder and Women's Advisory Groups, NIHR HS&DR, the BRACE Steering Group and BRACE Health and Care Panel.
- A short summary report in digital format, supported by professionally produced infographics, highlighting the overarching findings from the evaluation focused on experiences, key learning and enablers and barriers to local hub set up and delivery. These may be of particular interest to policy makers, stakeholders involved in local implementation of Women's Health Hubs, providers and commissioners of women's health services, voluntary sector organisations, academics and researchers working in this field, and the wider general public.
- A slide-pack of key high-level findings for each of the four hub sites involved in the in-depth research. We will also offer each of our four sites the opportunity to attend a local workshop event to share and reflect on their findings.
- Papers published in high quality, peer-reviewed, academic journals.
- Presentations at conferences, seminars, workshops and meetings.
- Sharing findings more widely on social media platforms, such as Twitter.
- Disseminating findings through BRACE networks, including to key bodies and stakeholders, including the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare, National Voices, the Primary Care Women's Health Forum and Royal College of GPs. The team will work closely with topic and communications specialists, including our Stakeholder Advisory Group (please see page 29), Women's Advisory Group, BRACE steering group members and members of the BRACE Health and Care Panel,[2] to tailor outputs to different audiences in order to maximise reach and impact. Through our scoping research, we have already started to foster links with key national bodies, including leading voluntary sector and professional associations in women's health. We will continue to build these networks and explore opportunities to disseminate through them as the project progresses.

Project management, governance and quality assurance

This protocol has been reviewed by Dr Jo Ellins (BRACE Interim Director) and by two independent reviewers: a consultant in women's health and a policy stakeholder in the field.

[2] The BRACE Health and Care Panel provides advice and support for the design and delivery of BRACE projects. Its 50 members include services users and members of the public, senior and operational managers, frontline professionals, voluntary sector organisations, national bodies and researchers.

The principal investigator Dr Beck Taylor (University of Birmingham) will be responsible for the overall delivery and quality assurance of the evaluation. Kelly Singh (University of Birmingham) will be responsible for project management and co-ordination of the study, with input from Lucy Hocking and Dr Jennifer Bousfield (RAND Europe), and Dr Louise Jackson (University of Birmingham).

We will apply the following project management principles and processes: ensuring clarity of team members' roles and the delegation of tasks and reporting duties; development and use of project plans; and regular team meetings. RAND Europe's approach to project management is guided by its ISO 9001:2015 certification and is seen as fundamental to the successful and timely delivery of the evaluation.

Throughout the duration of the evaluation, there will be fortnightly (or more frequently if required) team teleconferences in order to update progress and promptly address any arising issues. The project will formally report to the BRACE Centre executive team (including regular progress reports and prompt sharing of any concerns or identified risks for resolution), Steering Group and NIHR HSDR as and when required. We describe potential risks and mitigation strategies in Table 6. Senior supervision and support will be provided by Dr Jo Ellins, BRACE Centre Interim Director, who has current, overall accountability for all projects delivered by BRACE. All reports and other deliverables will be peer-reviewed by Dr Ellins and a minimum of two people, drawn from the following: academic critical friends (linked with the BRACE collaboration or elsewhere), the BRACE Health and Care Panel, and Steering Group.

Formal sign off of outputs – including this protocol – is by Programme Directors for HSDR.

Table 6. Potential risks and mitigation strategies

Risk	Impact	Likelihood	Mitigation
Non-engagement from exemplar hub sites	High	Medium	Success of this rapid evaluation will depend on the co-operation of exemplar hub sites for supporting processes associated with participant recruitment and data collection in a timely manner, as well as any required local governance approvals. The team have already begun building relationships with various stakeholders involved in developing women's hubs in a range of local areas - some of these areas may be invited to take part in the in-depth research. Our project team is experienced in building and maintaining relationships with key stakeholders, such as with these exemplar hub sites. The scoping phase highlighted a clear need for this evaluation to be undertaken and an appetite and enthusiasm from stakeholders to be involved. Additionally, the team will seek advice and guidance from the Stakeholder Advisory Group, as necessary, about the most appropriate ways to engage and secure exemplar hub sites. The research team will be clear with potential exemplar hub sites about the objectives of the study, and the time and resources required from participating sites. A member of the research team will also be allocated to each exemplar hub site to build relationships and for ease of contact.
Delays due to inability to recruit participants/ as a result of Covid-19 and associated increased pressures on stakeholders	High	Medium	The team will adhere to good practice in developing relationships with potential participants and have a clear and planned strategy for recruitment. Interpersonal skills will be key, particularly when recruiting service users at the exemplar hub sites. The team will produce detailed and clear, descriptive information sheets to inform potential participants about the importance of the evaluation, why we have asked them to take part, their involvement, and associated risks and benefits. For recruiting women to take part in service user interviews, the team will take a locally tailored approach to ensure that the recruitment methods used are appropriate and take account of local context and needs. Though the country is beginning to adapt to 'life with Covid-19', there is still a risk that there that we may be delayed in recruiting participants in a timely manner, due to the pandemic. To mitigate this, we: • Have allowed for a period of recruitment to avoid undue pressure being placed on participants to be involved; • Will build relationships with, and familiarity with exemplar hub sites, including through a named lead contact on the research team and at the local hub site; and, • Will ensure we take a tailored, appropriate, and flexible approach to recruitment that considers the context and situation for each exemplar hub site.
Absence of staff on the team	High	Low	Although the project team is small, in the event of staff absence, there is capacity for other staff with experience of conducting health and social care evaluations to join the team offering additional support, where needed, particularly from RAND Europe. Both the Principal Investigator and project team members have extensive evaluation and research experience.
Loss of data	High	Low	Although unlikely that data loss would occur, the University of Birmingham and RAND Europe have resilient, well-tested IT systems with data from all computers backed up in multiple locations enabling the recovery of any lost data on local servers. The study team will ensure transfer of data from case study sites to the University of Birmingham or RAND will be done according to GDPR guidelines.

Research team

Table 7. Study team members

Team member	Role and contribution	Relevant expertise
Dr Beck Taylor, Clinical Associate Professor, University of Birmingham	Principal Investigator	Beck is a Clinical Associate Professor in the Institute of Applied Health Research, and is an Honorary Consultant in Public Health at the Office for Health Improvement and Disparities. She is a mixed-methods researcher, with an interest in service design, policy and health systems, and a focus on maternity care and women's health research, and is involved in a range of NIHR-funded studies in collaboration with women and NHS staff. She has a long-standing interest in women's and sexual health, including working in genitourinary medicine during her clinical training.
Dr Jennifer Bousfield, Analyst, RAND Europe	Preparation of research materials, data collection, data analysis, report writing	Jennifer has a background in research on health and social care topics. This includes research on health, symptomatology and more recently, evaluations on new and emerging technology for social care, and Covid-19 home monitoring, as part of BRACE. She has extensive experience in collecting and analysing qualitative data. She was recently a researcher on a study of social inclusion and mental health, conducting and analysing interviews and focus groups with staff, service users and carers.
Lucy Hocking, Senior Analyst, RAND Europe	Preparation of research materials, data collection, data analysis, report writing	Lucy has experience in public health, health improvement and innovation and health services research, using a range of qualitative and quantitative research methods, including literature review, conducting and analysing interviews, developing in-depth case studies and designing and analysing surveys. She is a team member for other BRACE evaluations including the "Early evaluation of the Children and Young People's Mental Health Trailblazer programme" and "Digital First Primary Care for those with multiple long-term conditions". Lucy has an MSc in child public health, which explored the impact of different sources of parenting advice on postnatal depression in new mothers.
Dr Louise Jackson, Senior Lecturer, University of Birmingham	Contribution to identification of outcomes which are/could be used to assess impact	Louise is a Health Economist within the Institute of Applied Health Research, with a broad range of methodological experience and expertise. She is particularly interested in applied research that improves health and care services, especially for young people and women. Louise is involved in leading economic evaluations in the areas of public health, sexual health and women's reproductive health and has carried out methodological research exploring the methods used to measure outcomes in relation to interventions in sexual health. Louise has specific expertise in relation to economic evaluation; outcome and cost measurement; preference elicitation; and qualitative evidence synthesis and reporting. Louise works closely with stakeholders and is interested in mixed methods research that aims to meet the needs of decision-makers, particularly in public health.
Kelly Singh, Evaluation Fellow, University of Birmingham	Project Manager. preparation of research materials, ethics processes, data collection, data analysis, report writing	Kelly has over eight years of experience in managing and undertaking applied health services research and evaluation for public sector and charitable organisations. Her research interests include person-centred care, integration, health service delivery and patient and service user experience and involvement. Kelly has been a core team member on other BRACE evaluations including the "Early evaluation of the Children and Young People's Mental Health Trailblazer programme".

Expert input

Stakeholder Advisory Group

As previously mentioned, to support the team and the evaluation, we have established a stakeholder group offering expertise and advice to support study design and delivery. The Stakeholder Advisory Group is made up of a range of members with significant experience in the field of women's health, including clinicians, policy stakeholders and a woman with lived experience.

Specialist advisor

The team will also be supported by a specialist advisor, Sophia Christie, who will work closely with the team supporting the design and delivery of the evaluation, analysis and interpretation of findings, and the production of outputs. Sophia has been involved in NHS Commissioning since the early 1990s, led initiatives to tackle Health Inequalities and economic regeneration at Director level across health and local government, and during her 10 years as a Chief Executive in the NHS, featured regularly in "changemaker" lists. She was regularly involved in policy development by central government departments. She has a track record of innovation in health and care, including service re-design and population preference profiling and has written widely on organisational development and participation. She has taken a consistent interest in improving access and response to underserved populations and vulnerable people, including tackling teen pregnancy and infant mortality, wider access to reproductive health support, and specialised mental health services. Since 2012, Sophia has concentrated on strategy and organisational design for performance, as Managing Director of UKPrime Ltd. Academically, Sophia has degrees from the Universities of Oxford and York, and training in research methods from Durham University. Sophia will also be part of our Stakeholder Advisory Group.

Involving women

The scoping work undertaken to inform the design of the study and development of the protocol included rapid consultation with three women who have experience of NHS care for women's health issues. The participants shared their views about the concept of Women's Health Hubs and what they think the evaluation should focus on.

We will also recruit up to eight women to form a Women's Advisory Group to provide input throughout the evaluation and use their experiences to shape the evaluation and influence the wider women's health sector. To recruit women to the group, we plan to work with BRACE partner National Voices as well as approach other organisations, for example, Wellbeing of Women, Women's Health Concern and the Royal College of Obstetricians and Gynaecologists who have a Women's Voices Involvement Panel of over 600 members of the public. We will ask these organisations to share details of the opportunity to be part of a Women's Advisory Group on their websites and with their network members.

We will aim to recruit a diverse group of women of different backgrounds and ages, with a range of experiences of NHS care for women's health issues such as coil and implant fitting, smear tests, heavy bleeding, and menopause. Our ongoing consultation with this group will fulfil the following aims:

- Advising on effective ways to carry out the evaluation, for example, to reach women to take part, including ethnic minorities, those who are disadvantaged and the seldom heard.
- Reviewing relevant research tools, for example, topic guides for interviews with women receiving care from Women's Health Hubs.
- Sharing and asking for comment on emerging findings – for example, about whether the focus, activities and progress being made in Women's Health Hubs is addressing priority issues and concerns for women.
- Discussing which outcomes valued by women could/should be measured to assess impact and appropriateness of using these.
- Seeking advice about the best ways to frame and disseminate the research findings to the public and professionals.
- Seeking advice about how to work with the public and professionals to translate research results into practice.

Meetings with the Women's Advisory Group will either be face to face or undertaken virtually, to best suit the needs of the group. Any face-to-face meetings would take place at a venue agreed by the group. The women involved in the study as part of the Women's Advisory Group will be paid for their time and have their expenses reimbursed, consistent with best practice guidelines (INVOLVE 2015).

Ethical issues and approvals required

An application for ethical review by the University of Birmingham's Research Ethics Committee will be made at the earliest possible opportunity. The project team has received confirmation from the Head of Research Governance and Integrity at the University of Birmingham (which is the study sponsor) that this project is categorised as a service evaluation. Therefore, approval by the HRA or an NHS Research Ethics Committee is not required.

Participant consent

As explained in the methodology section, research processes will be designed to ensure that participation is informed and voluntary. Information sheets and consent forms will be shared with potential participants, which will detail the study aims, design, risks, benefits and who they may contact if they have further questions. The information sheet will also make clear that participants have a right to withdraw from the study up to a specified cut-off date, without needing to give a reason. Potential participants will receive an email inviting them to take part in the study, along with an information sheet and consent form. Each participant will have returned a consent form prior to commencing their interview. As noted above, our team have considerable experience conducting research with professional stakeholders and service users.

Confidentiality

The identity of all participants will be kept anonymous. Data stored on research team laptops will be both password and bit locker protected. All electronic data will be stored and held securely on a restricted access network, and paper copies of information sheets and consent forms will be kept in a locked filing cabinet. Participant identifier codes will be stored separately from the anonymised interview transcripts.

Indemnity and insurance

The University of Birmingham holds the relevant insurance cover for this study, as confirmed via our BRACE contract with NIHR.

Sponsor

The University of Birmingham will act as the main sponsor and guarantor for this study.

Data storage

All data will be stored in accordance with the University of Birmingham's Data Protection and Research Data Management policies, and in compliance with GDPR and the UK Data Protection Act 2018. All electronic data will be stored on the University of Birmingham research data store (RDS), in a folder accessible only to members of the study team. The project team will store data at the University of Birmingham for up to five years after data collection is complete (or until it is no longer necessary). Data will then be archived in accordance with University of Birmingham research governance processes.

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Appendix 1: Women's Health Hub models identified through the scoping work so far

Through our scoping research, we identified at least 20 examples of care models which could be described as Women's Health Hubs, which are already in place, or currently in development. Appendix Table 1 below documents the spread of the hubs identified.

Appendix Table 1. Examples of hubs/hub-type models uncovered in the scoping research

Liverpool	Tower Hamlets
Manchester	South East London
Leeds	Greenwich
Bradford	Islington
Sheffield	Hackney
Durham	Hertfordshire
Sunderland	Hampshire
Birmingham	Guildford and Waverley
Leicester	Reading
Belfast	Somerset
Edinburgh	Cornwall

Across those hubs identified, a range of services are offered. For example, provision of long-acting reversible contraception (LARC), menopause management, pessary fitting and heavy menstrual bleeding treatment. Multiple reasons for establishing a Women's Health Hub were highlighted including to improve women's experiences and health, reduce the usage of secondary care services, provide holistic care and care closer to home, reduce service fragmentation, tackle inequalities in care and train/upskill the workforce (Primary Care Women's Health Forum, 2021a; Primary Care Women's Health Forum, 2022a,b; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020).

There is divergence in hub types with a range of commissioning and delivery models. For example, in Durham, two gynaecology hubs have been established, driven by a GP, which take referrals from general practices across Durham for issues such as heavy menstrual bleeding, prolapse and menopause (Primary Care Women's Health Forum, 2022a). Another example is in Manchester where community gynaecology and reproductive health consultant led, community-based gynaecology services have been set up, and women's presenting problems are managed in a single visit (Primary Care Women's Health Forum, 2021a). The scoping work suggested that it may be useful to categorise hubs according to the lead individuals driving implementation: GP-led, sexual and reproductive health consultant-led, and commissioner-led.

Key outcome measures include uptake of long-acting reversible contraception (LARC), patient satisfaction reductions in referrals to secondary care services, and waiting times (Primary Care Women's Health Forum, 2021a; Primary Care Women's Health Forum, 2022c; Faculty of Sexual and Reproductive Healthcare, 2019; Bayer, 2019).

Appendix 2: Findings from project design workshop on 22nd February

Project design group with key stakeholders e.g. hub leaders, clinicians

To be seen as a hub, there should be more than one provider/practice
A Women's Health Hub offers more than standard care
Drawing a boundary around what a hub is will be important both for the evaluation and in local areas – to ensure clear communication, shared understanding and that hubs are recognisable to women
Understanding the 'what' is important – is there a core offer/set of principles/key features shared across Women's Health Hubs?
ICSs, PCNs and a focus on place offer opportunities for establishing Women's Health Hubs – there is potential to shape what is offered locally and work together more collaboratively. Though other aspects of health, including the Covid-19 backlog, are likely to be prioritised and PCN driven models may present barriers to working with other partners/wider integration.
Local context is key for setting up and implementing hubs, one size does not fit all
There is some degree of cross service/sector working involved in Women's Health Hubs
The term "hub" may be confusing to some – it might imply a physical location when virtual approaches should also be considered
Women's health is not just about sexual and reproductive health
There is a balance to be struck between primary care and Women's Health Hubs and what is managed where – what impact do Women's Health Hubs have on primary care?
The role of the voluntary sector is important, particularly for engaging women who are harder to reach
England has a particular set of contextual features, which will be relevant for hub development e.g. commissioning challenges, establishment of ICSs and PCNs
Leadership is crucial in local hub development – and models of leadership vary
Access and equity/inequalities should be key themes to explore as part of the evaluation
Part of the work for the evaluation should be to define Women's Health Hubs, though there are existing definitions e.g. from the Primary Care Women's Health Forum (2021) that could be built on or used as an existing framework
Women are at the centre of this approach, it should be driven by what women want/need and the evaluation should include their experiences
The experiences of staff within the wider health and care staff should be included in an evaluation e.g. local clinical/admin staff, referring GPs, hospital gynaecologists
Commissioning will be a feature of the evaluation but not a sole focus
The landscape is complex with a variety of models at different stages, mapping the 'current state of art' will be helpful
It will be important to map hubs across the UK - there will be good learning from the devolved nations, such as Northern Ireland, to share
It would be interesting to explore what can be done via hubs working collaboratively/collectively that can't be done by only one service/sector individually

It would be helpful to explore issues around workforce (clinical and non-clinical) e.g. workforce skills, training, recruitment and retention, multidisciplinary team working
Levels of integration in a model is an important consideration for selecting exemplar hub sites ('lift and shift' models should not be included) as selecting sites for learning may be. Another consideration might be to select sites linked to their different organisational leads e.g. primary care led, local authority led.
There may be evidence from pre 2012 health and social care reforms e.g. GP with special interest work that could be looked at as part of the evaluation
It would be valuable to ensure diversity in the different services offered by hubs included in the in-depth research e.g. not all models should be focused on long-acting reversible contraception
Evaluating effectiveness and impact is key in the longer term, but first it is necessary to understand the 'what' and map and describe what's currently in place.
If it is too early to measure outcomes as part of this evaluation, hub processes may be something that could be captured e.g. numbers of procedures that couldn't be done without a hub