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Supporting survivors of sexual violence: a mixed methods, co-researched study of the role, funding and commissioning of specialist services provided by the voluntary sector in England

The PROSPER study: suPporting Role Of SPecialist sERvices

RESEARCH PROTOCOL FOR STAGE 2: CASE STUY RESEARCH ON THE PROVISION, COMMISSIOINING AND USE OF SERVICES BY VICTIM-SURVIVORS OF SEXUAL VIOLENCE IN FOUR AREAS OF ENGLAND

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Terminology used in this protocol

Sexual violence: we use the term 'sexual violence' to encompass all forms of sexual violence and abuse experienced by children, young people and adults, including child sexual abuse and sexual exploitation.

Victim-survivor: whilst recognising the limitations of terminology, we use the term 'victim-survivor' to refer to children, young people and adults.

Specialist service:

We would characterise a specialist service as such because:

- Its primary purpose is to support victim-survivors and reduce the harms associated with sexual violence. Alternatively, key aspects of the service's work are focused on sexual violence.
- Staff have received training in sexual violence and have dedicated expertise in supporting victim-survivors.
- Its aim is to empower victim-survivors and to challenge the stigma and silence engendered by sexual violence and abuse (i.e. the service understands the social and/or political dimensions).

List of abbreviations and acronyms

- CCG - Clinical Commissioning Group
- GP – General Practitioner/Practice
- IICSA – Independent Inquiry into Childhood Sexual Abuse
- LA – Local authority
- NHS – National Health Service
- GUM - Genito Urinary Medicine Clinic
- MoJ – Ministry of Justice
- OPCC - Office of the Police and Crime Commissioner
- PROSPER - The PROSPER study: suPporting Role Of SPecialist sERvices
- SARC – Sexual Assault Referral Centre
- SRN – Site Reference Network
- SVSSV – Specialist Voluntary Sector Sexual Violence Service

Background and rationale

Role of the voluntary sector in supporting victim-survivors of sexual violence

The voluntary sector has historically played a key role in providing specialist services to victim-survivors of sexual violence. Sexual violence is defined as any sexual act or attempted sexual act involving coercion [1]. In most parts of the country, grassroots voluntary organisations have developed specialist services for victim-survivors in response to local needs. These may include: crisis and longer-term counselling/therapy; telephone helplines; face-to-face advice; information about sexual violence and local/national services; advocacy; practical support in accessing other services; support groups, and social activities. Most organisations offer specialist services to local victim-survivors, whilst others provide for particular groups such as children/women/men-only services. Upwards of 90% of victim-survivors are female, although male victim-survivors may be less likely to come forward for help. Some services are grounded in feminist responses to sexual violence, e.g. Rape Crisis, whilst others take a more neutral political approach. The majority of victim-survivors self-refer to voluntary sector specialist (SVSSV) services. These services can also be accessed by a referral from a GP/health/social care professional [2}, with an increasing number referred by police or Sexual Assault Referral Centres (SARCs), which provide crisis support and forensic medical examinations for victim-survivors following recent (and sometimes non-recent) sexual assault. As of January 2018, there were known to be at least 207 SVSSV organisations in England providing support to victim-survivors [3], with 162 affiliated to one or more of the three umbrella organisations, The Survivors' Trust, Rape Crisis and the more recently formed Male Survivors Partnership. Given the multiple long-term consequences of sexual violence, many other agencies/sectors will also be providing services to victim-survivors, for example, housing or education.

National policy and the commissioning of SVSSV services for victim-survivors

In the last 12 years there has been increasing national recognition that SVSSV services are essential in providing crisis and longer-term support to victim-survivors, enabling them to recover their confidence and thrive in the longer-term. National commissioning guidance in 2013 highlighted the need for good linkages between all services for victim-survivors [4], and SARC specifications in 2015 required SARCs to have clear pathways into, and working relationships with, relevant third-sector services [5].

Despite national guidance, evidence suggests that national policies have not necessarily resulted in local improvements, with SVSSV services under increasing funding pressures [6]. In England, the funding and commissioning of services for victim-survivors has become increasingly complex, as a result of changes to the structure and funding of health [7], and criminal justice. Funding for SVSSV services comes from charitable trusts plus local and national statutory sources, via health, local authorities and criminal justice organisations. This creates a complex network of responsibilities at the local level, and requiring a high degree of collaboration between commissioners [8]. The complex and changing nature of commissioning and provision creates additional challenges for providers in ensuring there are integrated, multi-disciplinary care pathways for victim-survivors [9]. Service commissioning has also become fragmented [8]. In some areas, new local models of collaborative commissioning are emerging, such as contracting with a lead provider for a network of local services, which may include SVSSV providers. In other areas, SVSSV providers are taking the initiative and collaborating between themselves, moving to common standards and seeking to join up services locally. Commissioners in turn are looking for evidence to support these new approaches 4,5], however, little is known about their effectiveness and how they might impact on services for victim-survivors.

Evidence for the value of SVSSV services for victim-survivors

There is little empirical evidence about the scope, range and effectiveness of SVSSV provision, or what victim-survivors value and want from services. The few previous studies are small-scale and local, typically with less than 20 staff and/or victim-survivor respondents. The exceptions are one national survey with 395 adult victim-survivors of child sexual abuse [10], and evidence from 172 victim-survivors of child sexual abuse submitted to the Independent Inquiry into Child Sexual Abuse [11]. Victim-survivors typically want timely locally available services, a choice of therapy, and long-term support from agencies taking a joined-up approach. They want to feel listened to, believed and respected, and the independence of SVSSV services from statutory services is seen as a key benefit [12].[1]

Independent Sexual Violence Advisors (ISVAs) report that: victim-survivors have greater trust in and preference for SVSSV services compared with statutory services [12,13], want flexible services which respond quickly; and services which are delivered in ways which empower victim-survivors and give them control [13]. Groups underserved by SVSSV provision include older victim-survivors [14], and male victim-survivors of rape [15,16.] There is evidence that not all SVSSV services identify and engage with under-represented populations in a consistent way and this may affect the quality of support victim-survivors receive [17].. It is thus important that commissioners recognise the different political and philosophical rationales which underpin SVSSV services, as this can affect the quality and nature of provision for different population groups.

Referral routes between organisations have been noted as complex. SVSSV staff report that referrals from other agencies are inconsistent and their knowledge about SVSSV services is variable [12]. There is no literature on the effectiveness of different approaches to commissioning services for victim-survivors. Anecdotal evidence suggests significant problems exist, including: over-reliance on short-term funding; poor understanding amongst commissioners of what SVSSV services do, leading to service cuts; lack of engagement by the health sector; confusion by non-specialist services about the difference between domestic violence and sexual violence; and confusion about which agencies are responsible for funding what services [8]. There is also a paucity of evidence about the needs and experiences of staff working in SVSSV sexual violence services, some of whom do so in a voluntary capacity [18].

Theoretical background

Voluntary sector organisations have potentially unique attributes as organisations. Many voluntary organisations involve current and former service users as volunteers or subsequently as paid staff, and have relatively flat hierarchies which blur the distinction between staff, volunteers and service users [19,20].Where voluntary organisations work closely in partnership with the public sector, the relationship has been theorised as a collaborative one, suggesting there is scope for synergy between statutory and voluntary organisations [21]. However, the commissioning and performance management arrangements expected by statutory funders could undermine the distinctive characteristics of the voluntary sector, imposing expectations derived from business models of operation which dissociate voluntary organisations from their social foundations.

For this study, the underpinning theory is Billis and Glennerster's theory that the voluntary sector has a comparative advantage in the provision of human services compared with the statutory sector [19]. This theory will help us to understand and explain the prominence and distinctiveness of the voluntary sector in providing support to victim-survivors of sexual violence and identify the unique features (and perceived limitations) that shape their response to victim-survivors. Our study therefore seeks to understand: the nature of the distinctive features of voluntary organisations providing support to victim-survivors; the relationship between these features and the particular support needs of victim-survivors; and how these shape, and are experienced in interactions with victim-survivors.

Study rationale

Given the evolving nature of national policies on sexual violence, the complex nature of the commissioning and funding arrangements which support the local implementation of policy and the absence of any good quality evidence, the first step of this study (Stage 1: National surveys) was to describe and analyse the patterns of SVSSV service provision across England. This included identifying what needs are being met and for which groups of victim-survivors and mapping the funding and commissioning patterns that underpin these arrangements. Stage 1 involved:

- Stage 1a: Exploring the unique features of specialist voluntary sector sexual violence (SVSSV) services and the funding and commissioning landscape in which they operate. Stage 1a was an exploratory qualitative study, drawing on data from interviews with SVSSV practitioners, practitioners working in statutory services and commissioners of services for victim-survivors (n=26) and two focus groups with female and male victim-survivors.
- Stage 1b: A national online survey study of specialist sexual violence providers and commissioners. Three parallel online surveys were designed and disseminated to three key groups: 1) SVSSV services 2) SARC services 3) Commissioners of services for victim-survivors. At the time of writing this protocol, the surveys are live and preliminary analysis of findings has begun.

For Stage 2 - a case study research project in four areas of England - we will continue to explore these lines of enquiry at the local level. Moreover, in the absence of high-quality evidence about victim-survivors' experiences of SVSSV services, the research places victim-survivors' views and experiences at its centre. It will analyse the degree to which provision meets their expressed needs, looking for: gaps and overlaps in service provision; under-served sub-groups in the population; the use of service rationing; the use of recognised service quality standards; and the extent to which SVSSV services are a coherent part of an area's service offering to survivors, with SVSSV services also supporting victim-survivors to access other services (e.g. mental health, sexual health, substances misuse) in the statutory, voluntary and potentially private sector.

This protocol relates only to Stage 2 – the case study research – and should be read in conjunction with the accompanying amendment application for ethical review.

Study aims and objectives

The over-arching aims of the PROSPER study are to develop a comprehensive national profile of SVSSV services for victim-survivors in England, giving voice to service users' experiences and using a comparative analysis of the range, scope and funding of services, service models and approaches, service linkages and commissioning arrangements, in order to make policy and practice recommendations that will strengthen the overall service response to victim-survivors. Stage 2 of PROSPER builds on the results of the national surveys to undertake an in-depth exploration of how SVSSV services are provided and commissioned, and the value and benefits victim-survivors derive from these services.

Specific objectives are to:

1. Explore victim-survivors' experiences of accessing and using SVSSV services, identifying what needs are being met for which groups of victim-survivors, and what encourages victim-survivors to take up services.
2. Analyse the range, scope and funding of SVSSV services and how demand is managed.
3. Explore the usefulness of different approaches to service delivery (including peer support and delivery by volunteers) and different therapy models.
4. Explore how different principles underlying service provision influence service delivery, including feminist and trauma-informed principles of care.
5. Investigate referral patterns and pathways, and how SVSSV services fit with each other and link to the wider network of services for victim-survivors.
6. Explore how arrangements for commissioning and funding services for victim-survivors across health, local authorities and criminal justice have evolved over the last 3-5 years, and how they have impacted on SVSSV service provision.

Stage 1 - National online surveys

The focus of the survey component of the study is on voluntary organisations which provide support to victim-survivors of sexual violence, and on those who commission or co-commission specialist sexual violence support services. Thus, the majority of the survey's intended recipients are not NHS staff, nor are they employed by NHS organisations, and there is no recruitment of NHS patients. Consequently, University of Birmingham ethical approval is being sought for these participants.

A small number of NHS staff will be invited to take part in the national provider survey for Sexual Assault Referral Centres (SARCs) staff, as some SARCs are managed by the NHS and all SARCs are in part funded and commissioned by NHS England. There will also be a small pool of NHS commissioners, specifically those who work for Clinical Commissioning Groups (CCGs) who will be eligible to take part in the commissioner survey. Participants in these groups are subject to Health Research Authority (HRA) approval, and a separate application is being made to the HRA to cover participation of these individuals/organisations.

Survey objectives

The national surveys will generate evidence to map the types of services that are provided and commissioned across England, and will explore the linkages between services. The surveys will also explore providers' and commissioners' views about the quality and nature of service provision, and perceived gaps and limitations in services.

Survey design

Lines of enquiry

The two surveys (for providers of SVSSV services and commissioners of services to support victim-survivors of sexual violence) will follow the same lines of enquiry, but with slightly different emphasis and question wording so that the surveys are each of maximum relevance to their respective audiences. Surveys will cover the following topic areas:

1. Principles underpinning service provision (e.g. feminism or trauma-informed care)
2. What SVSSV services are provided, how they are delivered, by whom (e.g. peer support), and to what quality standards. For commissioners, questions relate to a) the services they currently commission, and b) that they anticipate commissioning over the next five years
3. Criteria for accessing services, limits on service use (e.g. waiting lists, measurement of outcomes)
4. Referral patterns and pathways (frequency and nature of contact with other services), perceptions of the quality and nature of joint working, perceptions of the relationship between SVSSV and statutory services
5. How services respond to diverse population needs, unmet needs or service overlaps; exploring who is thought to be under-represented in current provision and why
6. Sources of funding and funding trends over the past five years, including how funding pressures have been approached locally and impacts on SVSSV provision. This includes examples of innovation to respond to changing funding and commissioning landscapes
7. Commissioning approaches/models being used, the factors affecting the perceived effectiveness of commissioning and if/how it could be improved.

Survey question types

Both surveys include a mix of closed questions (tick box or Likert-scale), supplemented by questions where a free text response can be given. Questions that are not relevant to individual respondents based on their answers to previous questions will not be asked, with the electronic survey tool automatically skipping to the next relevant question.

Survey development and piloting

Surveys were developed following detailed preparatory work. Both draw on the relevant academic and policy literature, and content is further based on the findings from two focus groups with victim-survivors (one female, one male), telephone interviews with service providers and commissioners (n=20), and telephone interviews with national policy, provider and commissioning leaders (n=10). The research team, co-applicants and patient involvement and engagement (PIE) representatives all discussed survey development, and surveys were piloted within the West Midlands by staff from SVSSV services (provider survey) and commissioners (commissioner survey) and the study co-applicant team. The survey development and piloting process provided feedback on the format, clarity of wording and relevance of questions to their intended audiences, and both surveys were modified to incorporate this feedback.

Survey tool

The surveys were created by, and will be administered using the *Online Surveys* tool (formerly Bristol Online Surveys), for which University of Birmingham holds an institutional licence. Surveys will be made available electronically, via a web link sent to potential participants by email. *Online Surveys* was chosen as the survey platform because it is designed to protect respondent anonymity – the system does not use cookies for survey completion, and information about respondents' IP addresses cannot be accessed. Survey respondents will be able to take part in the survey in any location, at a time of their choosing, minimising any potential inconvenience of participation in the research. The *Online Survey* allows participants to save their answers when partway through the survey and return to it for completion at any point.

The provider survey and commissioner survey will each take around 20 minutes to complete.

Sample and recruitment

University of Birmingham ethical approval is being sought for the participation of the following groups in the national surveys:
1. Providers of voluntary sector specialist service for sexual violence victim-survivors in England [SVSSV provider survey]
2. Commissioners who commission or co-commission services for sexual violence victim-survivors in England [commissioner survey]. This will include:
    - Local Authority commissioners (in unitary and council authorities) who commission services for adult and/ or children who have experienced sexual violence or abuse (e.g. as part of their public health, safeguarding or community safety remits)
    - Police and Crime Commissioners who commission support services for victims of sexual violence
    - Health and Justice Commissioners (employed by NHS England), who commission Sexual Assault Referral Centres (SARCs) and some specialist therapeutic services for child victim-survivors

Participants in other target groups for the provider and commissioner surveys (SARCs and Clinical Commissioning Groups) will be subject to HRA approval.

Inclusion and exclusion criteria
Inclusion and exclusion criteria with respect to the national provider and commissioner surveys are summarised in Table 1.

Table 1: Inclusion and exclusion criteria for the provider and commissioner surveys

	Provider survey	**Commissioner survey**
Inclusion criteria	Senior staff working in voluntary sector specialist services (nominated representative from their organisation)	1. Senior staff from Police and Crime Commissioner offices who have a dedicated role commissioning services for sexual violence victim-survivors 2. Senior staff from local authority commissioning who have a role commissioning services for adult or child victims of sexual violence

		3. Health and Justice commissioners who have a dedicated role commissioning SARCs and/or therapeutic services to child victim-survivors
	Currently in post or who has been in post within the last 12 months	Currently in post or has been in post within the last 12 months
Exclusion criteria	Staff who are not, in the routine course of their work, involved in planning and decision-making with respect to seeking and managing funding or who are not involved in the commissioning process of their service	Commissioners who are not, in the routine course of their work, involved in planning and decision-making about specialist voluntary sector services for victim-survivors of sexual violence

Sample size

There is no formal sample size requirement for this study, and we aim to obtain responses from as many organisations as possible: SVSSV services (n=250); Health and Justice Commissioners (n=10); Police and Crime Commissioners (n=41), local authority commissioners (n=343).

For the provider survey, only one participant per organisation will be invited to fill in the survey, as we are interested in respondents' experiences of service provision and commissioning practice at the organisational level (rather than individual employee level). However, for the commissioner survey, there may be some exceptions to this principle as there may be instances where there are multiple individuals involved in service provision or commissioning of sexual violence services who have different remits within their organisations (e.g. adult sexual violence vs. sexual violence involving children and young people). In these instances, we will aim to obtain more than one response from an organisation in order to capture service provision and/or commissioning practices as fully as possible. Because we ask participants about their job role, remit and the geographic region that they cover, we will be able to identify duplicate responses.

Participant identification

The landscape of service provision and commissioning is highly complex, and there are many logistical challenges associated with sharing surveys with participants working across different professional, organisation and geographical boundaries. Consequently, we will adopt several parallel strategies to identify potential participants for the national provider and commissioner surveys.

Provider survey

- Information about the survey has been shared with senior practitioners working in SVSSV services. A number of organisations have agreed to share information about the survey with their colleagues, and key umbrella organisations (e.g. Rape Crisis and Survivors UK) have agreed to share the link to the survey across their affiliated organisations. We have a senior member of Rape Crisis England and Wales on the study steering group and the CEO of Survivors' UK is a study co-applicant.
- A list of the specialist sexual violence/abuse services provided by large national voluntary organisations such as the NSPCC, Children's Society and Barnardo's is currently being compiled, so that we have named contacts (e.g. service manager or lead practitioner) for each of these specialist services.

Commissioner survey

- We have contact with the Victims' Commissioner Network (which encompasses victim support services commissioned by Police and Crime Commissioners) to share information about the survey

- We have made contact with the lead for the Health and Justice Commissioners, who has agreed to share information about the survey with their network of commissioners
- We are compiling a list of the local authority commissioners who commission sexual violence/abuse services for adults or children/young people.
- We will make contact with the Sexual Assault and Abuse Strategy partnership board at a national and regional level to identify relevant commissioners.

For organisations where key individuals will share information about the survey with their colleagues, and where the information will be disseminated via key umbrella organisations, we will send the web link to the survey to these individuals so that they can pass it on as appropriate. These individuals will also be asked to share information about the survey with the relevant providers and commissioners through professional press/e-bulletins/e-newsletters. For organisations for which we have compiled distribution lists, invitations to participate in the national surveys will be sent directly by the research team by email to the named contacts we have identified.

Information to promote the survey will also be made available via our project website (hosted by University of Birmingham), and via our project social media accounts (Facebook and Twitter). Those interested in participating in the survey will be able to contact the research team, who will screen the contact for eligibility – i.e. to check that they or their organisation have not already been included in the survey mailing. If appropriate, the individual will then be sent the web link to the survey for completion

Handling and storage of survey distribution lists

The database of intended survey recipients compiled by the research team will be password protected and accessible only to members of the core team involved in the distribution and management of the provider and commissioner surveys. The database will be kept on secure University of Birmingham network servers, and data will be stored in accordance with the revised General Data Protection Regulations (2018) and the Data Protection Act (2018). Survey dissemination.

The first page of the survey will provide information about the study and the purpose of the surveys, how data will be collected and analysed, and participants' rights to anonymity and confidentiality under the Data Protection Act (2018). Participants will be assured that their response is entirely voluntary, but that they will not be able to withdraw their data once they have submitted their survey response. Although respondents will be encouraged to answer all survey questions relevant to them, they are also informed that they do not have to answer any questions they do not wish to complete.

Contact details for the study team are provided on the front page of the survey, and participants are encouraged to contact the team by phone or email if they have any questions about their participation, how their data will be handled, or why they have been invited to complete a survey. When respondents submit the survey, they will receive a copy of their responses in PDF format to keep.

Consent

Although written informed consent will not be obtained, participants will be asked to confirm that they have read and understood the information about their participation in the survey by clicking a consent box embedded on the survey's first page. They will not be able to progress to the main body of the survey until this box has been checked.

Response rate

As noted above, we will aim to obtain responses from as many individual organisations as possible. The survey will remain open to responses for three months after initial distribution. The expected minimum response rate is 30%, in line with recently conducted national surveys of providers and commissioners

[22,23]. Publicity about the surveys in the relevant professional press combined with endorsement of the survey by national leads for sexual violence and the national umbrella organisations will help to prime potential respondents and increase the likelihood that they will respond. Following initial survey distribution, actions to potentially exceed a 30% response rate will include: reminder e-mails and a further link to the electronic survey 2-3 weeks after the initial survey request and additional publicity via professional networks.

Data analysis

Surveys will be analysed descriptively, to map patterns of SVSSV service provision and commissioning of specialist services across England. The analysis will focus on identifying key features of voluntary services which vary the most across the country (e.g. funding, referral patterns, populations served, access criteria etc.). This will in turn be used to inform the development of a taxonomy of service provision and commissioning. The taxonomy will allow the selection of case study sites for stage 2 of the project, by identifying contrasting and/or representative case study sites which will be explored in-depth (subject to a further application for ethical approval).

The views of survey respondents about the adequacy of services, possible improvements, and how commissioning is working will also be analysed descriptively, looking for differences and commonalities by stakeholder group e.g. comparing commissioners with providers or SVSSV providers with statutory providers. This analysis will also identify key issues which merit further exploration through the case studies and will aid the development of topic guides for qualitative data collection in the case study work. Any free text data provided by survey recipients will be analysed thematically.

Informed consent

All participants in the national surveys will be required to consent before responding. All potential participants will be informed of their right to decline participation, that participation is entirely voluntary and that all responses they give will remain completely confidential.

Data protection and confidentiality

No personal or signifying data will be collected as part of the national provider and commissioner surveys, and no identifying information will be shared or quoted in any report, academic publication or any other means by which results may be disseminated (such as conference presentation). Survey data will be stored electronically in a password-protected database within a secure folder on the network for the Institute of Applied Health Research, using the University of Birmingham's research drive which provides secure, backed up storage of research data. The secure study folder will only be accessible to named members of the research team. The folder is protected by the University's high level of security that protects against spam and virus scanners. In accordance with University of Birmingham's requirements for the storage and retention of research data, study data will be retained for ten years.

Strategic and managerial responsibility for the datasets generated by the study will lie with the CI who will in turn be responsible to University of Birmingham. The research team will comply with the requirements of the revised General Data Protection Regulations (2018) and the Data Protection Act (2018) with regards to the collection, storage, processing and disclosure of personal information collected as part of the national provider and commissioner surveys:
http://www.legislation.gov.uk/ukpga/2018/12/pdfs/ukpga_20180012_en.pdf
https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/

The anonymised survey datasets will be stored in a database format. These data will be prepared for archiving after study completion, and will be deposited in the UK Data Service to provide access to the data by the academic and wider community, subject to further permissions being obtained as required.

Please note: The following protocol contains the following amendments:

1) **Information relating to Stage 2, the case study phase (marked in track changes)**
2) **Staff interviews, including those with NHS staff and relevant to the HRA amendment (section heading is highlighted in yellow)**

The case studies

Permissions

The focus of the case study research phase is on victim-survivors of sexual violence, specialist voluntary sector organisations who support victim-survivors and the commissioning and funding of services for victim-survivors. Thus, the majority of intended participants are not NHS staff, nor are they employed by NHS organisations.

A small number of NHS staff will be invited to take part in the case study research, specifically those who work for Sexual Assault Referral Centres (SARCs), as some SARCs are managed by the NHS and all SARCs are in part funded and commissioned by NHS England. There will also be a small pool of NHS staff working in sexual health, mental health or substance misuse services who will be invited to participate alongside NHS staff working for Clinical Commissioning Groups (CCGs).

Case studies as a research method

Case studies are well established as an appropriate method for studying contemporary complex phenomena in a holistic way in their real-life contexts, particularly when the boundaries between the phenomenon and context are not clear [24]. They benefit from the prior development of theoretical propositions to guide design, data collection and analysis, and so rely on multiple sources of evidence which need to converge and triangulate in order to provide plausible explanations of observed phenomena. They also help to build theory, providing thick information-rich descriptions, which lead to a holistic understanding of the case [25]. This research is largely based on Stake's approach, where multiple perspectives on the case need to be gathered, with a flexible design allowing data collection to adapt in response to experiences in the field, and an inductive analysis of data [26,27].

Co-production with victim-survivors

Co-production of the research is built into the study design. This is a highly participatory and empowering methodology which will: amplify the voices of victim-survivors; enhance the collection of highly meaningful data; empower victim-survivors who are participating in the research; and promote learning and development of new skills among the co-researchers. Co-researchers will contribute to: devising publicity; sensitive approaches to survivor recruitment; developing information sheets and interview schedules; and advise on anxieties victim-survivors may have in taking part and how to overcome them. They will also be involved in data collection, analysis and dissemination, with a focus on victim-survivor data.

As of February 2021, a team of six co-researchers was recruited to join the existing study team. Our co-researchers have considerable personal and professional expertise (both in practice and research settings) working with victim-survivors and other 'vulnerable' groups. Prior to the case study phase starting, the co-researchers will receive training in key research skills and methods; this will complement one-to-one support from an assigned mentor (who is a member of the PROSPER team) and form part of a bespoke training and development needs plan for each co-researchers. Throughout the study, co-researchers will be invited to participate in wider research team meetings in addition to peer group support sessions. Professor Caroline Bradbury-Jones, whose research expertise and experience lies in co-production, leads the co-researcher strand of the project and she will work closely with the case study site leads to guide and support the work of the co-researchers.

Case study settings

The case study setting is here characterised as: all specialist provision, provided by the voluntary sector, in a given area. This means that all SVSSV services for victim-survivors which are located within that geographical boundary will be included. In addition to services whose sole focus is supporting victim-survivors or sexual violence, case studies may include services who provide strands of specialist work (e.g. counselling or advocacy services specifically for victim-survivors of sexual violence) but whose wider work encompasses other areas (e.g. mental health, children and families). The case studies will also encompass relevant statutory services (SARC, mental health, sexual health, alcohol/drug services, etc.) who support victim-survivors. The majority of statutory services will be located within the NHS.

Initially, selection of sites was to be driven by findings from the national surveys. However, due to COVID-related delays, this data was not available to us at the time of site selection. As an alternative method, we developed a long-list of 11 sites (with the intention of selecting four) based on:

- Interviews with 10 commissioners of specialist sexual violence services, 13 practitioners based within specialist voluntary services and 3 individuals working in statutory sexual violence organisations.
- Recommendations and conversations with senior members of specialist sexual violence umbrella organisations who understand their member services and have familiarised us with local funding/commissioning tensions, unique approaches to service delivery, etc.
- Publicly available data from the Charity Commission (but only when financial information is available for year ending March 2020 – in recognition of the rapidly changing funding context) and the websites of specialist voluntary services.
- Demographic data has been drawn from the 2011 Census (with estimated population projections used for some areas) and the 2019 Indices for Multiple Deprivation Index (IMD) as organised by upper tier local authorities.
- When this information was gathered, decisions about site selection were discussed and advice sought from the study steering committee meeting and the wider co-applicant team.

To achieve maximum variation across sites, we mapped the following factors onto a selection matrix:

Factor	Relevance to site selection
Rural vs. urban settings	To capture geographic and social variation across the sites.
Demographic/ deprivation index	To capture demographic diversity and representation from areas with different social-economic backgrounds. Also, to compare population sizes.
SVSSV service model of care	To understand the types of services provided, their scope and range and what principles/approaches inform their delivery.
Commissioning/ funding approach	To capture diversity in commissioning approaches across areas.
Commissioning tensions/ challenges	To identify examples of commissioning tensions and challenges – e.g. absence of one or several commissioners, limited value placed on voluntary sector specialist services, lack of engagement with SVSSV services and users, etc.
Political context	To identify the political context that shapes commissioning and provision: e.g. if the area was involved with IICSA or where the MoJ Rape Support Fund has been devolved.

Existing contacts	Identifying connections and networks within the wider research team that would aid site set-up and engagement.
Additional info	Interest in specific local factors, grassroots services, historic issues that shape provision for victim-survivors.

Site geographic boundaries

Achieving diversity across the four sites is an important consideration. Overall, we have selected sites based on achieving maximum geographical variation spread across England (north/midlands/south); population density (urban/ rural); demography (disadvantaged/ affluent/ mixed); and diversity (high/low black and ethnic minority populations). However, our principal criteria for site selection was to achieve variation in the sites' SVSSV service models and their underpinning funding and commissioning arrangements.

Sites are defined geographically by city and/or county boundaries, or groups of neighbouring districts. It is not feasible for the sites to be of exactly the same population size or area given the varied ways that services are configured, funded and commissioned in different areas in England. For example, the catchment areas for local authorities, CCGs and OPPCCs are rarely coterminous; similarly, SVSSV may receive dedicated funding to work with victim-survivors in one area, but seek to provide the same service to victim-survivors in another area, drawing on funding from charitable trust or fundraising. It is also the case that certain areas have no SVSSV services and have to cross city/county boundaries in order to access those services.

The sites

The selected case study sites are:

1. Nottingham city and Nottinghamshire county
2. Birmingham city and Solihull
3. Gloucester and Gloucestershire county
4. Rochdale town and metropolitan borough area (including towns such as Middleton, Heywood and Littleborough and Milnrow).

The research team have approached the principal SVSSV services in each of the four site areas and, following discussions, these key services have agreed to take part in the research and play a role in the Site Reference Networks (see following section).

Site Reference Networks (SRNs)

Site Reference networks (SRNs) will be convened in each of the four areas. Prior to the fieldwork phase of the research, we will be in close communication with the key members of the network, who will play a role in:

- Bringing together the organisations likely to take part in the research
- Contributing to building a picture of the local context
- Discussing data collection tools; helping to publicise the research
- Facilitating access to staff and survivors for the interviews
- Discussing emerging findings; and help plan dissemination.

In some areas it may be judicious to include services which are located in neighbouring areas, as some victim-survivors prefer not to use local services and/or there are no available SVSSV services in those areas. Similarly, decisions about which non-specialist services and commissioning bodies are invited to take part in the research will be discussed and agreed with the SRN, recognising the variation and complexity in these arrangements across England. It is likely that not all invitations to participate will be taken up in each of the sites.

Each case study will be led by a member of the research team (see page 2) who will convene the network/communication with individual group members. Where possible, the research team will try to work with existing groups (e.g. multi-professional sexual violence forums in local areas) so as to reduce the research burden on individual organisations and to learn from existing initiatives and groups. SVSSV providers in the selected sites will be paid an honorarium of £500 in recognition of their expertise and the time involved in setting up and taking part in interviews and providing documents.

Research methods

The following section outlines the three, parallel methods of data collection in each case study site:

1. Documentary analysis, drawing on organisational documents
2. Interviews with staff (practitioners and commissioners, across participating services).
3. Interviews with victim-survivors aged 13 years and older.

Documentary analysis

Document analysis is a systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and Internet-transmitted) material that is analysed using the same core technique and principles as other qualitative research (e.g. interview or focus group transcripts) [28]. For each site, documents from SVSSV providers, statutory services for survivors and commissioners will be collated and analysed looking for data related to the lines of enquiry. Documents from the previous three years will be included and the types of document, which are typically publicly available, to be included are:

- Local policies that explicitly relate to sexual violence (e.g. as part of a Violence Against Women and Girls' strategy, a combined domestic and sexual violence strategy)
- Local public sector bodies' needs assessments and/or commissioned research about the needs of sexual violence victim-survivors (that may or may not be part of the commissioning process)
- Local public sector bodies' tender documents (for services for victim-survivors)
- Service specifications for services (to meet the needs of victim-survivors)
- A sample of reporting documents that SVSSV services are asked to provide to various funders and commissioners over the past 12 months (e.g. including outcomes monitoring, work and financial summaries, etc.)
- SVSSV services' mission/value statements
- SVSSV services' annual reports (including financial summaries)
- SVSSV services' training programmes for staff/volunteers

Not all types of document will be available from each organisation and no documents will be collected that contain identifying staff or service user information. Careful attention will be paid when anonymising the documents and de-identifying participating organisations in the reporting to study findings. Documentary analysis will be on-going throughout the case studies, allowing points identified from documents to be explored further through staff interviews.

Staff interviews (including NHS staff)

Staff interviews will be carried out with people working for a range of organisations, located in the voluntary and statutory sector. One strand of the interview work will be carried with NHS staff members. We are aiming to complete 24 interviews with NHS staff across the four case study sites.

An amendment for HRA approval has been submitted in parallel with an amendment for University of Birmingham ethical review. These amendments together seek regulatory and ethical approval to carry out the NHS and non-NHS staff interviews.

Overview of the staff interviews

- Interviews will be semi-structured, with an initial interview topic guide based around the broad aims of the project and Stage 1 results. This will be piloted with two commissioners and two providers in order to improve question validity. There will be interviews with 17-19 staff per site, 68-76 in total across the four sites (Table 1):
- SVSSV services, 3-5 organisations per site (CEOs and frontline workers) (n=8-10)
- Staff in other organisations working with survivors:
    - SARC manager and frontline support worker/ISVA (n=2)
    - Mental health manager/team leader (n=1)
    - Alcohol and drug service manager/team leader (n=1)
    - Sexual health manager/team leader (n=1)
- Clinical commissioning group and specialised services commissioner; local authority commissioner; police & crime commissioner (n=4).

Table 1 : Case study interview recruitment	**Case study sites**				**Total**
	1	2	3	4	
Staff in SVSSV services	8-10	8-10	8-10	8-10	32-40
Staff in other organisations working with survivors	5	5	5	5	20
Commissioners	4	4	4	4	16
Total staff	**17-19**	**17-19**	**17-19**	**17-19**	**68-76**
Survivors using SVSSV services	**6-12**	**6-12**	**6-12**	**6-12**	**24-48**

Potential participants will be identified in consultation with each Site Reference Network and it is through these connections/information that we will approach potential participants. As a result, recruitment for staff participants will not require the support of Research and Development teams in NHS sites.

Potential participants will be sent an electronic information pack which will include: a participant information sheet, consent form and contact details for the study team. Potential participants will be given at least two weeks to review the information before the study team make contact to ask if they would like to participate in an interview. Participants will have the opportunity to ask questions about the study and what participation entails before the interview.

At the start of the interview, the researcher will check the participant has read and understood the study information leaflet and ask them to sign two written consent forms. See attachment for the staff interview participant information sheet, consent forms and interview schedules.

Measures taken to ensure anonymity and confidentiality of participant data will be explained as will the process of archiving and storing data. One copy of the consent form will be kept by the research team and one by the participant. The interviewers will be mindful that staff participants may also be survivors of sexual violence, and will have information about local support services, should any participant require this.

At the time of writing, it is intended that interviews will take place at participants' places of work or by telephone/video-call. If participants need to travel to the interview location, their travel expenses will be paid. Staff participants will be offered the option of the interview taking place virtually or by telephone.

For people taking part in research in a professional capacity – speaking about a topic on which they have knowledge and, in general, does not involve disclosure of personal information – telephone interviews can provide a convenient way of taking part that does not hinder their comfort or confidence. As part of Stage 1a data collection, the majority of interviews were conducted via telephone and this resulted in rich, nuanced accounts. We know, through these interviews, that rapport can be built and we found that for many busy professionals, telephone interviews were a preferred and often more convenient way of participating in the study.

Victim-survivor interviews

The purpose of the interviews is to explore victim-survivors' experiences of using services (or not using them), taking a narrative approach, which will illuminate core concepts emerging from victim-survivors' stories. Consultation with SVSSV services suggests many victim-survivors will not want to take part in an interview, particularly if they are awaiting court proceedings or undergoing initial counselling/therapy, whilst victim-survivors who are former service users may worry that participation will stir up traumatic memories. As such, they suggested that recruiting 3-5 victim-survivors per SVSSV organisation is realistic. This will not allow for prospective sampling by age, gender and ethnicity unless more victim-survivors come forward for interview than anticipated. Given that each site is expected to have three to five SVSSV organisations, a minimum of six victim-survivor interviews will be undertaken per site. This is in line with expected research participation rates for victim-survivors of sexual violence/other forms of trauma [29, 30]. The research team will however aim for 12 interviews per site. The total number of survivor interviews is therefore expected to be between 24 and 46 across the four sites.

Inclusion and exclusion criteria

Inclusion

- Victim-survivor of sexual violence (self-defined; recent or non-recent)
- Subjected to sexual violence six months or more ago
- If accessed SVSSV services, done so within the last five years
- People aged 16+
- Children aged 13-15
- Able to provide consent to take part

Exclusion

- Subjected to sexual violence less than six months ago
- If accessed SVSSV services, done so more than five years ago
- Children aged below 13
- Children aged 13-15 who do not meet Gillick competency
- Any adult for whom the research team has concerns about their safety or wellbeing taking part
- Adults who are unable to consent to take part

The majority of interviews will be with victim-survivors using SVSSV services in the past five years, so that experiences and views relate to recent/current service provision and are of maximum relevance. Because participating SVSSV services are likely to play a key role identifying potential participants, there is a risk that participants who have had a positive experience of SVSSV services will be over-represented. To address this, we will also actively recruit victim-survivors who have not accessed services/only accessed them for a short time and will explore the reasons for their non/brief use of services within the interview.

Recruitment

The information pack for potential participants will include a participant information sheet, consent form and contact details for the study team. Two information packs will be available: one for adults and one for children (13-15 years). The packs will be available electronically and in paper form if requested. Design and development of the information packs has been reviewed by co-researcher members of the study team, with the aim of enhancing the sensitivity of the materials and their ability to engage a diverse group of victim-survivors.

Local organisations in each site will approach victim-survivors who they think may be interested in taking part. This will be negotiated on a site-by-site basis, ensuring that any approach to victim-survivors is carried out in an ethical and non-intrusive way and there is no selection bias. This approach to recruitment will be supplemented with publicity going out through national organisations and local networks of SVSSV professionals and their partners, where feasible. A variety of media will be used including leaflets, newsletters, e-mails, and social media. Twitter, Facebook and Instagram will be used as they have been found to be particularly effective for recruiting hard-to-reach groups [31]. Social media will also increase recruitment exposure through snowballing [32]. Tailored social media messages will be used to target groups under-represented in the initial group of victim-survivors expressing interest in taking part. The use of a wide range of recruitment methods is expected to maximise the chances of recruiting victim-survivors who are not currently in receipt of SVSSV services or those who have had negative or mixed experiences of SVSSV services.

Potential participants can contact the study team to request an information pack; however, the packs will also be available on the PROSPER website and their availability will be promoted across the study's social media accounts, which will be monitored on a daily basis. Pack materials will encourage potential participants to contact the study team if by e-mail or by phone. At this point, participants will be asked how and when they want to be contacted, in order that they cannot be identified incidentally by others as victim-survivors of sexual violence and will be asked if they wish to have any one else (e.g. a friend or relative) included in their communications.

In the first instance, potential participants aged 13-17 years will be identified by SVSSV practitioners working with them. Practitioners will share information packs with young people and, if a young person would like to find out more about the study, the practitioners will make contact with the research team to arrange an initial conversation. Initial contact with young people will be determined on a case-by-case basis; however, it is anticipated that SVSSV staff will play a key role facilitating contact and communication (e.g. joining joint phone or video-calls, being included in emails, etc.). Parent/carers will also be invited to these initial meetings. Only young people (aged 13-17) who are currently receiving support from SVSSV services will be interviewed.

Consent process

It is important that participants are not considered necessarily or inherently vulnerable, just because they have experienced sexual violence. Such an approach can exclude people from sharing their views and contributing to the development of knowledge [33]. Researchers working on sensitive topics have found that participants make careful choices about what they disclose within the research space and often enter it with the intention of developing knowledge to benefit others [34]. Furthermore, participants can derive emotional and social benefit from being listened to in a meaningful way, particularly if they have had experiences of being silenced or marginalised in the past [33, 34]. It should be stressed that participants will not be asked about their experiences of sexual violence and abuse. The focus in on exploring their views and experiences seeking support. However, given the complex (and sometime re-traumatising) experience of seeking support and the sensitivity of the topic matter, participants' emotional safety and well-being is a key consideration.

Adult victim-survivors

Holding pre-interview discussions can help to create a reflective space for participants to consider the potential implications of participation and to learn about the research process. It can also support participants to make informed decisions about what information they would like to share during the interview and what, if any, support they might need afterwards.

Prior to the interview taking place, the researcher will share a copy of the interview guide prior to the interview, to increase the participants' ability to prepare for the discussion and to enhance their sense of control during the interview. The researcher will also talk through the strengths and limitation of remote and in-person interviewing. If the researcher has any concerns about the participants' safety or welfare they will discuss this with them and the researcher may seek advice from the wider research team and the SVSSV services which they use/have used (with the participants' consent). Interviews will only go ahead if and when these concerns are addressed.

At the time of the interview, the researcher will ensure there is time at the beginning of the meeting for the participant to ask questions. The researcher will verbally summarise the purposes of the interview, its voluntary nature, measures to ensure anonymity and confidentiality, etc. before asking the participant to sign one copy of the consent form. The participant will have already received a written copy of this information. The interviewer/s will ensure that the participant understand the potential benefits and limitations of taking part in the interview.

If they choose to go ahead, the research team will ensure that the participant will be made aware of the benefits and limitations of receiving a copy of the interview transcript. The expectation will be that participants receive a copy of their transcript, unless they choose not to. Participants who receive a copy of their transcript will have four weeks to review it and to identify any changes that need to be made (e.g. to enhance anonymity, to clarify meaning) to the research team. Participants will be informed that if they do not identify the need for changes, the transcript will be used as it is.

*Note: We are a predominately female study team. As a result, participants will be offered a female interviewer (both from the research and co-researcher team) in the first instance. Our experience is that because the majority of perpetrators of sexual violence are male, it is often appropriate and preferable to offer female researchers to both female and male victim-survivors. If the participant would prefer to be interviewed by a male then we will make every effort to facilitate this choice.

Victim-survivors who are children and young people

As a group who are disproportionately affected by sexual violence, children and young people's experiences of SVSSV services are particularly important to surface and explore. Concerns about the sensitivities of talking with younger victim-survivors need therefore to be carefully balanced against the risks of not affording them meaningful opportunities to share their views [33].

The consent process for adults and young people will follow the same principles: developing and maintaining consent, offering multiple and repeated opportunities to check participants' understanding and readiness to take part in the research, and carrying out the research at a time and place of the participants' choice. Participants aged 16-17 years old will be invited to have a parent/ carer or other appropriate adult (e.g. support or social worker) with them when meeting with a member of the research team and taking part in an interview; however, parental consent will be not be required when interviewing 16-17 year olds.

For child victim-survivors aged 13-15 years, the decision about participation will be made jointly between the young person, a parent/carer and the SVSSV staff member who knows them best: at least one of whom will be present at the interview. It is not possible to determine capacity based on age alone and there is likely to be considerable variation in the decision-making capacity of young teenagers, for 13-15 year old potential participants, we will follow the principle of seeking assent rather than consent:

- We will provide them with tailored, age-appropriate information about PROPSER and what taking part would involve. The information sheet also outlines the potential risks and benefits of participation.
- This information will be provided by SVSSV staff who have experience and training working with children. Members of the research team involved in the children's interviews all have professional and/or research experiences working with vulnerable children and young people (e.g. as support workers, carrying out therapeutic work, as social workers, nurses, etc.)

- Every effort will be made to understand the child or young person's explicit wishes regarding if and how they take part in the study.
- In parallel, we will seek consent from their parents/ carers and provide a tailored participant information sheet, ensuring an opportunity for parent/carer queries and discussion with the research team.

All children and young people (aged 13-17 years) must be in current receipt of SVSSV services at the time of interview and the research team will be guided by the judgement of SVSSV practitioners about the suitability of interviewing young victim-survivors. Practitioners will have detailed knowledge of these young people (which they will not share with the research team) and are therefore far better placed to make recommendations about their suitability to participate.

In addition, if young people do express an interest in taking part, the Gillick guidelines [35] will be used to inform an assessment of young people's capacity to consent to take part in an interview. There is no set of defined questions to assess Gillick competency, so it is incumbent on researchers to consider several things when assessing capacity to consent, including:

- The child or young person's age, maturity and mental capacity.
- Their understanding of the issue and what it involves - including advantages, disadvantages and potential long-term impact.
- Their understanding of the risks, implications and consequences that may arise from their decision.
- How well they understand any advice or information they have been given.
- Their understanding of any alternative options, if available.
- Their ability to explain a rationale around their reasoning and decision making.

In practice, we anticipate that SVSSV practitioners will play a key role informing the research team's assessment of children and young people's capacity to take part in the research.

Interview with this age group will be carried out by members of the research team who have professional and/or research experience working with 'vulnerable' children (e.g. in their professional capacity as nurses, social workers, other forms of support or therapeutic work, etc.)

As with the adult interviews, at the time of the interview, the researcher will ensure there is time at the beginning of the meeting for the participant (and if relevant their parent/carer) to ask questions/discuss any concerns. The researcher will verbally summarise the purposes of the interview, its voluntary nature, measures to ensure anonymity and confidentiality, etc. The participant and their parent/carer and SVSSV practitioner will have already received a written copy of this information.

Interview locations – in person and remote

Victim-survivors will be offered a choice of interview location. Given the potential sensitivity of the topic, it is important that participants have the opportunity to consider and discuss with the research team which environments would enhance their feelings of safety and comfort. This can help to minimise the potential emotional risks of taking part in the research process and it is recognised that there are potential strengths and limitations to all site options [33].

Victim-survivors will be offered a choice of carrying out the interview:

- At the site of the SVSSV service that they have used. Returning to a known service/location may enhance feelings of safety and reassurance for victim-survivors, particularly when they are familiar with and trust the staff. It is also possible that returning to the service may have an inhibitory effect on participants – for example, if they have had a poor experience with a particular service or worker.
- At community venues such as libraries or community centres, where a confidential, quiet space can be assured and the location is not associated with either voluntary or statutory services, or the

research team. Although interviews will only take place in confidential rooms, some victim-survivors may be concerned about being identified/running into people they know. The availability and costs of these rooms will be factored in when making arrangements.
- Remote interviews (telephone or video-call). See the following section for more details on this method.

Given the key role that SVSSV staff will play facilitating young people's involvement in the research, the research team will suggest that children and young people's interviews are carried out at the known SVSSV service.

Remote interviewing

The UK government's Roadmap out of Lockdown outlines the gradual lifting of restrictions over Spring/Summer 2021, contingent on the successful rollout of the vaccination programme, enhanced track-and-trace measures and a low, stable Covid-19 case rate. In this context, it is plausible that PROSPER will be able to carry out in-person interviews at the anticipated case study start time (Autumn 2021). This is the plan as set out in our study protocol, as approved and funded by the NIHR. It is also credible that some restrictions will remain in place or be re-imposed in the colder months of Autumn/Winter 2021 and that some organisations and individuals will need to retain protective measures and minimise social contact beyond the end of official restrictions.

The process of carrying out remote interviews – carried out by telephone or using video-call – will share several key features with those carried out in-person. For example, participants will be recruited using the same methods, a pre-interview discussion will take place to assess safety and readiness and the same interview guide and follow-up methods will be used.

Potential benefits of remote interviewing

The question of remote interviewing has been bought to the fore by the Coronarivus pandemic and it is important to note that since March 2020, familiarity with and innovation using remote communication has increased significantly amongst many population groups. This has happened in the context of work and personal life, as well as accessing specialist support services (e.g. counselling, peer groups, etc.). Remote (and in particular telephone) interviews are also an established research method than can confer benefits for participants. These include:

1) Flexibility and convenience: absence of travelling time and planning; easier to find mutually convenient times to 'meet' and to rearrange; potentially a more inclusive method that enables participants with work/caring commitments to engage with research.
2) Enhanced feelings of safety and control: some participants find home a safe space and a good place to talk, as it enhances their feeling of comfort and control during the interview [32].
3) Experienced as more anonymous: Linked with the point above, telephone interviews (and to some extent video interviews) can help to maintain a sense of distance from the researcher and this may help participants to feel freer to talk and to explore difficult feelings or experiences.

However, there are some key differences that require assessment and planning and the following table outlines how the research team will identify and address these issues:

Issue	Potential challenges	Strategy to address
Access to digital communication.	The costs of digital, particularly good-quality Internet access is likely to prohibit some victim-survivors from taking part remotely. Victim-survivors living in areas of poor Internet connectivity (associated with more rural areas) may also face	The research team will also offer telephone interviews, which may be more accessible to a wider number of participants. We will also offer to reimburse people for the cost of using their telephone/data (i.e. as an alternative to travel expenses).

	practical barriers. It is therefore critical that victim-survivors are offered a choice in how they take part and that remote interviewing is not presented as the default position.	
Technical difficulties during the interview.	Related to point 1), poor connectivity or telephone access may result in disruption during the interview (e.g. poor sound quality or visibility, loss of Internet connection). Clearly, it is undesirable for this to happen, as it risks interrupting the flow of conversation and rapport between the researchers and participant. Talking about potentially sensitive and emotive topics, responsivity on the part of the interviewer/s is particularly important [36].	In pre-interview discussions, we will ask participants about the likelihood of technical problems occurring and recommend that we do not go ahead with a remote interview if this has been problematic in the past. Researchers will ensure, as far as is practicable, that they have the requisite equipment and good quality Internet connection.
Ensuring privacy and confidentiality.	Remote interviewing relies on both the interviewer and participant taking steps to ensure privacy and confidentiality within the course of the interview; this shared responsibility differs in some ways from conventional face-to-face interviews [37]. For example, only the participant can check and give assurances that they are alone and have access to a quiet space where they will not be overheard. In a face-to-face interview, this responsibility will typically be that of the researcher convening the interview.	For remote interviews, the researchers will talk with participants about the need to have a private and confidential space and be flexible about the timing of interviews so as to facilitate this (e.g. working around participant's caring or work commitments). They will check in with participants at the start of the interview to remind them about these issues.
Safety and suitability of interviews held from home.	For victim-survivor participants, considerations about privacy and confidentiality are part of wider considerations about taking part in an interview from their home. Some victim-survivors may live with the person/s who has perpetrated sexual violence against them, or live in a space where this person/s has access. Evidently, it would be inappropriate and unsafe for remote interviewing to take place in this instance. Perhaps more commonly, victim-survivors may live with someone who they do not want to tell (or re-tell) their experience of sexual violence and/ or seeking help (e.g. a partner, children, parents).	Participants need to make informed decisions about any possible negative implications of talking about their experiences of sexual violence/using services at home. For example, whether discussions could engender memories and feelings that the participants wants to keep outside of their home/family environment. This will be discussed further in pre-interview conversations.

Potentially reduced capacity for body language cues and interactive participation.	Telephone or video-calls reduce the ability to 'read' body language (e.g. someone tapping their feet nervously or shifting in their seat). For children and young people, or people who dislike or are not used to communicating using technology, these are likely to be disadvantages and may result in participants' feeling uncomfortable, confused or under-confident [38]. However, some participants may finding that turning off their cameras enhances their feelings of safety and provides an additional layers of anonymity when engaging with the research team.	Preparing for remote interviews, researchers will be sensitive to the need to use non-verbal communication (silences, facial expressions, hand gestures, etc.); however, they will also talk about the potential challenges of remote communication with participants and suggest ways of overcoming this. For example, identifying a 'diversion topic' that can be used to signal that the participant wants to move on or avoid a question, routinely asking if the participant would like a break [37]. We have also transferred interactive activities (e.g. visually mapping a participant's timeline of using services, network of important people) using the Zoom whiteboard function. The chat function in Zoom may offer some participants a more comfortable, anonymous way of taking part in the research.

Please note: The research team will only contact and, when appropriate, carry out remote interviewing with staff and victim-survivor participants using their University of Birmingham accounts (e.g. Zoom, Microsoft Teams). Telephone or smartphone contact (e.g. to send text messages) will be carried out using a separate sim card and number (from the researchers' personal account). The sim will be topped up with credit for the duration of the study and then returned, and taken out of use.

Data collection

Victim-survivors can choose to have someone with them in the interview for support. Interviews will last between 30 and 60 minutes and will be recorded on a digital audio-recorder. In the first instance, victim-survivors will be offered a female interviewer and co-researcher. An interpreter will be provided for participants whose first spoken language is not English.

Interviews will be informal and will use the critical incident technique [39] which asks participants to recount experiences rather than talk in general or abstract terms, and has been used successfully with vulnerable groups [40]. A narrative approach to interviewing will encourage people to tell their stories about how they have used services [41], using a small number of open-ended stimulus questions designed to open up a conversation about survivors' experiences of services. This will be combined with more traditional semi-structured interviewing [42,43] so that once the narrative section of the interview is concluding, a second stage of more defined questions will be asked. Please see the attached interview schedules for more information.

Victim-survivors will be encouraged to join the interviewer and co-researcher in co-creating a physical timeline on a large sheet of paper (or on the Zoom whiteboard in the case of video calls) to represent their journey through services. Alternative digital tools will be used when interviews take place remotely, however flexibility will be needed to adapt this aspect of the interview process if it does not work well and/or participants elect to carry out telephone interviews. It is anticipated that this narrative approach will allow the interviewer to naturally ask about which services were and were not accessed and when, and the reasons why, allowing gaps in service provision to be identified. For children, the interview will be shorter and the questions focused primarily around the participant's experiences of using SVSSV services, what they valued and what they think could be improved. Offering participants choice about the way they express and explore their experiences can be particularly valuable when exploring 'sensitive' and potentially emotional issues [44]. Timelines also provide concrete ways of comparing victim-survivors' journeys through different services.

At the end of the interview, there will be time to de-brief the participant and reflect on the discussions, with time to 'wind down' from the interview. Information about local support services will be made available to participants, with a named contact from the specialist SVSSV services involved in the site reference network featured on this list. For young victim-survivors, they will be able to access support from the SVSSV service with whom they are already engaged with. In line with NIHR Involve guidance, adult participants will be given a £45 voucher in recognition of the time involved, and will have travel expenses reimbursed. A £20 voucher will be offered to 13-15 year old participants. Participants will not be asked to return the vouchers if they subsequently withdraw their interview from data analysis.

Although the main purpose of the interviews is to gather views about the SVSSV services, it is recognised that some victim-survivors may not immediately distinguish between statutory and SVSSV services, so the timelines will not be restricted to SVSSV services. However, the more detailed exploration of victim-survivors' service experiences will focus on SVSSV services. Although the research is focussed on SVSSV services used in the past five years, some survivors of non-recent sexual violence will want to talk about experiences of services going back further than this, which will provide context for more recent service use. Although victim-survivors will not be asked direct questions about their experience of sexual violence, if this comes up naturally, researchers will be led by the interviewees and support them to talk about their experiences of sexual violence should they wish to. The research fellows, co-researchers and co-applicants all have previous experience of interviewing and/or working with people who have experienced sexual violence, abuse and wider forms of victimisation/'vulnerability'.

Concerns about participants' welfare or safety

It is important to emphasise that the focus of the interviews is on victim-survivors' experiences of SVSSV services. If however, in the course of the interviews, victim-survivors share information that raises concerns about their immediate safety or well-being, or that of a child, the researcher will stop the interview. Potential issues include: risk of suicide or serious mental health distress, or threat of ongoing violence or abuse from an intimate partner or family member. The researcher will discuss their concerns and explore what options are available to the participant. The researcher will offer sign-posting information and, if requested, support the participant to make initial contact with services who can provide support or advocacy and it is likely that these services will be represented within the site reference network. If survivors are in contact with a SVSSV service it may be appropriate for them to contact SVSSV staff, supported by the researcher. It is recognised that 16-17 year olds are likely to need additional support making contact with services and/ or exploring their choices.

Participants will be informed if, in exceptional circumstance (for example, the disclosure of a serious crime or threat to life) that the researcher will notify statutory authorities (e.g. police, social services). The researcher will notify the PI of any such concerns at the earliest opportunity and the wider study team will also be informed. The site reference network will be consulted if more information is required about local services, maintaining the anonymity and confidentiality of the participant.

If 13-17 year old participants raise concerns about their safety or well-being, the researcher will discuss their concerns with the participant and it is also important to note that 13-17 year old participants will only be recruited if they are in receipt of a SVSSV service. The researcher will support the participant to share concerns about their safety and well-being with SVSSV staff. However, if they feel unable to do so, the researcher will talk directly with the SVSSV staff, informing the young person that this will happen.

Distress protocol

As part of the set-up of the case studies, agreement will be reached in each site about how interviewees can be supported if they become distressed. We will follow the principles of the McCosker et al [45] distress protocol to guide these decisions. This is likely to be via one or more of the local SVSSV providers in the area. Information about local sources of support will be included in the written documentation about the study and interviews will be halted if the interviewee becomes upset. Regular breaks will also be offered to interview participants. Regular peer and one-to-one supervision for researchers (including co-researchers) will be available throughout the project. Team members who become distressed/negatively affected by the work will have access to immediate telephone support from the Principal Investigator, followed by face-to-face support. If more specialist support is required, this will be accessed from existing services within the University or the West Midlands.

Participant withdrawal

Participants can withdraw from the project at any point and do not need to explain to the project team their reasons for doing so. This will be made clear on all participant-facing documentation (e.g. consent forms, information leaflets) as well as in verbal communication with the research team. Once participants have taken part in the project, they can request to withdraw their contribution for one calendar month following participation in the interview. If participants withdraw from the study all of their data will be removed from the study folders, and their withdrawal will be recorded on the study's databases. However, it will not be possible to remove their data from the study once data analysis commences. All participants will be made aware of this prior to participating.

Analysis

Analysis of each site's written documents will use conventional content analysis [46] and be undertaken contemporaneously with qualitative data collection, so that issues identified from the documentary analysis can be explored in interviews. Staff and survivor interviews will be recorded digitally and transcribed using a professional transcription company. Transcripts will be checked against audio files for accuracy. Coding and analysis will use NVivo software. Victim-survivor interview data will be analysed using an inductive classification system designed for critical incident data [39]. An initial coding framework and fields will be generated by two researchers using a broadly representative sample of transcripts, with results reviewed by the team, to produce a codebook and framework. Interviews will then be analysed thematically site-by-site. Queries will be recorded and discussed by the team, with codes amended as needed. Ten per cent of transcripts will be independently coded by two researchers to ensure consistency.

Initial analysis will identify emerging themes based on the data, which will be discussed and refined in team meetings. Where data does not fit with existing themes, new themes will be developed or existing ones revised until all the data can be assigned to themes. Analysis will look for patterning and clustering of issues across victim-survivor timelines, along with unique cases that illustrate different pathways through services. Although the analysis will primarily be data-led inductive analysis [27] additional analysis will compare victim-survivors' views about the value of services against the six principles of trauma-informed care. The same analytical processes will be undertaken for a site-by-site analysis of the staff interviews, using thematic analysis [47] and sub-group analysis by professional role where appropriate. Data from the separate analysis of staff and survivor interviews, and documentary analysis, will then be combined, building a detailed picture of each site.

A preliminary cross-site analysis will use a matrix to enable comparison of themes across sites and across groups (victim-survivors, staff and commissioners). This will look for: triangulation of themes from multiple sources; the frequency with which themes occur across sites; patterns and plausible explanations of themes; and identify those themes which have the greatest explanatory power. The context, facilitators and barriers to SVSSV service delivery and commissioning will also be synthesised. For victim-survivor data, sub-group analysis on demographic variables will be undertaken across sites, where there are sufficient respondents (e.g. male versus female, or younger versus older victim-survivors). Analysis will also look for differences and patterns within sub-groups of victim-survivors. The analysis will continue as an iterative process of synthesis, queries and further analysis between and within sites.

Expected impacts

This study as a whole will generate new knowledge and understanding about the role of SVSSV services in providing support to victim-survivors of sexual violence. It will provide high quality evidence about what victim-survivors want from SVSSV services, how they currently experience these services and how services could be improved. This will provide impartial evidence which can be used by both providers and commissioners in the short to medium-term to improve existing services, drawing on examples of innovative practice which could be implemented more widely. Commissioners will be able to compare their local services against the national picture so that gaps can be identified and new/improved services commissioned. Evidence about how commissioning arrangements are working across the country will enable local leaders to assess the adequacy of their local arrangements and configure them optimally so that SVSSV services are not disadvantaged. Policy-makers will be able to use the findings to develop future policies on SVSSV services in the medium-term, so that the current general statements about valuing SVSSV services are backed up by concrete national priorities for action that will lead to thriving SVSSV service provision across the country. In the medium-term, victim-survivors will benefit, as strengthened SVSSV support enables them to move from being a victim to a victim-survivor of sexual assault and then to thriving. Improvements in victim-survivors’ health and well-being should then help to reduce demand on services in the longer-term.

This is a large study and a range of key products targeted at different audiences. The dissemination plan will be refined following discussions with co-researchers, the Advisory Group and national umbrella organisations, who will advise on networks to link with and appropriate media for different audiences, in order to maximise impact. The stakeholder engagement and publicity strategy will support dissemination activities, with end-products publicised widely. Co-authorship will be invited as appropriate from the co-researchers, who may also be involved in dissemination workshops and meetings.

Outputs

Multiple outputs will be produced for different audiences, and the research findings will contribute to the academic evidence about services for victim-survivors and the further development of theories about the role of the voluntary sector. Specific dissemination activities will include: presentations made on an ongoing basis to national/regional meetings of key stakeholders (e.g. NHS Clinical Commissioners, Association of Police and Crime Commissioners, Association of Directors of Children and/ or Adults Services); a written report of findings and a national report of the national provider and commissioner surveys; seminars in each of the four case study sites; end of project regional workshops to disseminate the findings to a range of stakeholders; webinars; a project report to the funder, and bite-sized findings and infographics for SVSSV staff, commissioners and victim-survivors. Practice guides, policy briefings and academic articles will also be developed to summarise the results and identify their policy implications.

Research management

The Chief Investigator (CI) and researcher co-applicants are all highly experienced in managing large and complex research projects. The CI, research fellows and project manager will meet every two weeks throughout the project to review progress, discuss issues that have arisen, and put remedial actions in place as required. The CI and all co-applicants will meet regularly throughout the project (monthly when required; less frequently at other points in the study) to oversee study progress. A Study Steering Committee (SSC) will provide oversight and governance to the study, supporting stakeholder engagement and publicity about the project. The SSC will meet at least twice a year, and includes ten members with extensive experience and expertise in psychology, engagement with the NHS and voluntary sector, sexual health, forensic psychology, criminal justice, and SVSSV service provision. Key stakeholder organisations are represented, including Survivors UK, Rape Crisis, the Department for Health and Social Care, Ministry of Justice, Local Authority services, and the Office of the Police and Crime Commissioners.

Ethical processes

The research will be undertaken in line with the University of Birmingham's code of conduct for research which covers all legal data protection requirements.

Patient involvement and engagement

Patient Involvement and Engagement (PIE) is integral to this study. Survivors' views fed into the application for funding through the NIHR CLAHRC West Midlands PIE group, which included a survivor who had used SVSSV services; the Survivors' Trust, and staff working directly with victim-survivors. There are two PIE representatives on the co-applicant team, one of whom is a survivor. As discussed, two focus groups with survivors were convened in the development stage of the survey and data generated from these groups discussions informed the lines of questioning pursued in the surveys. Six co-researchers work as part of the study team and are involved in a range of study design, research and dissemination activities. This study has been peer-reviewed by six independent expert peer-reviewers as part of the NIHR's review process, prior to funding.

Peer review

This study has been peer-reviewed by six independent expert peer-reviewers as part of the NIHR's review process, prior to funding.

Indemnity and insurance

The University of Birmingham has in place a Public Liability Policy for this study which provides cover to the University for harm which comes about through the University's, or its staff's, negligence in relation to the design or management of the study and may alternatively, and at the University's discretion provide cover for non-negligent harm to participants.

Role of study sponsor and funder

The study is sponsored by the University of Birmingham Research and Governance Department. As the head of this department, Dr Birgit Whitman is the study's named sponsor and point of contact. The University of Birmingham assumes overall responsibility for the initiation and management of the study.

The study is funded by the National Institute for Health Research (NIHR), Health Services and Delivery Research Programme. The NHIR is not responsible for the management or governance of the project. The NIHR does not control the final decisions regarding the design, conduct, data analysis and interpretation, manuscript writing, and dissemination of results.

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