



Scoping Study: Violence Against Women and Girls Services

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Scoping Study: Violence Against Women and Girls Services

Summary

Aims and Key Research Areas

The overall aim of the scoping review was to examine ways in which funding approaches and service provision for Violence Against Women and Girls (VAWG) in England and Wales could be improved.

Objectives:

- To explore existing VAWG services, initiatives and funded projects in England and Wales
- To enhance understanding of the barriers and challenges to VAWG advancement, including key gaps in provision and funding.
- To identify ways to improve funding and commissioning approaches and delivery models for VAWG services at risk.
- To explore opportunities for Funders to work together to fund a comprehensive VAWG delivery model
- To document areas of best VAWG practice as identified by participants

Methodology:

Over 70 professionals with experience of commissioning for VAWG services were contacted via email for possible recruitment to the study. A total of 34 interviews with 35 individuals were undertaken in 2017.

Key Findings:

- The declining level of funding received was cited as the most prominent problem facing the VAWG sector. This was followed closely by the limited time for which services received funding.
- Service providers stated that they often had to make difficult compromises as funding sources often determined which approach to VAWG was adopted, which did not necessarily reflect their values or gendered understandings.
- Four major issues emerged relating to need and capacity: prominence of crisis led provision; increasing demand; undervaluation of Black and Minority Ethnic services; lack of services for wider marginalised groups for example LGBTQ+.
- The impact of reductions in services such as youth services, mental health services and other wraparound provision placed increased pressure on already constrained VAWG services to both identify need and support survivors and their children.
- The problem of public perceptions around VAWG reduced agencies' ability to raise revenue, especially in relation to sexual violence services.
- There was a consensus among participants that there has been, and continues to be, a move towards more universal VAWG services. However, this shift has occurred at two levels: firstly, there is a move towards more generic VAWG services and; secondly, alongside this, a move towards VAWG services being encompassed *within* generic non-specialist services.
- The majority of participants, including government representatives and commissioners, acknowledged that the shift to universal VAWG provision was often detrimental to specialist knowledge and the ability to really meet the specific needs of survivors and service users.
- Most commissioners interviewed for this research recognised the need to have specialist provision from VAWG agencies. Some saw this as a central requirement whilst others felt this needed to be included although not as an overall priority of the tendering process.

- Unsurprisingly, suggested improvements to the VAWG sector centred on the length and amount of funding made available. An additional solution suggested was the need to create and maintain strategic leadership in the VAWG sector.
- Funders clearly recognised the need for investment, the necessity of strategic leadership roles in the sector and also demonstrated a good understanding of the issues but also recognised the enormity of the work required.
- Large funders expressed enthusiasm for working collaboratively across charitable trusts and with the statutory sector. Smaller funders however lacked the capacity to do so. Service provider views on the benefits of a shared funding body were more mixed although generally positive.
- Participants raised a range of concerns regarding current commissioning processes. These included: obstructive procedures; lack of survivor consultation; disregard for women only services; lack of wider VAWG understanding; problematic commissioning framework; large size of tenders; competitive tendering; and difficulties with collaborations and consortiums.
- In the context of a challenging financial climate, commissioning approaches across the country emerged as inconsistent, with some good examples being provided as well as some less favourable practices.
- Overall, most interviewees recognised the potential benefits of a united VAWG funding partnership, if the diversity of funding requirements were sustained. The main benefits identified were:
 - Shared resources and a reduction in administrative burdens.
 - The opportunity to build collective learning, especially around best practice, robust evaluations, cost-analysis and evidencing added value.
 - Supporting the voice of VAWG survivors and service users in the commissioning process was an area where a funding partnership could have influence, along with supporting VAWG consortium development.
 - Providing a strategic independent leadership body for specialist VAWG services, especially in relation to smaller charities and those addressing less 'sympathetic'

issues, such as sexual violence and survivors from BME groups, asylum seekers and those with complex needs.

Recommendations

Based on the findings we have provided recommendations for four groups: Government; Commissioners; Independent funders and Service Providers.

Recommendations for Government

- To undertake a national review of implementation of commissioning guidance and hold local areas to account.
- To work with the proposed Domestic Abuse Commissioner to monitor and audit VAWG at a local level.
- The National Statement of Expectations (Home Office, 2016) needs to be embedded across all localities and systematically implemented.
- To influence Health and Wellbeing Boards to prioritise VAWG services, including sexual health and women only provision, as a central part of their strategic plans.
- Increased investment in evidencing service user and survivor needs and the 'added value' of VAWG place-based service provision.
- Support the shift in public perceptions around VAWG especially in relation to sexual violence.

Recommendations for Commissioners

- Comprehensive consultations should be routinely undertaken with a diverse range of survivors and service users throughout the commissioning and tendering process.
- Wider Consultations with independent external VAWG national organisations or independent experts should also inform the commissioning and tendering process; this should include organisations which represent BME survivors and those with complex needs.
- Realistic commissioning timeframes should be implemented to enable the development of strong and diverse VAWG partnerships.

- Within larger tender remits, there should be ring-fenced provision for specific groups including BME and LGBT+ survivors and service users with additional needs, including the need for women only services
- Grants should be seen as an appropriate avenue for ensuring smaller charities can continue to offer specialist local support; this is especially important for those agencies supporting BME survivors and women with additional needs.
- The scope of tenders needs to ensure that early intervention services are included as well as high risk crisis intervention work.
- While tendering clearly needs to address cost issues, these should not be allowed to override quality issues. In particular, tendering processes should take account of the long-term value and added social value that investment over time in locally-based expertise can deliver.
- Providing voice and provision for male survivors is important but this should not occur at the cost of services for women.

Recommendations for Independent Funders and Charitable Trusts

- Support a national forum for commissions and trust funders alongside local ‘think-tanks’ to learn from one another in relation to VAWG best practice
- Aid survivor scrutiny through supporting service users’ commissioning reference groups across localities and thereby develop good practice models to support ‘genuine co-production in VAWG commissioning’.
- Facilitate better communication between survivors, service providers, commissioners and funders to inform national, regional and local funding priorities and decisions across different sectors.
- Provide core funding to better support smaller organisations to build the capacity to collaborate and become members of larger consortiums.

Recommendations for VAWG Service Providers

- Providers need to adapt to the changing funding landscape and recognise the need to be part of larger consortiums and apply for larger tenders.

- Nationally, lead consortiums needed to invest in partnership working with smaller local specialist VAWG organisations to ensure that services are genuinely needs led.
- The added value that local VAWG services provide need to be properly evidenced and cost benefit shown (see recommendation for trust funders to support this).

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Research Aims

The overall aim of the scoping review was to examine ways in which funding approaches and service provision for Violence Against Women and Girls (VAWG) in England and Wales could be improved.

Objectives:

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Methodology

Over 70 individuals with experience of commissioning for VAWG services were contacted via email for possible recruitment to the research. An initial list was provided by Comic Relief and expanded upon following conversations with the Connect Centre team. A small number of participants also suggested colleagues who might be interested in participating in the research.

We contacted ten English local authorities and commissioners in five areas agreed to participate in the scoping study (in one area, two participants were interviewed). Some of these areas were approached as they had been identified by wider respondents as areas of best practice in relation to VAWG commissioning.

A total of 34 interviews¹ with 35 individuals were undertaken, roles included:

- Grants Officer/ Programme manager/ Funding Manager x8
- CEO/Director or Operations Manager x8
- Other Manager in third sector x5 e.g. Development Manager
- Strategic Commissioner/ Commissioning manager x3
- Community Safety Partnership Manager x3
- Public Health Specialist/ VAWG Strategic Lead x3

Interviews were mainly conducted by telephone with two being held face-to-face in response to interviewees' requests. A snowball approach to recruitment operated whereby participants emailed relevant contacts and invited them to participate in the study. The study's tight time-scale limited opportunities for recruitment and reasons given for non-participation included a lack of time, resources or relevant expertise and knowledge. Interviews lasted between 20 minutes to over an hour (see Appendices 2 and 3 for interview guides). Ethical approval was gained from the University of Central Lancashire PsySoc ethics committee. Participants were assured of confidentiality and anonymity. Interviewees came from a range of settings and roles as shown in Table 1.

Table 1 – Study Participants

| Participants | Service Providers | Second Tier Organisations | Commissioners | Funders/ Trusts | Statutory Sector | Other |
|----------------------|-------------------|---------------------------|---------------|-----------------|------------------|-------|
| Number of Interviews | 5* | 7 | 6 | 8 | 4 | 5 |

Boxes 1-5 provide details of the characteristics of the different participant groups.

¹ All interviews were telephone interviews with the exception of two face to face interviews, as requested by participants. Two people involved in the same commissioning process were interviewed together.

*One service provider also represents a second-tier organisation but has not been double counted. Where quotes are used they will be referred to as a service provider

Box 1: Service Provider participants

Service Providers: representing 1 small; 4 large organisations (total = **5 participants**). This included representatives of independent organisations providing frontline support for domestic violence and abuse (DVA) and sexual violence and abuse (SVA) and a specialist charity for children and young people (not focused on DVA or SVA). These service providers brought a wide range of knowledge and expertise in terms of experience and service delivery. Projects and services included delivery of: training, programmes such as the Freedom Programme and Recovery Toolkit, peer support and survivor groups, children and young people's services, accommodation and refuge based services, drop-in centres, BME VAWG provision, helpline provision, IDVA provision, advice, outreach support, online forums, immigration advice, prevention work and a small amount of perpetrator work. There was more of a focus on DVA rather than SVA services in this group but the organisations represented did provide support and information relating to other areas such as CSE, trafficking, gangs, migration, child sexual abuse, sex work and mental health.

Box 2: Participants from Second Tier Organisations

Second Tier Organisations: representing 3 small; 2 medium; 2 large organisations (total = **7 participants**). These second-tier organisations worked at a national level to represent the expertise and perspectives of frontline, specialist VAWG organisations. All organisations represented were gender based violence specialists, including one BME specialist organisation. One organisation supported all areas of equality for women/ women's movement beyond DVA/ SVA. Other second tier organisations (VAWG specific and generic) were approached to participate in the research. These second-tier organisations' primary role was to represent and support frontline services, often in the form of an umbrella body or national charity. Activities included awareness raising, consortia support and co-ordination, partnership working, infrastructure support, policy, research, training, information sharing, development of service standards or quality assurance, consultancy, strategic and sustainability work.

Box 3: Commissioners and Local Authority Participants

Commissioners/ Local Authorities: from South East; North West; and East Midlands of England (total = **6 participants**). The aim of these interviews was to identify good practice models which could be replicated in other areas.

Box 4: Independent Participants

Independent Participants: **3 participants** who between them had experience of grant making, previous but recent commissioning, academia/research and service delivery. All those interviewed were still involved in the VAWG sector in some way. **One** representative of a large housing provider was also interviewed. For reasons of confidentiality these four participants have been grouped together and will be referred to as 'other' where direct quotes are used.

Box 5: Participants from Charitable Trusts and Funders

Charitable Trusts and Funders: Those interviewed included representatives of one very small (less than £1m); 3 small (less than 20m); one medium (less than £40m); one large - £60m; and 2 very large – over £100m (total = **8 participants**).

Amounts of funding provided by these organisations were hugely variable (from 5k per year to 500k over 5 years) depending on the size of the charity and regulations. Those interviewed reported funding a wide range of provision including: children and young people's services, anti-trafficking and prostitution provision, ISVA, IDVA, mental health, centre or refuge managers, FGM, early intervention, prevention, recovery programmes, perpetrator programmes, refuges, care leavers, older people, CSE, refugees, migrants, unemployment, prevention, employment support, counselling, healthy relationships lessons in schools, male victims services, child to parent violence, stalking etc (see Appendix 1 for detailed breakdown).

Box 6: Statutory Sector participants

Statutory Sector: This included public health, police and community safety managers (total = **4 participants**) and National Government Office: **1**

Limitations

It is important to acknowledge that the picture provided by this report is not representative of all VAWG service providers, charities or funding trusts in England and Wales, but rather seeks to illuminate the current complex and shifting situation from the perspective of those interviewed. The research team contacted a number of generic providers of VAWG services; however, none chose to participate.

Findings

A. Current VAWG Climate: Challenges and Impact

'I have never experienced in my time (forty years in the VAWG sector) the level of fatigue... Really, really strong women that have been at the forefront of (VAWG) social change..... [where all the avenues we have gone]...the doors are closing.' (Provider 1)

Funding Levels

The declining level of funding received was identified by all participants as the most prominent problem facing the VAWG sector. This was followed closely by the limited length of time for which services were funded. Participants emphasised that the VAWG sector had never been adequately resourced. For example, one affluent geographical area had historically never received any substantial local authority funding for VAWG services. Where positive local work had previously existed, these services were now described as 'fragile, hanging by a thread'.

Interestingly, three trust funders as well as VAWG organisations highlighted that agencies were now expected to provide the same level of service for less money. The short-term nature of funding was also commonly highlighted as a significant issue due to the length of time victims/survivors may need support as well as gaps² between funding applications, which often resulted in breaks in service provision until the next pot of funding was secured: 'I think it's really difficult for people to think that long term. It's difficult in times of plenty but it's particularly difficult now' (Other 1).

Funding issues also included problems related to capacity. This centred on service providers having inadequate funding levels to provide the numbers of staff required to respond to both the level of referrals and to undertake long-term recovery work. This point was raised by three funders and two large VAWG organisations.

Exacerbating these funding problems were the timescales and expectations of statutory funding bodies. Participants cited examples of: late decision making; short turnaround for tenders; removal of ring-fenced funding; late payment; payment by results; and the localism agenda. Examples of this can also be found in a report by the Women's Resource Centre (2006) and more recently Smith and Miles' (2017) report of women seeking refuge. Many interviewees stated that local authorities failed to

² Some charitable trusts require organisations to have a break of 12 months for example before they can reapply for further funding

recognise that VAWG organisations were unable to function from reserves as these were, at best, limited and certainly not sufficient to facilitate a full cost recovery model. This often meant a gap arose between the funding received for specific service provision and organisational costs. Building on this, larger VAWG sector organisations (first and second tier) explained that sources of core funding were very limited. The impact of these combined funding issues meant that already vulnerable services were described as at risk of ‘closing overnight’. Smaller organisations were considered to be under particular threat:

‘The fragility of the sector needs to be understood. The insistence on project funding while not achieving full cost recovery, not allowing organisations to achieve full cost recovery. We need core funding. It’s nightmare-ish. You’re moving from project to project to project. You’re often trying to get on with doing the work... the frontline services that are supporting women to stay alive and then you’re having to prove innovation when actually your ability to innovate has been squeezed out by the difficulties you’re facing. Or you’re constantly having to innovate because that’s the only way to survive....’ (Second Tier 2)

As the above quote illustrates, a related impact of the current funding climate was to reduce innovation. Some participants felt that trust funders were now currently filling gaps rather than helping to develop new ways of working, supporting robust evaluations and establishing best practice models:

‘...more and more funders are looking to fund services and fill the gaps, which means that they’re not funding work that would actually move the evidence base forward.’ (Second Tier 1).

Many felt that there needed to be greater emphasis on investment in research, monitoring and evaluation work, especially around measuring cost effectiveness and longitudinal studies to demonstrate sustainable impact and cost benefits (see also Big Lottery Fund, 2016). Some participants also questioned which services should be funded and on which scale: national, regional or local:

‘Other kinds of support services may be appropriately planned and funded at Local Authority level, but not refuges - so we have a current situation which is not just about funding cuts, but about funding at the inappropriate scale of government... I’m saying we’re doing things at the wrong geographical scale on some of these services so we’re never going to get it right if we’re funding things at the level women don’t need. What do women need, where and when? And start from that premise. How and where? Just round the corner or a long way away? Turn it round and say how would it work better for women and children rather than how do we retain what we’ve already got.’ (Other 4)

'When it comes to refuges, the need for a national network so people can access them out of area is critical.' (Funder 6)

Funding Driving the Approach

Some participants stated that, in the context of the current funding landscape, they often had to make difficult compromises as funding sources often determined which approach to VAWG was adopted. The Office of the Police and Crime Commissioner [OPCC] would advocate a criminal justice approach and Clinical Commissioning Groups [CCG] a health response. Service providers stated that, even when they had been successful in obtaining funding, the approach implemented by funders sometimes resulted in services which failed to meet survivors' needs. In addition, this also meant that the funding criteria did not match the ethos or values of their organisation:

'...can start to lose autonomy... because you're following funding rather than what is right for victims and survivors'. (Provider 1)

Participants also reported that localism meant that, whilst some funding streams for VAWG work increased, other forms of provision failed to be prioritised. One participant explained that the rigidity of funding streams affected an organisation's ability to provide support. Another participant spoke about funding for sexual violence services:

'... I've been here over three decades and I've seen funding cycles change, go back to what they were, change, go back to what they were... [we were] awarded 3 years of funding... had to apply annually for 3 years. What emerged was a focus around criminal justice... that...resulted in programme of funding that was specifically focused on the Criminal Justice response and what we saw emerge from that was a hierarchy of need... so if you decide to engage with the Criminal Justice System... those individuals were prioritised... don't report, choose not to report, or chose to withdraw were left with nothing....' (Provider 1)

The quote above also demonstrates that even where funding is available, providers are still required to re-apply year after year.

Need and Capacity

Two major issues emerged from the analysis relating to need and capacity: crisis led provision and increasing demand.

- **Crisis Led Provision**

Many interviewees (funders, providers, second tier and other participants including two from the statutory sector) stated that over the past decade they had experienced a shift in focus to high risk/crisis driven or risk led provision due to the current emphasis on criminal justice responses. Many worried that this shift to short-term crisis provision failed to recognise that some survivors required longer-term recovery work:

'Police are very crime focused, narrow sense of what they're trying to achieve – short term intervention of IDVAs, police etc. If someone is seen as safe they're done, you're left on your own which takes longer. In women's lives the starting point is needing to be safe but you then need to recover from all you've experienced and what CYP have experienced long term process needing holistic support.' (Other 4)

'The increasing focus on risk and short-term focus on risk has drained the resources from longer term recovery projects that were based on health and wellbeing. The more that people have been wanting to be able to tick boxes about reducing risk, the less interested commissioners have been which surprises me really in terms of long term recovery and change... it's more expensive.' (Second Tier 5)

Second tier organisations and funders identified a pressing need to improve approaches for those not at highest level of risk alongside continuing to develop services for high risk groups:

'There was a lot of good practice that was going on on the ground anyway but a lot of the funding was very much targeted at high risk and they (service provider) wanted to broaden it out.' (Funder 2)

Some participants felt that local authority provision was increasingly based on risk (or crisis) rather than need, which meant that holistic services, including counselling and emotional support for sustained recovery, were being lost.

- **Increasing Demand**

Participants referred to the growing needs of service users and increasing caseloads. This was in part connected to a reduction of other relevant services, such as mental health provision, which put additional pressure on VAWG providers. There was also a general feeling expressed that more DVA survivors were coming forward to access services. Sexual violence services had also seen an increase in referrals due to increasing media coverage of high profile cases such as that of Jimmy Saville. Service providers described being expected to support increasing numbers of service users with little, if any, additional funding:

'We see 2007 as a time of plenty, relatively speaking... but actually we were still at the very very early stages of a very long road in terms of really tackling DA... its volume... it's vast... you never have enough resources to deal with because as soon as you build confidence in the community and people come forward the bell curve never comes back down again, it just keeps going up and up and up.... It's an enormous problem... nobody is prepared to come up with sort of resource that we really need to deal with it.' (Other 1)

Perceptions of VAWG

The problem of public perceptions around VAWG was emphasised by interviewees. This was related to the fact that VAWG is not an attractive cause to support; it is still seen as a private problem and does not generate the same sympathy as other social issues:

'You know when you get those little coins at the co-op? We can't even look at what we've got in there because the local hamster society has got it.' (Provider 1)

One second tier VAWG organisation thought that this was also the attitude of some funders:

'Increasingly, when people talk about VAWG now they mean Domestic Violence and Sexual Violence gets kind of ignored. If you look at funding streams that are for both they tend to end up going to DV.' (Second Tier 3)

The historical underfunding of sexual violence services has also been recognised elsewhere (e.g. Hawkins and Taylor, 2015; Women's Resource Centre, 2006). This was a common response from agencies seeking to specifically address sexual violence and some have moved to include wider issues of gender-based violence so they can apply for VAWG money. The issue is not that specialist VAWG agencies should not provide both sexual violence and DV services - often these issues overlap - but that service specifications in tenders do not include specific sexual violence provision. As one sexual violence provider stated:

'For example, the domestic violence bill that's coming through, we're going to have to fight really hard to make sure we were in there.' (Provider 1)

One funder pointed out that the fundraising climate for VAWG services was 'very tough' and that public perception, especially around rape culture, impacted on this. Related to this, some participants also felt that that a victim-blaming culture still existed in some wider organisations, for example, the police and Local Authorities, and that this lack of understanding and poor practice needed to be addressed. Issues of xenophobia and racism were also seen to compound negative public perceptions for BME survivors and were considered particularly worrying due to the current rhetoric surrounding

refugees and migration. Overall, interviewees felt that these perceptions contributed to reducing the potential for fundraising to provide a reliable income stream for some services, especially those around sexual violence; this also suggests that further public educational and awareness-raising work is needed:

'(Name of funder) when they announced their VAWG fund... it was actually a domestic abuse fund... only two (sexual violence) groups received funding from that. They said we were single issue. We said that's ridiculous.' (Provider 1)

It was interesting that although we contacted three large national children's charities only one responded. This may be due to capacity issues or possibly that they do not perceive their work coming under the VAWG remit. Similarly, some trust funders who did reply and spoke favourably of work in this area found it very hard to differentiate VAWG projects as this was not currently used as a funding category. Some said this failure to distinguish such projects would now be addressed.

Increasing Complexity

Overall, many participants, across all sectors, felt that over the last decade the scope and complexity of VAWG work had increased while funding had, in real terms, decreased. This meant that although a greater range of services was now being provided by the VAWG sector, including prevention, education and work with perpetrators, this had not been accompanied by increases in resources. Expansions in some areas of work were, according to some participants, at the expense of services for women survivors (see also Hirst and Rinne, 2012):

'There is no doubt that money that was going into women's services is being diverted to fund work with perpetrators and work with male victims. It's not that they've introduced another pot of money. The small pots of money that were not enough anyway for women survivors have been further reduced by women's organisations being expected to deliver services to male victims and perpetrators as well.' (Second Tier 5).

Participants did not question the importance of perpetrator programmes, early intervention or preventative education; indeed, many stated they required more funding, development and research, but it was argued that these activities should not divert funds from already stretched services for survivors.

B. Key Gaps in Provision and Funding

Participants identified specific shortfalls in both provision and funding for BME survivors and women and girls from wider marginalised groups including those with complex needs.

Black and Minority Ethnic (BME) Women and Girls

By far the most commonly cited gap in funding and provision was for BME VAWG services. This included general VAWG provision for BME women but also specific provision focusing on travelling communities; race and cultural understandings; BME women with disabilities; women with no recourse to public funds; immigration issues; and women with language barriers. These obstacles are long standing and have already been well documented (see Imkaan, 2015, 2016; Hirst and Rinne, 2012):

'Across London... the problem when individual Local Authorities make decisions about cutting a service is that it actually affects women elsewhere it doesn't actually affect local women a lot of the time. Can end up with death by a thousand cuts if each Local Authority makes its little decision. The whole specialism disappears and then you might have a generic provider that might provide a service for BME women but that's completely different from a specialist related to particular issues.' (Other 4)

Many BME organisations felt that their work on VAWG was sometimes viewed by commissioners with suspicion; some stated this was due to institutional racism:

'People don't understand why race might be an issue in terms of BME provision... why it may be important to navigate cultural nuances... Xenophobic narratives have found their way to local level... organisations are treated with suspicion... you have gaps around ethnicity [in leadership and provision relating to other intersections]... that are not an add-on to the mainstream service... there is a real lack of understanding of the needs of BME girls... so many gaps... it's not rooted in evidence of poor performance by BME orgs... there really is an issue around racism... we continue to fail BME women and girls' (Second Tier 2)

BME providers also considered that BME issues were often perceived by funders and commissioners as being predominately about 'cultural' abuse, for example Female Genital Mutilation, Forced Marriage and Honour Based Violence, rather than more general forms of DVA, child abuse or CSE (see Chantler et al 2018). These interviewees emphasised the need to address broader issues of BME experiences rather than adopting a narrow approach:

'The assumption that the only thing we experience is FGM, FM, or HBV...we continue to be affected by other forms of violence e.g. DVA. That impacts on what people understand is needed and should be commissioned... the need to not have contracts for BME women focused

only on FGM, FM, HBV... The current counter extremist strategy... includes FM, FGM and HBV. Those are the only forms of violence names within those strategies and so we're also grappling with a context where the counter terrorist/ counter extremist agenda is really affecting where money goes and what money should be used for... That agenda is increasingly overlapping with a woman's rights agenda in a way that is really problematic...' (Second Tier 2)³

Some interviewees, including service providers and trust funders, also stated that the smaller BME charities faced competition from larger generic women's organisations which didn't have the same understanding of the intersection of race and gender, making partnership working difficult (see Chantler, 2006 and Batsleer et al, 2002). The neglect of some minority groups, such as the Chinese and Albanian communities, was also commented upon. Lastly, some felt that the current move towards targeted service provision and away from wider community working meant that the background of BME organisations, rooted in activism against racism, was being lost. The need to ensure good relationships with commissioners also meant that it was more difficult for organisations to provide a critical voice locally as this might jeopardise future working and their involvement in VAWG partnerships.

Wider Marginalised Groups

In terms of wider issues, the most pressing concern was the loss of additional services such as youth services, mental health services and the very limited provision for LGBTQ+, drug and alcohol users, wider drop-in centres, education and skills work and children's centres. Many felt that current services were not set up to support the most marginalised groups due to blanket service delivery policies that failed to acknowledge the complexity of the work required for more specialist provision:

'More excluded groups are becoming more excluded' (Funder 4)

'We've always had a battle on our hands but it feels to me that it's possibly the worst time ever.... the gains that we've made, because we have made gains, have only addressed specific manifestations. They have not got down to the root of the problem – because if they had those gains would not be able to taken away from us so quickly. We haven't changed institutions and so we're still at the mercy of them when austerity hits'. (Second Tier 6)

Many specifically highlighted the lack of services for survivors with substance abuse problems, a history of violent behaviour and mental health needs. This was identified as an issue for all VAWG

³ See Chantler et al (2018)

services but refuges were viewed as particularly affected as they were often unable to accept women with the above additional needs due to capacity and safety issues⁴. It was also noted that survivors with additional needs faced structural barriers within statutory services.

There was agreement that the shift towards a 'one size fits all' model disproportionately affected more specialist service provision. The importance of these specialised services was emphasised by the Government representative:

'And then when you get into more specific specialist support, for example working with BME organisations, some communities won't feel as able to come forward or engage with support services that are not from within their own communities and you need to have an understanding of the community and cultural pressures that some people might be under in order to be able to give them the support they need. You also need the second layer almost of specialist understanding. Then finally when you get into complex needs, so women with substance misuse issues or mental health problems, homelessness...it might not be appropriate for them to access mainstream provision...They might be disruptive, they might cause trouble to other people accessing the service; but actually that's because of all the myriad of problems that they're dealing with and those women need the specialist wraparound support to deal with all of their needs.'

Many providers and some commissioners reported that the loss of these additional services had negatively impacted on the provision VAWG survivors could access and placed additional pressure on already constrained VAWG services to identify need and support survivors and their children. A major area of concern highlighted was the lack of housing provision. For example, interviewees described some London boroughs as 'swamped with demand' as families were moved to cheaper areas, resulting in long waiting lists and placing increased pressure on services in these areas. Many considered this issue was exasperated by a lack of cooperation between agencies, for example, the Police and Housing, and the divide between adult and child safeguarding, and argued that a much better co-ordinated response was urgently required. Some interviewees also considered that service reductions resulting from austerity policies meant that survivors were being forced to return or remain with abusive partners due to lack of alternatives.

⁴ For a detailed report documenting difficulties women with needs listed above face when accessing refuge space see Smith and Miles (2017). Work by Holly (2017) maps service provision for women with complex needs across different sectors.

Additional obstacles to service provision were commonly identified for the following groups:

- Refuge provision for Transsexual women
- Disabled survivors including deaf women
- LGBTQ+ survivors both at the local level and nationally following the closure of Broken Rainbow
- Teenagers and younger women⁵
- Teenage sons of refuge users
- Older women
- Issues re sex workers
- Homelessness survivors
- Survivors with no recourse to public funds

Other groups also mentioned included: male victims; boys and young men; victims of trafficking; children with learning difficulties who had been sexually exploited; young people who were leaving or had left care; parents; and vulnerable young people around the age of 18.

Independent Funders' Perspectives

All independent funders interviewed recognised the challenges facing the VAWG sector as highlighted in the section above. Some had developed their own solutions to tackle these issues, although smaller funders stated they didn't have the capacity to do this in any substantial way due to their size. For example, some had set up specific VAWG funds, however they acknowledged that the recurring issues of sustainability, breadth and scope of the problem meant that major gaps still existed. All stated that their funds were always oversubscribed and they could not resource all those projects they felt warranted funding.

Independent funders took different approaches: for example, some sought to fill small gaps in provision while others aimed to increase innovation and learning – all felt this was an important balance for service providers. The case example below provides a good illustration of a collaborative project that aimed to build knowledge in relation to new forms of intervention.

Case Example: Tech vs Abuse. This is cited as an example of an independent funder (Comic Relief) working collaboratively with Safe Lives and other providers on a research project that aimed to understand opportunities, gaps and risks – in this case around technology. This project is currently

⁵ A detailed research report on 13-17 year olds has been produced by Safe Lives (2017).

ongoing at the time of writing but a report⁶ has been produced which highlights the potential opportunities for technology to play a supportive role in the context of domestic violence and abuse and how to minimise the associated risks. DVA

Overall, independent funders had a very high level of confidence in independent VAWG service providers' ability to understand the needs of their service users, and recognised that a one size fits all approach would be inappropriate. Some funders had started to develop regional hubs/ managers to help build closer relationships with projects and understand local needs more fully. For example, one trust only operated in London and had very close relationships with the services they funded. Another fund had operated in the north of England for many years and understood the needs of the local communities their funded projects served.

However, funders generally felt that more needed to be done to evidence the work of specialist VAWG providers through utilising more robust measurement tools which could clearly demonstrate the outcomes achieved for survivors and identify best practice. Funders were also looking to deliver capacity building programmes in the VAWG sector: At least one large funder was seeking to build capacity through allowing successful projects to apply for additional funding rather than having to re-package the continuing work as a new intervention. Another funder had funded a large-scale programme with evaluations built into the programme at individual and system levels. Funders clearly recognised the need for investment, leadership roles in the sector and demonstrated a good understanding of the issues but also recognised the enormity of the work required:

'due to a recognition for specific investment into the women's sector, a £45 million investment into the women's sector was also launched in 2015... This was about supporting this sector... Planning the fund: When we set up the programme we had round tables with key people from the sector and other funders working in this area to kind of look at what were the priorities for this sector, you know, if we were going to put money in, what should we be focusing on? That's where the four outcomes came from (evidence base, holistic working, co-production and improved services) ... So that had some kind of leadership role within the sector. We also knew that BME groups were particularly affected by austerity cuts so we wanted to support those. We tried to get local knowledge to understand who were the key players in the sector, avoid

⁶ Snook, Chayn and SafeLives (2017) Tech vs Abuse: Research Findings. January 2017. <https://www.techvsabuse.info/research-findings>

duplication – it was difficult put it that way... And we know there were some real gaps even when we finished. It's a huge amount of money but it only goes so far.' (Funder 2)

C. Shifting Climate in VAWG Services

Wider VAWG Understanding

A widely reported concern, raised by second tier organisations and some funders, was that there had been a move away from a gendered understanding of domestic violence and abuse. This was partly attributed to a misunderstanding of equality legislation. Respondents were keen to highlight that treating people equally does not necessarily mean treating them the *same*. This was also echoed by at least one commissioner interviewed. The Government representative was very clear on their standpoint:

'Our government policy is not to have gendered neutral policy that they should absolutely be couched within the gendered inequality of these crimes and having a gender-neutral approach is not appropriate for either men or women. It's not just about 'because it only happens to women you need to understand women needs'. If you've got male victims of DVA going to a women's centre that's just really not appropriate. Actually, you need to understand the gender dynamics of being a male victim in order to address that properly and provide the support that they need. It's really important for us that it's got a kind of gendered understanding and it forms part of VAWG strategy.'

The misinterpretation of statistical data was also raised in relation to understanding prevalence and the gendered impact of violence. It was acknowledged by participants that men and boys can be victimised, that specialist services need to work with men, and that commissioners had a responsibility for commissioning services for male survivors:

'Not even asking what is appropriate for men because male survivors are asking for different things and are in a different position and the patterns of coercive control play out differently for them as well. So we're not denying that they experience domestic abuse, we're challenging if they need the same services as women... what they're asking for is different...' (Second Tier 5)

However, participants emphasised the nature and prevalence of violence and abuse against women and girls means this is an issue that can only be effectively tackled through a gendered analysis:

‘VAWG is not about it being illegal... it’s not like any other crime, it’s a foundational necessary part of women’s oppression. That’s completely different from getting burgled. It’s a whole different arena... we need investment in service provision, in prevention and work done in schools...’ (Second Tier 6).

There was a consensus among participants that there had been, and continued to be, a move towards more universal VAWG services. However, there were two levels to this process. Firstly, they described a move towards more generic VAWG services and secondly, alongside this, a move towards VAWG services being encompassed *within* generic non-specialist services was identified. These moves were viewed as a direct consequence of less specialist VAWG commissioning or local authorities tendering over wider areas (regions or issues) by combining small contracts to make one large tender. Independent funders tended to agree that the move towards universal services was a consequence of some commissioners wanting ‘one organisation to do everything’. Some funders were less certain of how widespread this shift was but agreed it was a concern. A detailed report by the Lloyds Foundation (2016) also identified a similar pattern for small and medium charities across a range of sectors.

Generic VAWG Services

Generic VAWG services were seen as having the effect of reducing the total amount of funding available for survivor services:

‘For us there is a value of separating FGM, FM, HBV, sexual assault etc. as it has the potential to increase the funding for survivors... danger if you amalgamate the funding you reduce funding even further but there is a need for some overarching strategy. I think that’s what the government have tried to do but...’ (Second Tier 5)

There were concerns voiced that larger VAWG organisations were competing against smaller specialist VAWG ones. This was highlighted as being a particularly acute problem for BME and other minority services: ‘as money gets tighter [BME services] are quite often the first thing to go’ (Second Tier 1). For example, it was explained by at least four VAWG organisations that the number of specialist BME VAWG services had reduced and had been replaced one or two BME workers within larger VAWG organisations:

‘Whenever there are cuts there is a push to amalgamate services. And where you’ve had specialist expertise built up specific to BME to LGBT or disabled communities, there is a push towards merging those with generic services because then you can do it cheaper. So then you just have one BME worker to address the needs that were previously addressed by a whole

project. There's a huge loss of expertise there and that's something we're seeing quite a lot of.' (Second Tier 5)

One respondent expressed concern that commissioners seemed unwilling to issue contracts for BME VAWG services. A trust funder also emphasised the need to retain *both* women only and specialist BME VAWG services provided by specialist BME VAWG organisations. This was supported by information from two second tier organisations:

'Need to recognise the need to invest in the BME VAWG sector as an entity in its own right and as organisations that deserve to be funded.' (Second Tier 2).

Generic organisations providing VAWG services

The second concern was that VAWG organisations were increasingly having to compete against larger, better resourced generic providers (see Women's Resource Centre, 2006; Hirst and Rinne, 2012):

'Facing an influx from national generic organisations diversifying into an area that they can win a contract...' (Provider 3)

'The latest rounds of VAWG HO transformation fund, when we looked at what had been awarded it was really perplexing... its really worrying... local authorities and generic organisations have been successful not small specialists...national charities that didn't start off as DV specialists...' (Second Tier 5)

Participants were concerned about the number of contracts being won by larger generic services which jeopardised the future of smaller specialist services. Interviewees gave a number of examples of cases where VAWG consortiums had lost contracts to generic providers which meant that all those partnership agencies were at risk of immediate closure leaving no specialist providers in the locality:

*'Large, non-specialist organisations should think carefully before they compete with established specialist providers. Can they really provide **all** that they currently offer? Just because they can compete, doesn't necessarily mean they always should.'* (Other 1)

In part, this shift was attributed to commissioners placing larger tenders which required providers to supply a wide range of services for diverse groups, including, for example, support services and emergency accommodation for male survivors and perpetrator work. There was a general feeling that more work was being included in large tenders for the same - or in several instances. a reduced - price. Often local specialist VAWG agencies were unable to provide this broad range of services.

Additionally, in some areas, VAWG work was being aligned with wider victim support work, that is, seen as including all victims, not just VAWG:

'Another trend I see is DV and SV services getting pulled into more generic victim services. Some of that is a function of funding streams going to PCCs and some of them have a greater priority on VAWG and some of them don't... ..' (Other 1)

There was agreement that more generic organisations often had higher revenue levels and were more financially protected and therefore able to undercut VAWG service providers who, in contrast, were often financially uncertain. Generic organisations were widely seen as having more capacity, and in some cases dedicated national bid-writing teams, to respond to tenders. Smaller grass-roots VAWG organisations who relied on staff, often their CEO, to undertake this role (see also Hirst and Rinne, 2012) were disadvantaged in this respect:

'We never had any money but I watched what happen to them overnight and other generic providers taking over their contracts, or big refuge providers have bid writers [which] meant local groups were under serious threat.' (Provider 1)

Many providers, funders and commissioners highlighted that when local VAWG services lost contracts they were often unable to survive and the depth of local expertise, understanding of local need and wider advocacy on local issues was lost:

'Some generic providers have the level of staffing so people can concentrate on putting together a really good bid, that's the size of the org. Smaller organisations are always at a massive disadvantage. They [the generic providers] get the contract and they don't provide a good service. Maybe the police or whoever assume that all the other services (smaller VAWG providers) will continue and they all disappear because of lack of recognition and what happens when you get rid of expertise. Even uncertainty can get rid of expertise e.g. renewal of contracts. Staff leave because they don't know what's happening. Even if they are recommissioned they then have to get new staff as expert staff have moved on due to uncertainty...' (Other 4)

Anecdotal evidence was provided by more than one participant of generic services winning a contract on lower costs but then failing to deliver services that matched the quality of those previously provided by specialist organisations.

'For example, in one area, their floating support has become generic and when I made a referral for a woman suffering domestic abuse it [the worker] was a man and then it's about, what level of

training have they even had? And also it would be interesting to know where is the accountability? How are they being measured?’ (Other 3)

The need to ensure that quality remained central to commissioning was also highlighted by the Government representative:

‘But I would question the term value for money versus quality. I would say it’s cost vs quality because quality will be values for money. Because we know that VAWG issues can go on and on and where people, particularly where you are working with women who have been victims multiple times, and we know that, for example children who witness abuse in the household or are abused themselves are far far more likely to go on to be in abusive relationships themselves either as a victim or as a perpetrator. So a cheaper intervention that just patches you up and sends you on your way, that isn’t specialist enough, won’t - well it might help and it might solve the problem potentially but it is less likely to actually provide the lasting change that people need that means they don’t get re-victimised. Good quality is value for money.’

These shifts in provision have occurred relatively recently and we currently lack robust evaluations to determine the impact of these changes for survivors and their children. However, one could assume that the loss of VAWG specialism means that more generic organisations may lack the specialist experience to work with survivors. VAWG prevention and intervention is multifaceted and requires long term effective support (Hague & Bridge, 2008).

Health and VAWG Provision

A few participants also discussed the lack of engagement from Health and Wellbeing Boards. This issue was also identified by commissioners and the government office representative who stated that Health commissioners were generally not engaging sufficiently in VAWG agendas:

‘Centrally, there’s definitely a point about making a case and building the evidence base for violence as a health problem, which we’ve done a fair bit of, but there is always more to be done. ..There’s a point about demonstrating there is a cost attached ...recognition that health bear the brunt of a lot of it so actually need to do some more about identifying that that’s what the problem is. We are working very closely with the Department of Health to try and encourage all of this.’ (Government Representative)

Integrated approaches to commissioning were not flagged up by this group of participants and although public health specialists contributed to the interviews, the recent shift of public health to local authorities was not identified as a means of improving health services’ engagement in

commissioning processes. Interviewees attributed the lack of engagement from health services to insular working practices within local authorities and a lack of recognition from health organisations in general. However, the potential value of Health contributing to commissioning was highlighted:

'If you invest in health kind of thinking then they can get back on their feet a lot quicker. Acute crime based things can be done under a PCC but physical and mental health etc. requires more of a health commission. Everywhere struggles to get health to take a coherent role when they're actually doing masses of it e.g. A&E, GP etc., day in day out. Symptom by symptom basis.' (Other 4)

A minority of participants mentioned the involvement of health organisations or commissioners, noting varying degrees of success. A central issue was the lack of women only provision due to a reluctance to commission dedicated women only services. Similarly, Holly (2017) also found a lack of women only health provision for service users experiencing multiple disadvantage. The overall picture was characterised as requiring a much higher level of involvement from health services:

'...I would definitely say health and wellbeing boards really generally haven't engaged or accepted that domestic abuse should be absolutely core to the strategic work that they do. Here and there we do see some good engagement – tends to be on the basis of an individual who really cares... just not seen as a core part of health... It's just not good enough.' (Second Tier 5)

D. Suggested Improvements to Increase Sustainability

Funding

Unsurprisingly, suggested improvements centred on the length and amount of funding made available. It was suggested, that due to the current situation, funding needed to be considered in two ways:

- Short term – the here and now
- Longer term - in five to ten years' time.

A number of respondents said funding should be consistent, stable and ongoing. Quality needed to be valued over or proportionate to cost and this included staff salaries which were generally thought to be lower compared to those in the statutory sector, affecting quality of work and morale. A five-year minimum funding term was suggested with a need to move away from short-term project based funding. The Tampon Tax fund was considered helpful in providing much needed additional funding but this again raised issues around sustainability. Recommendations for sustainability were provided

by the All-Party Parliamentary Group on Domestic and Sexual Violence Inquiry in 2015 (see Hawkins and Taylor, 2015).

Interviewees generally called for punitive systems such as payment by results and payment in arrears to be withdrawn since they were unsustainable for smaller charities. It was suggested that budgets for VAWG services should be ring-fenced, including BME and other minority groups. Three participants regarded the 'Supporting People' system positively. Proposed solutions for additional funding included greater investment from the health sector and more involvement from the private sector – it was suggested this could be secured by emphasising social responsibility. Linked to the above was the need to make the case for cost effectiveness and sharing of best practice to increase the evidence base so that services received appropriate funding.

Diversity from Funders

Each of the trust funders participating in this study covered different priorities and remits. VAWG agencies generally seemed to understand which trusts to approach depending on their funding requirements. Some funders sought to support services that were already working effectively in the area and recognised the difficulty of trying to continually provide innovation. As one funder explained, 'not everything needs to be new and shiny'. Some service providers echoed the need to look at what was working rather than insisting on something 'new'; one charity gave the example of only securing further funding for an existing project once it had been rebranded.

'No-one ever says 'this stuff's really good - let's fund more of it... there's lots of stuff out there that works' – focus on new/innovation/transformation.' (Second Tier 1)

Government was seen to exacerbate this tendency by establishing one-off funding sources whose descriptors included terms such as 'transformation, innovation'. Such initiatives were considered to reduce funds for existing provision that was already working. However, some funders emphasised that they wanted to support innovative work as it was based on specific areas of need and continuous improvement. This point was supported by some providers as innovation funds gave them somewhere they could take new ideas, pilot suggestions or provision based on evidence from elsewhere.

There was also a criticism of 'one-off' funds offered by the charitable sector which, while recognising the chronic underfunding facing the VAWG sector, were described as failing to provide strategic support or long-term vision for sustaining the sector.

Some interviewees also pointed out that service providers were now increasingly expected to work in partnerships but questioned whether funders were doing the same:

'We're busy trying to form partnerships with local providers, we don't always see those partnerships between commissioners but we don't always see them between the funders... there is a lot of good will in some of the big foundations and trusts towards supporting the VAWG sector, and they have supported us for years... historically they've worked on their own.'
(Second Tier 5)

Another funder explained that although they do fund consecutively for nine years (3 x 3 years), many organisations simply assumed they didn't do so or didn't want to appear greedy. One small funder preferred to fill smaller gaps, for example: core costs, recognising that this would not sustain services but would enable organisations to access funding that wasn't available from other funding bodies, for example, rent payments.

The issue of ongoing funding was most prominent in participants' accounts of how government and trust funding was used to set-up or 'prop-up' services in the short-term but was not sustained beyond that. Some felt that funders held an incorrect assumption that local government would continue to fund services once they proved they were effective.

'Funders have often provided initial funding for a few years to test out new models to show its getting positive outcomes with the assumption that local government will then continue to fund it if it's successful. It sounds like a really nice model of doing it but there's also the challenge of local government getting their funding cut really radically and they are barely able to fund things they are statutorily obliged to fund.' (Other 2)

Many providers stated that organisations could not access grant funding for services that were deemed to be statutory but it was not clear what these statutory responsibilities were, especially in a climate of austerity:

'If they're [independent funders] not prepared to pick up what they think the state should fund and the state don't think they should fund us, we fall through a mighty big hole.' (Provider 1)

Strategic Leadership

One solution suggested, beyond increased resources, was the need to create and maintain strategic leadership in the VAWG sector, which would in turn provide stronger influence over provision. Interviewees argued that there was a lack of any real cross government strategy on VAWG

commissioning due to compartmentalised working at central government level. This meant that local commissioners were simply left to get on with it; many called for a firmer strategic steer.

Linked to this was the need for commissioners to consult meaningfully with a range of survivors and service users from diverse backgrounds, rather than making tokenistic gestures which meant that the experiences of one or two survivors could disproportionately influence provision. These consultations should run alongside dialogue with external VAWG practice providers and academic experts to ensure that a clear and consistent understanding of VAWG issues and local need underpinned the tendering process:

'That's the overarching system approach that I think is the best. How you get that in a local area is by really great leadership, you have the commissioning and investment of services so you commission the right kind of services which are person centred, needs led, intersectional. That you have a strategy that is really solid and is consulted on. Not just by stakeholders but also by people who are going to be affected by the delivery of the strategy – survivors, young people, people from BME communities in your area... you consult, you consult, you consult.'
(Other 5)

Strengthening relationships between commissioners and local providers was also seen as key, although it was recognised this was problematic in some areas and might require external facilitation to re-build confidence. Some commissioners were described by providers as appreciating input from the local and national VAWG sector but others were described as bound by rigid procurement rules and regulations.

Other solutions included: the auditing of local authorities around VAWG priorities, including services to BME women and those with additional needs; centralised commissioning; more commissioners working together; and joint strategies. The Welsh Government initiatives to move towards a regional model with pooled budgets and standard set of outcomes was viewed by some as good practice although others were critical of consortium models.

E. Opportunities for Collaboration between Funders

Overall, the Independent funders interviewed had a comprehensive understanding of the issues faced by the VAWG sector. Large funders expressed enthusiasm for improved working across charitable trusts and with the statutory sector. Smaller funders however lacked the capacity to do so.

It was acknowledged that there was currently a lack of ongoing communication between funders/trusts and statutory funders/commissioners. For instance, a funder who was often asked at short notice to provide references for organisations applying for government funding had failed to hear subsequently if organisations had been successful. It was suggested that issue based networks could be developed which would potentially provide more coordination and agreement on what could be achieved. Funders could then pool resources for some specific areas of work, for example, evaluations to strengthen the evidence base. As one second tier provider stated; ‘Where there is no evidence base at all, it’s quite hard to show the need for the work’ (Second Tier 1).

However, reservations were expressed as some funders were concerned that multiple funding streams for a single project would make it harder to demonstrate impact. Smaller funders also held reservations around joint funding models: ‘because our grants are quite small, we don’t want to just be a drop in the ocean compared to what somebody’s costs might be’ (Funder 1).

It was suggested that mapping of funding and provision would be helpful for funders but due to the volatile and rapidly changing nature of the sector this seemed an impossible task:

‘They often do something around a pilot, scoping or good practice etc. – need the funding to put it into practice. Useful, but if [there’s] no money to put into practice that’s the problem. Trusts can’t provide routine services. They can only fund bits of research or bits of piloting. If the statutory commissioners aren’t prepared to take on board the recommendations you have a pilot for a year or 2 years and then it closes down again.’ (Other 1)

Some funders had sought to include a more strategic and collaborative approach to VAWG funding at both the national and local level:

‘When we set up the programme we had round tables with key people from the sector and other funders working in this area to kind of look at what were the priorities for this sector, you know, if we were going to put money in, what should we be focusing on? That’s where the four outcomes came from (evidence base, holistic working, co-production and improved services) ... So that had some kind of leadership role within the sector. We also knew that BME groups were particularly affected by austerity cuts so we wanted to support those. We tried to get local knowledge to understand who were the key players in the sector, avoid duplication – it was difficult, put it that way.’ (Funder 2)

Similar recommendations can also be found in a study of commissioning by Knight et al (2017), including developing trusting relationships, collaborative commissioning, and networks of learning.

Benefits of Collaboration

An ongoing collaborative and sustained approach which involves funders, service providers and service users that builds on their strengths and avoids duplication was viewed by many participants as the main benefit of a more comprehensive funding partnership. It was considered that this would support shared learning across funders and service providers and allow a more consistent picture of 'what works' to be developed through shared access to outcomes and evidence.

Service providers felt that a comprehensive national VAWG funding partnership accompanied by smaller ones at the regional level would enable service users and the women's sector to contribute to shaping funding delivery and priorities rather than these being based solely on commissioners' needs and wants. Programme development could then be based on the long-term experiences of survivors, from a wide range of groups, rather than being driven by targets. Others commented that this forum might also move women's issues further up the social and political agenda which would result in further investment and support more consistent and targeted future planning and go some way to reducing the 'postcode lottery for VAWG provisions'. The proposed Domestic Abuse Commissioner offers the opportunity for establishing a strong national lead in this area. It is proposed that the Commissioner would have a remit to monitor/audit VAWG at a local level (HM Government 2018). This might provide the national leverage necessary for statutory sector organisations to prioritise VAWG. In view of this, it may be that local level funding partnerships may be best placed to ensure priorities are realised regionally. Participants across all sectors thought this model would also improve communication, lessen inconsistency across monitoring requirements and aid transparency. Trust funders seemed to generally welcome the opportunity this would bring to get to know named people with similar caseloads within other funding trusts so they could work more closely together to ensure VAWG outcomes. Central to this was enhanced opportunities for sharing best practice models and findings. Some stated it would aid clarification around who funded more innovative approaches and who funded continuation support.

Both funders and providers thought that collaborative working might assist service development as evidence and information could be held within a central repository. Some providers thought it would also support joint responsibility, ownership and accountability across the VAWG sector.

It was also felt that this approach might, in the long-term, be cost effective for both providers and funders through reducing administration of multiple applications and reporting formats. Funders and wider participants felt this might enable money to be freed up to support VAWG agencies in partnership working, thereby reducing competition.

It was hoped that an independent funding body might also assist commissioners to engage with the VAWG sector due to its primary aim of supporting best practice. A stronger VAWG funding partnership was also viewed as having more authority to question current policy decisions and poor commissioning processes.

Concerns in respect of Collaborative Approaches

Some providers had significant concerns regarding a joint VAWG funding model, especially if this involved statutory agencies:

'My concern is whenever statutory services talk about working with voluntary sector funders what they mean is trying to get charitable trusts to fund the stuff the statutory sector used to fund.' (Second Tier 1)

One funder was sceptical, feeling that this may result in a 'one size fits all model' which would be inappropriate for the VAWG sector. Others worried that the scale of the partnership would make it unwieldy and actually increase bureaucracy and decrease the impact of survivors' voices. Some providers felt that they were best placed to identify what worked for their service users, rather than funders.

Other concerns related to losing place-based understandings of the issues, as it would be difficult for a national partnership funder to build relationships across all areas. Some worried that trusts and foundations could be too influenced by state agendas and might therefore lose autonomy. It was argued that the fragility of the sector needed to be considered in any new form of partnership working and that this was especially important for BME service providers who often felt they were inadequately represented in consortium or partnership working. This view was supported by at least two second tier organisations:

'Partnerships tend to be quite difficult... some organisations understand why you should have women-only but might not understand why you need BME women. So again that intersection of race and gender being poorly understood... the struggle at local level continues.' (Second Tier 2)

Funding Partnerships: Promising Practice Examples

As part of the study we asked funders to provide what they considered to be positive examples of funding practice and initiatives. We acknowledge that there will be examples omitted from this

report. It was not possible to undertake further assessments of the examples provided and inclusion has therefore been a subjective process reliant on participants' experiences and observations. However, the examples included here provide a range of models which could be examined in more depth or evaluated.

The Corston Independent Funders Coalition (CIFC) was cited as a potential example which could be replicated. This was an independent collaboration of grant-making trusts and foundations who sought to bring their joint influence to bear on an area of social change where they considered themselves to be key stakeholders. The CIFC was established to press for the full implementation of the recommendations of the 2007 Corston Report, an independent review of vulnerable women in the criminal justice system. A review of this initiative can be found here: <http://www.thebromleytrust.org.uk/Indexhibit/files/CIFC-Report.pdf>

Association for Charitable Foundations Networks (ACF) is a membership body for UK foundations and grant-making charities. Funders explained that there are some useful actions and information available online but this is was not a VAWG specific body: <http://www.acf.org.uk/>

The potential for developing **issue based networks** was also suggested and the **CSE Alliance** led by Comic Relief was cited as an example that could be replicated for areas of VAWG work. A short evaluation report concerning the **Child Sexual Exploitation Funder's Alliance (CSEFA)** is available. This suggests positive outcomes in terms of knowledge, reach, resources and time saved http://www.thebromleytrust.org.uk/files/csefa_ivar_report.pdf

F. Commissioning Processes

Participants from all sectors raised a range of concerns regarding current commissioning processes these included: unhelpful procedures; lack of survivor consultation; a failure to commission women only services; a lack of VAWG understanding; commissioning framework; large size of tenders; over-complicated forms and restrictive competitive tendering. However, it is important to recognise the restricted financial climate commissioners are working in due to austerity, as well as the inconsistency of commissioning approaches across the country, with some good examples being provided as well as some less favourable practices.

Unhelpful Procurement Procedures

Overall, procurement procedures were regarded negatively, particularly across providers, second tier organisations, funders and statutory sector participants. The National Government Office also suggested these were not always appropriate. There were concerns that some commissioners and generic providers did not share the same values or agendas as VAWG services which impacted on service provision. Instead, participants (particularly frontline and second tier organisations but also some funders) overwhelmingly felt that commissioning was focused on short-term 'value for money' which tended to favour larger generalist providers. Such an approach was described as failing to recognise the importance of a proven track record of delivery and the added value of local expertise embedded in smaller organisations:

'It's an inefficient way of doing things. A much better model would be a rational evidence-based process of commissioning. Then once you have a service that are skilled, expert, you trust and believe - commission them for 5 years, 10 years. Why make them jump through all those hoops and then make them do it every year?' (Other 4)

Related to this was the wider community benefit that local VAWG providers contributed which was often invisible in the commissioning process. Local understanding of need and support networks, often built up over many years of work within communities, was not sufficiently recognised or valued. Consequently, many argued that commissioning generic services meant real losses in terms of the added value that specialist services bring. Some participants, including trust funders, stated that VAWG organisations require more support and resources to evidence this additional impact and added value.

The importance of added value was also identified in interviews with commissioners. Two commissioners described this in terms of the ability of specialist VAWG services to function as a strong advocate for survivors locally, regionally and nationally, ensuring that survivor voices were heard and informed both practice and policy. It was recognised by some of the commissioners that this 'added value' was lost when generic providers and, to some extent, national VAWG organisations not working in partnership with smaller local agencies took over provision.

Participants also stated that some commissioners viewed consulting with VAWG providers as compromising impartiality. Others stated that commissioners often responded defensively to providers inputting into the

commissioning process. Some providers stated this resulted in the commissioning processes delivering poor practice:

'I am increasingly hearing that specialist organisations in the (area of England) are just not going to go for the contract (due to time and capacity) but has much more to do with the fact that they don't agree with the way the contract is framed, they don't believe that you can get good outcomes for women with the amount of money available, the volumes. And they're resisting that drive down on standards.' (Other 1)

There was also a feeling that some commissioners lacked VAWG expertise and therefore had little real insights into the needs of survivors⁷:

'You get some very aspirational people amongst the commissioners but they've got pennies to play with... increasingly commissioners are commissioning things that they don't have very much experience of and that LAs and other local statutory agencies are losing their specialist commissioners. So people are researching standards without really realising what that means in practice and this leads to these very unrealistic tenders...we're putting out all these big contracts but actually they're only big because they're rolling up lots of other funding streams and they're usually cut at that point.' (Other 1)

Lack of Survivor Views/ Voices

Many participants (providers and some commissioners) stated that commissioners rarely consulted with survivors in any meaningful way. It was commonly felt that such consultation required greater investment if it was to direct service provision and not just constitute a 'one off' exercise. In-depth input from service users would also help to alleviate the frustrations that arose when isolated service user feedback was utilised in a disproportionate manner to influence the design of services:

'A service user might say I want a 24 hour service, that is a really difficult thing as a service provider to achieve and that might be written into a tender based on what one person has said.' (Provider 1)

Participants emphasised the importance of ensuring that all voices were heard in this process. This was particularly relevant for responding to women and girls with additional needs or in determining BME service user needs which many (service providers and funders) reported were often ignored or minimalised in the tender process:

⁷ See also Hawkins and Taylor (2015).

'Smaller, more specialist programmes might be losing out to bigger, more able charities or bigger projects that join up together to get contracts, bit more capacity, whereas little local projects haven't got that... you lose that specialism... domestic abuse projects that might have specialised or had a BME worker say or worked within a specific community.' (Funder 1)

Women Only Service Provision

The need for women only provision was highlighted by nearly all participants. However, many felt commissioners were increasingly adopting a gender-neutral approach, often due to an incorrect interpretation of EU equality legislation, which failed to acknowledge the need for women only spaces (Holly 2017). Overall, providers questioned whether the value of women only services was properly recognised by some trust funders and commissioners and some stated that this form of provision was actually opposed in some areas on the grounds of equity of access. One funder (Funder 2) explained that, in their general investment programme, a lot of mixed services were only being accessed by men, despite being open to both genders. They recognised that women did not feel comfortable using these generic services and that this issue was even more acute in relation to VAWG services. The need to provide a voice and provision for male survivors was commonly recognised but it was also emphasised that this should not occur at the cost of services specifically for women. Increased investment in evidencing service user needs was viewed as central to justifying the importance of women only services.

Commissioning Framework

A major concern, linked to the above, was the dependence on individual commissioners. This specifically centred on their expertise and experience. Under the grant system, service providers could apply to suggest the scope, nature and scale of provision (see Hirst and Rinne 2012). However, generally under the commissioning of services, this was specified by the commissioner and so understanding of VAWG was considered key:

'The commissioner is unaware of the specific issues that they are commissioning for and they're using templates that are coming out of procurement that are based on buying paper clips – you can quote me on that. So because procurement traditionally was around... the history of it is not about social groups, it was much more business focused. I have spent hundreds and hundreds of hours at commissioning events where we have tried to identify the specialisms that are required when a tender is put out.' (Provider 1)

The pressure on commissioners to reduce contract numbers and meet targets was also recognised by funders and second tier organisations: 'I do think there are commissioners who want to get this right... but it's a very hard time doing it' (Second Tier 3).

Independent funders interviewed asked what would happen if these small local charities disappeared and generic providers failed or didn't want to do the work anymore; who would be there? As one funder warned:

'The obvious concern is that small organisations may not have survived that period... Haven't got the time to make these mistakes.' (Funder 6)

Another question raised was who should fund transition work to ensure service users are supported and remain safe through moving from one provider to another. Some asked commissioners to rethink what was occurring:

'For local commissioners – think about the landscape that you want. Do you really want to be left with a few, big providers who might employ good people but whose main organisational concern is where the next contract is coming from? Or do you want local partners who are as committed as you are to driving change in your area? If you do want to keep them then resist the drive towards ever-bigger contracts... you have a choice...And you can still, on occasion, make good old-fashioned grants – contrary to popular belief they haven't been banned.'
(Other 1)

Large/ Combined Tenders

A wide range of issues were discussed in relation to combined tenders. Many funders and VAWG organisations highlighted the issue of large or combined tenders replacing smaller lots or grants⁸. As noted already, there were fears that smaller charities were losing out to bigger charities as combined specifications prevented them from responding. Commissioners often argue that it is cost effective as they only have one provider to deal with rather than multiple contacts, thereby reducing administrative costs. However, one second Tier provider asked, 'If we can just wean commissioners off this idea that they have to have a single provider for everything... then we can look to see if it is actually cost effective in the long-term given the add on value local VAWG services provide'.

⁸ The increased use of competitive tendering models of procurement creating challenges for small to medium sized charities is documented by Chapman and Hunter (2017).

Respondents felt that the grant system could, or should, still be used for the specialist VAWG sector. It was suggested by some that VAWG services should be exempt from the commissioning process and ring-fenced:

'We're at a critical point where if ...services aren't ring fenced outside the procurement process, there will be no more specialist services. In other countries [e.g. Sweden and Iceland] they've took out (exempted) VAWG services from this process... There needs to be a rethink about how we're funded... we bring issues to the table that other providers won't pick up.' (Provider 1)

One funder noted that they had witnessed the use of combined tenders more in the VAWG sector than any other area they funded. One reason cited by a second-tier organisation was that commissioners do not understand equality impact assessments. It was explained that they mistakenly believed that achieving equality meant treating all groups the same, rather than responding to specific needs to ensure equality of service (see also Hawkins and Taylor, 2015 for a fuller discussion). Others suggested it reflected commissioners' lack of long-term planning and inability to think beyond the immediate 'pot of money' or next service delivery contract:

'Boundaries are different depending on the kind of service e.g. helpline, refuge etc. Because historically one organisation would run all those different things, what has happened... with the commissioners they give all the services to one organisation or they take them all away rather than untangle which things do need to be in a particular location and which can be over a wider area and so you lose the contract. Commissioners don't really understand the diverse provision, it's not inefficient, it's because women need different things at different stages for different kinds of issues. It's not an inefficiency. You need a whole range of services and you can't lump them all together and say, which one do you want?' (Other 4)

Consortiums

Service providers generally recognised the value of working in partnerships. Benefits emphasised included: the sharing of good practice and learning; the development of a collective voice; and the ability to exert influence. However, difficulties were also highlighted. The most commonly reported issue concerned attempting to encourage partnership working between competitors:

'Consortium bids can work really well but it depends on the will of the local agencies. And where they've gone wrong is where they've pitted those agencies against each other since the SP [Supporting People] ringfence fell away...' (Other 3)

There was a general consensus across different interviewees that establishing consortiums often took a considerable amount of time and required high levels of commitment, resources and continuous development work prior to the actual bidding process. One participant explained that it took almost two years to implement the necessary agreements and documents. Time was also needed to negotiate when responding to tenders as a consortium:

‘The government all of a sudden announce a pot of money of £20m, which seems like a lot of money but it’s quite knee jerk and then everyone clamours to put a bid in in the best possible way, but loses out often because, like I said, they haven’t got the time or that capacity to build proper consortiums. It seems very reactive as opposed to structured...’ (Other 3)

It was also noted that a huge amount of time and effort could be wasted if the consortium was not successful. Generally, most interviewees seemed to agree that the VAWG sector was stronger together, however that ‘together’ was managed. This did not mean that smaller organisations were expected to merge with larger ones: partnership working should enable smaller dedicated pockets of expertise to survive. Successful consortiums needed to invest in partnership working, small organisations, local needs assessments and future sustainability. Providers wanted funders to be aware that this was not a ‘cheap option’ as investment in consortia development and operation needed to be built into core costs. This would allow the consortia member organisations to have a financial benefit from the consortium which would increase their capacity to raise additional funds for their wider work. This participant described the large amount of planning and negotiation required to submit a successful consortium bid:

‘Lost the refuge (had run since the 1970’s)... Organisation massively reduced in terms of its size. We learnt a lot from the first four/five years of the consortium. This time round we knew the contract was coming up, we knew the tender process. We invited another organisation into the LDVS consortium and we re-bid. It was still hard, because the things that we did separately to the contract, like drop-ins, groups, the LA in writing their tender spec decided they wanted those to be run by the contract as well but there was no funding for that. So we’ve had to integrate our not commissioned service into the commissioned service... we won the refuge contract back...’ (Provider 3)

The case study below was identified by one large funder and information was provided by statutory agencies and consortia leads.

Case Study

One established consortium had originally won and delivered a contract for domestic violence services, including IDVA provision and services for children and young people. When the contract was then put out to tender again the consortium's bid was unsuccessful; the contract was awarded to a larger national generic provider. Members of the consortium understood that they had been undercut on price rather than quality. The consortium also lost associated funding which was dependent on the partnership having the local authority commissioned work. Thus, having spent a considerable amount of time and resources building these working relationships, the focus for partnership working was lost. Following this decision, some local services closed completely which was described as resulting in the loss of over twenty years of community knowledge and expertise in those localities.

The impact of these losses was also experienced by the statutory sector. Firstly, this was in terms of the transition period to the new provider whereby there was a loss of provision whilst the new provider set-up the newly commissioned service and so it was not 'business as usual'. Secondly, this was described in relation to the 'added value' VAWG services brought to provision which referred to services beyond the tender e.g. refuge, outreach support or drop in provision which were described as the 'cherry on the icing'⁹. Some of these services had to close and therefore the added provision was lost.

*'...over years, you build up not just the commissioned bit but the add-ons... the extra funding; they'll put in another service... although they're not technically commissioned to do it, flows into support for a particular victim. I think we've lost a bit of that... There was a change in provision some 3 or 4 years ago. That took an incredible amount of time after that was introduced before we got **anywhere near** the [previous] level of service... every time we have a commissioned service we seem to go backwards for a period of time before it starts to build up again... the commission are asking for the same amount of stuff to be done as previously so you would say there is not lessening of services. But for instance in [areas], there were local DA services which actually shut. They were small and independent...'* (Statutory 1).

The Localism Agenda

Participants highlighted the ways in which the devolution of budgets from national to regional bodies had made for inconsistencies in VAWG provision. This decentralising was described as resulting in cuts

⁹ Similar evidence can be found in the All-Party Parliamentary Group on Domestic and Sexual Violence Inquiry in 2015 (see Hawkins and Taylor, 2015).

in discretionary areas of work whilst at the same time removing the structural analysis of women's discrimination (see Hirst and Rinne, 2012):

'The localism act is back to a kind of free for all; just do whatever your voters want and voters are very unlikely to prioritise VAWG services. That's the risk with PCCs and localism. The traditional forms of consultations they do, people often won't talk about VAWG in those contexts. Women wouldn't necessarily call it a police or crime matter.' (Other 4)

One example provided was the loss of DVA Coordinators. Localities moved to a position of isolated working due to funding restrictions, e.g. 'this is my area so can't go beyond it'. This isolation could also result in pockets of good practice not being replicated. The shift to localisation was perceived as representing a lack of collective responsibility:

'There's this sort of rhetoric about 'local is good, make things as local as possible' kind of thing so they'll be more appropriate to local people. But that only works for certain kinds of things. Other things people don't want them to be varying from local to local. Then they start complaining about a postcode lottery... .. Should only devolve where it's appropriate. DVA services where women need to relocate you're not remotely interested in your local area, local refuge, it wouldn't be safe. You need refuges everywhere else. Provides opportunity to standardize some services and localize when it's appropriate to localize them.' (Other 4)

Localism resulted in restricted catchment areas with services only supporting local survivors (see Women's Resource Centre, 2006). For national services, for example refuges, interviewees stated that national funding was required (Kelly and Dubois, 2008). The resulting picture was one of a post-code lottery with variations in service provision and its comprehensiveness (for example, whether sexual violence services were available or not):

'...I think we will always see a very patchy approach if it's left to local authorities to determine what provision should be... but we have to acknowledge that we're in a time where there isn't much funding at all.' (Second Tier 3).

A possible solution volunteered by some was to request more scrutiny and accountability nationally for VAWG commissioning. Services would value a commissioning approach that recognised the value of sustained, responsive, local community service provision. Some argued that the lack of strong national guidance or lead on VAWG commissioning was a major drawback. Many felt that the National

Statement of Expectations (Home Office, 2016) lacked ‘teeth’ providing no clear oversight or monitoring to ensure adherence:

‘80 pages of commissioning guidance of what to do properly regarding VAWG, the majority of commissioners will never have seen.’ (Provider 1).

Others were more hopeful and highlighted the potential influence of the new VAWG commissioner:

‘You’ve got the national statement of expectations, I think that helps provide some structure but obviously that can be interpreted in so many different ways by different Local Authorities... .. but it’s mad the disparity and I understand the decisions that are made at local level but if you have a VAWG commissioner that doesn’t have a clue that’s where it all falls down... (The) new commissioner that will be in post: I hope they go down the route of giving it teeth, basically pulling up practice where it’s going wrong.’ (Other 3)

The Government representative acknowledged that more work was required in this area:

‘National statement of expectations and commissioning toolkit, originally developed by Lloyd’s Foundation (is an) effort to try to provide some guidance to commissioners for VAWG services about what we expect as central government... different elements that are at play; having an almost intersectional understanding of VAWG... .. It’s gone down well with areas that already like this kind of thing, so I suppose our next steps will be to identify how we can get that guidance embedded locally where maybe it is new...trying to kind of demonstrate you need a gendered understanding and often they don’t really get it. Next stage is to give the national statement, basically monitor it, evaluate it. It’s been in place nearly a year now. It’s kind of time to start looking at how it’s being embedded and implemented.’

G: The View from Commissioners

We contacted ten English local authorities and commissioners in five areas agreed to participate in the scoping study (see methodology section). The aim of these interviews was to identify good practice models which could be replicated in other areas. Two of the areas had decided to introduce joint commissioning with other neighbouring areas:

‘It makes sense for the LAs to come together for a particular commission where like us, we know people are moving across borders or where they are living in one area but working in another. There is a kind of drive from our client group for cross border work. We’ve also seen some of that learning in things like Serious Case Reviews and DHRs where we’ve had people...

who have not always had the best response and some of that has been made more difficult because of those cross-border issues...It makes no sense to have two commissioners doing the same thing next door to each other. In terms of the service... part of the issue is people's ability to access a point of contact.' (Commissioner 1)

Value of Specialist VAWG Services

Four commissioners recognised, to varying degrees, that some services required specialist provision from VAWG agencies. Some saw this as a central requirement whilst two commissioners felt that while this needed to be included, it should not be an overall priority of the tendering process. Nevertheless, all four stated that specialist local VAWG services were important in ensuring reach and accessibility of provision and to meet the needs of local survivors.

'It was really clear that in order to support victims, survivors and perpetrators effectively there needs to be that (VAWG) specialism and there needs to be agencies that understand the nuances involved.' (Commissioner 4a)

How this could be best achieved was viewed rather differently. In the two areas where joint commissioning occurred, the commissioners had encouraged agencies to come together under a single consortium: one consisted of 10 specialist VAWG providers working across London boroughs; the second area had a partnership led by a single large specialist VAWG organisation with a long history of local involvement and in association with smaller specialist local agencies. In the other two areas, the landscape was more complex. In one, a generic provider had been commissioned by the OPCC to provide victim support including VAWG, statutory sector family teams had started to deliver services to families whilst specialist agencies had formed a partnership to provide additional support, for example, more in-depth therapeutic support. In another area, multiple contracts had been brought together to fund a range of services via a partnership agreement:

'As a Local Authority we have four specialist DVA contracts at the moment. All delivered by the same specialist consortium...with 20-40 years' experience of DVA and SV services locally. Came together to form a company, then sub-contracted specialist organisations to deliver certain parts of that contract which are mostly therapeutic... specialist male counselling service, specialist service for women who have experienced CSA, LGBT counselling, trauma informed counselling and rape crisis (by a) range of organisations under the three largest DV SA voluntary sector providers in the area.' (Commissioner 2)

All had to some extent recognised the need to ensure a mix of national and local providers with an overall focus on specialist VAWG provision as a central feature of their commissioning. To support this framework, all four had identified that smaller packages of work had been issued separately or within the overall tender which meant that local VAWG charities could apply for funding or have this ring-fenced within the partnership.

The value of specialist VAWG agencies was understood in terms of their expertise, knowledge and understanding of what service users wanted, especially in relation to survivors with additional or complex needs. Most valued the confidence service users had in these specialist agencies and their ability to respond to changing local need. These commissioners stated that they recognised the added value and social impact that local VAWG providers brought in relation to community development and involvement, established partnerships and grass-roots activism on related issues. Some also highly valued the ongoing relationships they had established with local providers which would be lost if a large national VAWG organisation or a generic provider was commissioned:

'They (the local VAWG agencies) have a lot of experiences, they are committed and already had in place many of the standards we were looking for e.g. Leading Lights accreditation, Respect accreditation. They were aware and already had working knowledge around Women's Aid national standards. They had understanding of each other, of how it is to deliver those services locally, what service users experiences were, what the challenges might be. They had tailored case management systems, had those working relationships with other partners and other structures such as MARAC.' (Commissioner 2)

The commissioners generally felt that the services provided by local VAWG agencies closely reflected the findings from survivor and service user consultations on issues such as risk, safety, support and recovery. These consultations were seen as providing a strong and convincing narrative supporting the importance of local VAWG services, especially for survivors with additional needs and BME groups. In addition, two commissioners also mentioned the ability of VAWG providers to be flexible and reflective in their service provision, and their willingness to address what was not working, as well as to identify what was.

Gender Informed Practice

A gender informed approach to VAWG service provision was seen as a central aspect of delivery by three commissioners. One interviewee stated they had adopted a gender-neutral approach to

commissioning. In common with the other interviewees, all commissioners recognised that male survivors required specific services which addressed their needs but stressed that these should not be provided at the expense of services for female survivors. Three commissioners stated the importance of women only services, noting that generic services would be difficult for many women to access. In two areas, services for male victims and perpetrators were provided in addition to the VAWG tendering process:

'It was absolutely gender specific. I have no time for gender neutral. I think it's a pile of rubbish... I would say gender informed...gender neutral commissioning it does a disservice to both women and men. So, for women I think our view is the majority of victims are female but the majority of our perpetrators are male and DV and SV and VAWG are a cause and consequence of a number of things including gender inequality... It means that it's important we talk about gender and ensure there are women only spaces for example.' (Commissioner 1)

Survivor and Expert VAWG Involvement in Commissioning

Survivor involvement varied across the four areas although all commissioners interviewed had undertaken some form of service user consultation. Two had commissioned specialist national agencies to provide survivor input into the commissioning process. In one area, survivors sat on the commissioning panel. Most commissioners interviewed felt strongly that survivor input needed to be an ongoing process rather than a one-off tokenistic exercise.

'It's easy to sort of say let's sort of wheel out the survivors, have a quick chat with them, thank you very much and off you go...it was about making sure those spaces were about more than that and actually there was a meaningful ongoing relationship, looking beyond the commissioning process looking at how survivors shape that work. There is a survivor's forum which is key to the integrated service... maintained throughout.' (Commissioner 4a)

Wider consultations with VAWG service providers and experts had also been undertaken in three areas. One area had commissioned a review before the commissioning process began to ascertain current strengths and weaknesses and this review identified a need for a greater community focus. One commissioner had bought in a national VAWG expert to advise on the development of the commissioning scope and remit. Three areas also undertook in-depth stakeholder involvement and consultations in determining the scope and breadth of the tender:

'So in the run up to commission we had consultation with the voluntary sector – this was before we went into formal procurement and market engagement. So we asked what works, what people think is important.' (Commissioner 1)

Other consultation activities included workshops with service users and VAWG providers, feedback from national VAWG sector representatives and academic input. Two commissioners specifically mentioned BME organisations as taking part in this process. These consultations were also extended in three areas through the involvement of local VAWG agencies, although this was restricted to the pre-procurement stage, as once the procurement stage was reached, it was noted that dialogue often ceased, due to possible conflicts of interest. To overcome this issue, one commissioner consulted with a national third sector agency in relation to tender design and scope, quality and cost assessments and a representative from the third sector agency sat on the commissioning panel, allowing the commissioner to maintain impartiality.

All felt that it would be informative to know how other commissioners had involved service users and VAWG representatives, at what stages and to what degree. Commissioners thought that this could be a future area that trust funders could support to enable a more systematic framework for survivor involvement across the tendering process locally and nationally.

Costs: Size and Scope of Tenders

Commissioned tenders described ranged in size from medium (3) to large (2). However, in all but one area, specific provisions had been made for specialist VAWG services. The most important consideration in the tendering process for four of the local authorities was quality; these commissioners all stated that, although costs were an aspect of delivery, this was not the only criterion. Two commissioners had adopted a ratio of 70% quality and 30% cost, stating that similar areas had adopted a reverse ratio. Three commissioners stressed that a more nuanced and longer-term approach to costs was required rather than concentrating solely on the short-term, although all recognised that austerity had had a profound impact on provision. As one commissioner stated: 'too great a focus on immediate price rather than depth and quality of work means that women's voices become lost so services don't meet their needs'.

The majority argued that the knowledge, skills and experience of VAWG agencies were central considerations in their commissioning process, informed by their service user consultations. The opportunity to have a diversity of service providers within a consortium or partnership offered a more resilient model with long-term economic gains than having a single generalist provider. One

commissioner provided an anecdotal example where a large generic provider had won the tender on costs but not delivered satisfactorily and now they were left with no other service providers willing to work with them.

Robust Evidence on Impact

Two participants stated that they valued VAWG agencies commitment to national standards, accreditation, and larger national organisations offered tailored monitoring systems. However, it was generally felt that more support was required, especially for smaller agencies, to evidence their direct impact on the lives of survivors and to demonstrate their added value. Three commissioners stated this needed to be very clearly articulated to challenge generic providers who could provide lower costs but lacked added local value.

What can the VAWG sector do to meet commissioners' requirements?

The most common response from commissioners was to request that the VAWG sector work together to reduce unhealthy competition and support each other through partnership working. The need for fragmented groups to come together to reduce silo working was one of the main drivers for partnership working for two of the commissioners interviewed.

It was generally seen as inevitable that local authorities would want to commission one large provider due to cost effectiveness. However, commissioners noted that this was not necessarily detrimental to smaller local VAWG organisations although clearly this was dependent on how the partnership was constructed and managed. It was felt that larger national VAWG organisations needed to accommodate and support smaller specialist local services, especially BME providers, to create fair and equitable partnerships. It was also recognised that large contracts required a great deal of work and that commissioners needed to be aware that smaller specialist agencies will find this burdensome even in a partnership. This was recognised as a problem and commissioners could understand why small agencies preferred grant based work. However, some felt that these grants these had not been well written or specified in the past and in practice providers were simply left to 'get on with it' with little input or monitoring from funders.

It was acknowledged that partnership working arrangements required time and resources to develop and that this process needed to be supported by the local authority. Commissioners recognised that balancing different requirements, statutory responsibilities regarding procurement and aligning partnership work was difficult.

Supporting Best Practice in VAWG Commissioning: Summary of points

National Infrastructure: The lack of any national infrastructure to guide local VAWG commissioning frameworks and enable learning was viewed as problematic and, in common with many providers, some felt a national steer on these issues would be welcomed.

Tender timeframes: Often the speed at which a VAWG consortium needed to be formed to respond to tendering timeframes was problematic. As the process of commissioning occurs before a tender is released, most felt that there was no need for unrealistic time frames which made meaningful partnership development difficult.

Grants: Although one commissioner rejected the use of grants, others thought that they offered an appropriate avenue for ensuring smaller charities could continue to offer specialist local support. This was seen as especially important for those agencies supporting BME and women with additional needs.

Scope: Some commissioners felt that they had a role in ensuring that early intervention services were included in the tender scope as well as high risk crisis intervention work. Many stated this would reduce costs in the long-term by reducing escalation of risk. Some also felt that within broad tender remits there was capacity to ring-fence provision for specific groups, including BME and LGBT+ survivors and service users with additional needs, including the need for women only services.

Benefits of a VAWG funding partnership for commissioners

All commissioners said they would welcome closer links with trust funders, although they did acknowledge it was essential to maintain the independence of VAWG funders. Six main suggestions were made:

1. The need for local 'think-tanks' and a national forum for commissioners and trust funders to learn from each other in relation to VAWG best practice was commonly highlighted
2. A three-way conversation between commissioners, trust funders and service providers was also called for to support the involvement of VAWG experts and service users in national and local funding decisions across different sectors. Commissioners felt this would aid infrastructure development, service provision planning as well as cascading of evidenced practice and promising innovative models.
3. Commissioners stated that better communication between funders and commissioners would be helpful as they were very rarely approached by trusts to consider funding priorities locally, regionally or nationally.

4. Opportunities for skill enhancement and knowledge sharing around financial modelling, cost analysis and best practice in evidencing added value were viewed as areas where collective working could be developed with without losing specialisms.
5. Funding partnerships could aid survivor scrutiny through supporting service users' commissioning reference groups across localities and thereby develop good practice models to support 'genuine co-production in VAWG commissioning'.
6. It was felt that an independent VAWG funding partnership could make a stronger case than VAWG providers for gender informed specialist provision. Commissioners felt that some local authorities were inappropriately wary of specialist agencies as specialist organisations were viewed as promoting their own agendas. This was also reported by service providers who had offered to support VAWG commissioners but felt they had been treated with suspicion.

Conclusion and Recommendations

Conclusion

The level and length of funding was cited as the most prominent problem facing the VAWG sector. Due to this, the approach adopted by providers was often determined by the funding source rather than the providers' values or gendered understandings. This was exacerbated by the prominence of crisis led provision, the increasing complexity of demand and a lack of specialist services for BME survivors and other marginalised groups including those with wider complex needs. The reduction of statutory services under austerity policies placed increased pressure on already constrained VAWG services.

Most participants agreed that there had been, and continued to be, a move towards more universal VAWG provision. However, this shift had occurred at two levels: firstly, there was a move towards more generic VAWG services and; secondly, alongside this, a move towards VAWG services being encompassed *within* generic non-specialist services. The majority of participants felt that the shift to universal non-generic VAWG provision was often detrimental to specialist knowledge and the ability to meet the specific needs of survivors and service users appropriately. However, as this shift was relatively recent, more robust evidence was required to properly evidence the impact.

Participants raised a range of concerns regarding current commissioning processes. These included: obstructive procedures; lack of survivor consultation; disregard for women only services; lack of wider VAWG understanding; problematic commissioning framework; large size of tenders; competitive tendering; and difficulties with collaborations and consortiums. We also need to acknowledge the

difficult financial climate for commissioning as well as the inconsistency of commissioning approaches across the country, with some examples of good practice being provided as well as some less favourable practices.

Independent Funders clearly recognised the need for investment, the necessity of strategic leadership roles in the sector and demonstrated a good understanding of the issues but also recognised the enormity of the work required. Most funders welcomed the proposal for a more strategic VAWG funding partnership; however, smaller funders felt they lacked the capacity to contribute.

Overall, although providers universally stressed that the current VAWG climate was particularly difficult they also recognised that they needed to adapt to this new landscape if they were to survive, although some were less certain how best to achieve this. This challenge was particularly pertinent to smaller specialist local agencies who were often trying to just stay in business, making wider strategic thinking very difficult, especially when core funding was being removed. Most felt this was not a fight they could win on their own. Recommendations to overcome some of these challenges are presented below.

Recommendations

We have provided recommendations for four groups based on the research findings: Government; Commissioners; Independent funders and Service Providers.

Recommendations for Government

- To undertake a national review of implementation of commissioning guidance and hold local areas to account.
- To work with the proposed Domestic Abuse Commissioner to monitor and audit VAWG at a local level.
- The National Statement of Expectations (Home Office, 2016) needs to be embedded across all localities and systematically implemented.
- To influence Health and Wellbeing Boards to prioritise VAWG services, including sexual health and women only provision, as a central part of their strategic plans.
- Increased investment in evidencing service user and survivor needs and the 'added value' of VAWG place-based service provision.
- Support the shift in public perceptions around VAWG especially in relation to sexual violence.

Recommendations for Commissioners

- Comprehensive consultations should be routinely undertaken with a diverse range of survivors and service users throughout the commissioning and tendering process.
- Wider consultations with and input from independent external VAWG national organisations or independent experts should also inform the commissioning and tendering process, including organisations that represent BME survivors and those with complex needs.
- Realistic commissioning timeframes should be implemented to enable the development of strong and diverse VAWG partnerships.
- Within larger tender remits there should be ring-fenced provision for specific groups including BME and LGBT+ survivors and service users with additional needs, including the need for women only services
- Grants should be seen as an appropriate avenue for ensuring smaller charities can continue to offer specialist local support, especially for those agencies supporting BME and women with additional needs.
- The scope of tenders needs to ensure that early intervention services are included as well as high risk crisis intervention work.
- While tendering clearly needs to address cost issues, these should not be allowed to override quality issues. In particular, tendering processes should take account of the long-term value and added social value that investment over time in locally-based expertise can deliver.
- Providing voice and provision for male survivors is important but this should not occur at the cost of services for women.

Recommendations for Independent Funders and Charitable Trusts

- Support a national forum for commissioners and trust funders alongside local 'think-tanks' to learn from each other in relation to VAWG best practice
- Aid survivor scrutiny through supporting service users commissioning reference groups across localities and thereby develop good practice models to support 'genuine co-production in VAWG commissioning'.
- Facilitate better communication between survivors, service providers, commissioners and funders to inform national, regional and local funding priorities and decisions across different sectors.
- To provide core funding to better support smaller organisation to build the capacity to collaborate and become members of larger consortiums.

- Overall, although some concerns were shared, most interviewees recognised the potential benefits of a united VAWG funding partnership, if the diversity of funding requirements were sustained. The main benefits were:
 - A shared resources and reduction in administrative burdens due to multiple grant applications, were the opportunity to build collective learning, especially around best practice, robust evaluations, cost-analysis and evidencing added value.
 - Supporting the voice of VAWG survivors and service users in the commissioning process was an area where a funding partnership could have influence, along with supporting VAWG consortium development.
 - Providing a strategic independent leadership body for specialist VAWG services, especially in relation to smaller charities and those addressing less 'sympathetic' issues, such as sexual violence and survivors from BME groups, asylum seekers and those with complex needs.

Recommendations for VAWG Service Providers

- Providers need to adapt to the changing funding landscape and recognise the need to be part of larger consortiums and apply for larger tenders.
- Where a national or large organisation (such as a VAWG specialist) leads a local consortium it needs to invest in partnership working with smaller local specialist VAWG organisations to ensure that services are genuinely needs led.
- The added value that local VAWG services provide needs to be properly evidenced and cost benefit shown (see recommendation for trust funders to support this).

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Appendix 1: Promising Practice Examples of VAWG Service Provision

Participants in this scoping study were asked to provide examples of good VAWG practice and initiatives. We acknowledge that there will be many examples not included in this report, including more localised models. No further assessments on the examples provided were undertaken by the research team and inclusion is therefore reliant on participants' views. To reduce bias we've excluded those examples where providers referred to their own organisations. Examples have been grouped by type of service provision.

Large second tier organisations who were seen to 'push through best practice' such as SafeLives and Women's Aid were cited by two funders as positive examples. Funders considered the principles or practice guidance developed by these organisations as helpful for capturing outcomes and standards and such tools enabled them to monitor if organisations applying for funding aimed to meet these effectively. One example given was the 'Shared Roadmap for System Change' whereby SafeLives and Women's Aid are working together. A briefing on this programme can be obtained using the following link:

<http://safelives.org.uk/sites/default/files/resources/2017%2001%2013%20Joint%20Evaluation%20Tender%20Brief.pdf>

More generally, multiple and varied examples of best practice were cited. One participant commented:

'probably in this country in between all the pilots we've tried we've probably got all the solutions but what we haven't got is all of it in any one place... take all the expertise... examples of good practice... bring it all together in one place and have a go and see if you can have an impact and change what is a really deep rooted social problem.' (Other 1)

Practice Examples of VAWG Service Provision

One large second tier organisation referred to many small specialist providers as delivering 'amazing practice'. These were described as having a 'community feel', being service user led and responsive. A whole person approach, peer support and options for long term support were also valued, as were trauma informed working models.

- *Trauma Informed Models of Provision*

As a response to the increasing number of women going into refuges with mental health and drug and alcohol issues, Solace looked at how they could provide a more inclusive response to women's

needs and recovery. The introduction of a Psychologically Informed Environment was considered transformational for the refuge residents and staff. <http://solacewomensaid.org/peaceofmind/>

Detailed information about trauma informed working models can be found here: <http://solacewomensaid.org/wp-content/uploads/2017/09/Peace-of-Mind-Summary-Report.pdf>

Further examples included:

- *Rape Crisis Provision*

Two funders and a second tier organisation identified rape crisis groups as representing best practice when working with survivors e.g. the empowerment model of working <https://rapecrisis.org.uk/>

- *My Sister's Place*

This service was referred to by a housing association and a small funder. My Sisters Place is an independent specialist 'One Stop Shop' for women aged 16 or over have experienced or are experiencing domestic violence. Their needs-led approach was cited as an example of influencing practice with women who are repeatedly referred to MARAC. <http://mysistersplace.org.uk/wp-content/uploads/2015/06/MARAC-ARTICLE-SAFE.pdf> <http://mysistersplace.org.uk/>

- *Solace, Immigration Advice Service*

One funder cited the existence of an immigration solicitor/caseworker for women experiencing domestic/sexual abuse who also have an insecure immigration status in London. This includes making immigration or asylum applications involving evidence of abuse <http://solacewomensaid.org/about-us/advice-service/>

- *Safe Net Complex Needs Refuge*

A specific VAWG refuge service was cited by a Lancashire statutory agency. 'Jane's Place' (opened summer 2017) provides a Complex Needs Recovery Refuge. Complex needs may include mental or physical health, drug or alcohol use, self-harming, offending behaviours, sex working, grooming, trafficking, or a combination¹⁰. The refuge delivers in-house domestic abuse support alongside drug, alcohol and mental health recovery programmes, supporting women and children's recovery to take back control of their lives, and move forward positively: '*When all other doors have closed, at Jane's Place we will keep our door open*'. <https://safenet.org.uk/#janesplace>

¹⁰ The difficulties faced by these women in particular is explored within the discussion on barriers and challenges and key gaps in provision.

- *Samira Project*

The Samira Project is a violence against BAMER (Black, Asian, Minority Ethnic and Refugees) women and girls outreach project. It is a partnership project between LAWA (Latin American Women's Aid, KMEWO (Kurdish and Middle Eastern Women's Organisation) and IMECE (Women Centre) providing advice, information and support to women from BAMER background in Islington who are experiencing any form of violence <https://imece.org.uk/services/violence-against-women/samira-project/>

- *Oranje Huis*

An alternative approach to refuges, The Oranje Huis (Orange House) developed in the Netherlands. There is an emphasis on transparency and visibility - the location and function of the refuge are public knowledge to reduce the secrecy surrounding domestic violence and refuge life in order to emphasise the shared community responsibility for tackling domestic violence¹¹. This model is currently being piloted in Sussex.

Work with Perpetrators or Whole Family Approaches

- *The Drive Partnership*

The Drive Partnership is developing, testing and evaluating a new model to permanently change perpetrator behaviour with the aim of ensuring the safety of victims and families. The Drive Partnership is made up of SafeLives, Respect and Social Finance. The pilot will be delivered in Essex, South Wales and West Sussex funded by Lloyds Bank Foundation for England and Wales, Tudor Trust and the Police and Crime Commissioners in all three areas. It has also benefited from local authority support and was cited by five respondents as best practice. <http://www.safelives.org.uk/drive>

- *The Caledonian System*

This is an integrated approach that provides a programme to reduce the re-offending of men convicted of domestic abuse related offences while offering integrated services to women and children. The Caledonian System was developed for the Scottish Accreditation Panel for Offender Programmes and the Equality Unit of the Scottish Government. The system is based on a risk and

¹¹ See: Blijf Groep (2011) *The Oranje Huis Approach: A New Style Women's Shelter in the Netherlands* Amsterdam, Stichting Blijf Groep; Stanley, N. (2015) 'Moving Towards Integrated Domestic Violence Services for Children and Families', in Stanley, N. and Humphreys, C. (eds.), *Domestic Violence and Protecting Children: New Thinking and Approaches*, London: Jessica Kingsley Publishers

needs assessment, and a risk management approach designed to deal with possible harm to women and children <http://www.gov.scot/Topics/People/Equality/violence-women/CaledonianSystem>

- *The Safe and Together Model Suite of Tools and Interventions*

This is a perpetrator pattern based, child centred, survivor strengths approach to working with domestic violence. Developed originally for child welfare systems, it has policy and practice implications for a variety of professionals and systems including domestic violence advocates, family service providers, courts, evaluators, domestic violence community collaborators and others. The model has a growing body of evidence associated with it including recent correlations with a reduction in out of home placements in child welfare domestic violence cases. <http://endingviolence.com/>

Wider Professionals and Multi-Agency Work

- *Multi Agency Risk Assessment Conferences (MARAC)* were cited as best practice. These are local, multi-agency victim-focused meetings where information is shared between different statutory and voluntary sector agencies on the highest risk DVA cases (see http://www.safelives.org.uk/sites/default/files/resources/MARAC_FAQs_for%20MARAC%20practitioners_2013%20FINAL.pdf for more information).

- *Oxfordshire DA Champion Training*

The aim is to provide a more joined up approach by working effectively with victims, aiming to ensure their safety. The training provides professionals with a common understanding of DVA and the ability to co-ordinate their efforts and work more efficiently. The Champion is the lead (and contact) for DVA issues within their agency. They advise their colleagues on management of individual cases and ensure that they are aware of and have access to local resources and support. Oxfordshire has trained approximately 1700 Champions from over 200 agencies/organisations since 2008. This model is being developed in different forms in Buckinghamshire, West Berkshire, Milton Keynes, the London Borough of Havering, Cumbria, Norfolk and Hertfordshire and Slough. <http://www.reducingtherisk.org.uk/cms/content/champions>

- *DCVI Project*

Domestic Violence: Coordinating the Intervention (DVCI) project aims to increase the skills and expertise of professionals, including statutory commissioners, policy makers and DV Coordinators who are responsible for leading and coordinating responses to domestic abuse and VAWG. The national project builds on the Coordinated Community Response (CCR) Model developed by Standing Together Against Domestic Violence and implemented in Kensington and Chelsea and other areas in the UK. The DVCI aims to standardise accredited training that focuses on strengthening competencies and skills to support the role of DV/VAWG Strategic Coordination.

The curriculum for the accredited course is based on a training needs analysis that was carried out with DV Coordinators, Strategic Leads, and Commissioners in England. See: <http://www.standingtogether.org.uk/about-us/european-work>

Legal Support

- *Family Rights Group/ Rights of Women*

This five-year project aims to enable women in London who are DVA survivors to be in a position to make informed decisions and influence what happens to their children when social workers are involved. The project focuses on child welfare law, practice, procedures and private law remedies. It provides extensive information for mothers experiencing DVA when children's social services are involved; accredited training courses for domestic violence advisers and social workers in London; on-line information and discussion board; seminars; campaign and an international practice review <https://www.frg.org.uk/involving-families/our-projects/domestic-violence-project>

Housing Services

- *Housing First Model*

Housing First¹² is a recent initiative originating from the USA based on the concept that a homeless individual or household's primary need is obtaining stable housing, and that other issues including mental health, substance or alcohol misuse should be addressed once housing is obtained¹³. The core principles of Housing First include providing robust support services, adopting a harm-reduction approach and tenant protection. It aims to target the most vulnerable.

¹² Further information about an investigation into the transferability of these models can be obtained from Burnet, G. (2017) *Winston Churchill Fellowship – Domestic Abuse and Housing: International Practice and Perspectives*.

¹³ See Pleace, N. and Bretherton, J. (2013) *Camden Housing First: A Housing First Experiment in London* (York: University of York).

Standing Together have been successful in securing capacity building for Housing First work as part of their transformation fund from DCLG.

The approach taken by MOPAC and some London borough councils was also cited as a means of increasing consistency across boundaries. One example given related to housing policies:

'Some things are being looked at a pan London level now and so improving the situation so it's not just down to individual boroughs in London and more things being done at a London level. Positive in terms of women who might need to move out of their local borough but they don't need to leave London. Looking at things around DV are things like they've already got a secure housing tenancy, keeping that tenancy and being able to do a reciprocal arrangement. Providing they move to another provider in London they keep their housing. Those kinds of measures whereby women who need to relocate get a consistent service across London rather than as soon as you step across your borough boundary you're on your own' (Other 4).

Others drew on international practice, in Australia and the USA for example:

- Flexible Funding Assistance

In the USA this seeks to offer a low barrier, quick response approach by providing financial assistance that can prevent victims from entering the homeless system or exiting homelessness as quickly as possible e.g. help with move-in costs, or utility bills, eviction prevention, back rent, car repair, day care, and tuition - anything connected to housing stability. In Australia a similar approach is known as the Family Violence Assistant Fund.

Community- Based or Prevention Approaches

One service provider emphasised the importance of community awareness training led by survivors. Other examples included:

- *Prevention Platform*

This website is based on the findings of research into the whole school approach. It aims to prevent Violence Against Women and Girls in schools and other youth settings. The Prevention Platform website is unique and free to access. It includes e-learning to help practitioners understand why <http://www.preventionplatform.co.uk/>

- *Change that Lasts Model*

Change that Lasts is a strengths-based, needs-led approach that supports domestic abuse survivors and their children to build resilience, and leads to independence. It has been developed by Women's Aid England, in partnership with Welsh Women's Aid and in consultation with survivors informed by a review of the literature and current approaches for tackling DVA. Change that Lasts is made up of three main schemes (Ask Me, Trusted Professional and Expert Support) that involve the whole community in taking a stand against DVA. See <https://www.womensaid.org.uk/our-approach-change-that-lasts/>

- *Community Training, Bystander Approaches*

No specific examples or details were provided, however, bystander approaches or community training were considered appropriate ways to reduce or prevent incidents of VAWG.

Consortia

- *Ascent Partnership*

Ascent is a project undertaken by the London VAWG Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils. Ascent improves service provision for those affected by sexual and domestic violence on a pan-London basis through the provision of front-line services as well as support to voluntary and statutory organisations by providing a range of training and support, including: training; borough surgeries; BME network; one to one support; policy consultations; and newsletters and good practice briefings¹⁴ <https://thelondonvawgconsortium.org.uk/>

- *Women's Lives Leeds*

Women's Lives Leeds is a partnership of eleven women and girls organisations from across Leeds. They provide specialist services addressing DVA, mental health, sexual health, sex work, trafficking, substance misuse, child sexual exploitation and education <https://www.womenslivesleeds.org.uk/> A small number of members of this consortium are also part of Leeds Domestic Violence Service (LDVS) which is a consortium of four domestic violence organisations who work together to provide helpline, refuge, drop in, group work and community provision <https://ldvs.uk/>

¹⁴ see <https://thelondonvawgconsortium.org.uk/wp-content/uploads/2017/03/CORRECT-Good-Practice-Briefing-Imkaan-Intersectionality.pdf>

- *The Angelou Partnership*

Angelou is a partnership of ten specialist organisations that have come together to support women and girls over the age of 13 experiencing domestic or sexual violence across Westminster, Hammersmith and Fulham, and Kensington and Chelsea. Services include support for Sexual violence or abuse, rape and child exploitation; Domestic abuse; Stalking and harassment; FGM and honour-based violence; and Faith-based violence <https://www.angelou.org/>

Other Relevant Services

Participants also explained the value of drawing on models from elsewhere to inform their own models. Interestingly, one national children's charity explained the importance of ensuring leaving custody and leaving care services were gender informed.

- *Pause Model*

Pause works with women who have experienced, or are at risk of, repeat removals of children from their care. Although this is not a specifically designed VAWG service, many of the service users have experienced VAWG. Pause offers an intense programme of support to provide women with the opportunity to reflect, tackle destructive patterns of behaviour, and to develop new skills and responses to create a more positive future. It offers an intense programme of therapeutic, practical and behavioural support through an integrated model. Each woman has an individual programme of support designed around their needs. <http://www.pause.org.uk/>

- *Geese Theatre Company*

Geese Theatre Company is a team of theatre practitioners who present interactive theatre and facilitate drama-based group work, staff training and consultation for the probation service, prisons, young offender institutions, youth offending teams, secure hospitals and related agencies throughout the UK and abroad. The company's projects have included gender based violence for young people. <http://www.geese.co.uk/>

Funding Approaches

- *Domestic Abuse Intervention Project Initiative*

<https://www.nr-foundation.org.uk/downloads/DAI-full-evaluation-report.pdf>

In 2004 the Northern Rock Foundation Domestic Abuse Intervention Project (DAIP) provided £3.5 million to two Multi-Agency partnerships to address DVA in innovative ways. The aims were to

provide holistic, early intervention, specialist services to victim/survivors of domestic violence, their children and perpetrators. New services were created to act as a hub to liaise with and coordinate multi-agency working with eleven partner agencies.

- *Welsh Government*

The Welsh Government was also described as ‘progressive’ by interviewees: this related to both its principles and strategy on VAWG and its approach to supporting the sector with direct funding. For example, the Welsh Government directly funds the domestic abuse and sexual violence helpline, domestic abuse co-ordinators and Independent Domestic Violence Advisers; and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 aims to improve the Public Sector response in Wales to abuse and violence. See <http://gov.wales/docs/dsjlg/publications/commsafety/161104-national-strategy-en.pdf>

Appendix 2: Interview Guide for Telephone Interviews

Draft Interview schedule for VAWG funders

Organisation

- Name of organisation
- Remit of funding
- Role in organisation

Current and existing VAWG services, initiatives and funded projects areas of best practice

- Please could you list of all your current and existing VAWG funded projects/initiatives – these can be domestic violence, sexual violence (including CSA, CSE, Sexual trafficking) or cultural gender-based violence (FGM, Honour violence, etc).
- Who are these aimed at? (adult Women survivors/Girls/ both/adult perpetrators/young people who use violence)
- What are the main aims of the projects/initiatives?
 - identification/referral
 - Primary prevention
 - intervention [eg safeguarding/ensuring safety for victims/stopping perpetration]
 - recovery
 - advocacy/legal
 - others please specify....
- Which of these do you think represent areas of best practice and why?
- What approaches do you feel have the most evidence base and models of best practice across the UK?

Do you think this approach is useful in your area?

Do you think priorities should be elsewhere?

Barriers and challenges to VAWG advancement, including key gaps in provision and funding.

- What are the main barriers/challenges to advancing work around stopping VAWG?

Prompts: age; children; disability; ethnicity; outreach services/political including how reduced levels of funding is impacting on balance between recovery/intervention/prevention. .

- How do you think these could be overcome?
- What do you see are the key gaps in provision and funding?

Improved funding approaches and delivery models for UK VAWG services at risk

Funding approaches:

- Can you describe the recent changes in provision (and patterns in commissioning) in the last three years?

(Where relevant) elaborate on current experience of provision/grant making in respect to VAWG sustainability

Delivery Models:

- Have you developed a different delivery model in response to funding approaches (if yes) what does that look like?
- Has there been a move towards more universal services? Any impact of health and wellbeing boards?
- How do you think VAWG funding approaches/delivery models could be improved/adapted to provide sustainability for the future given the reduction in public sector funding?

Prompt – beyond the need for more resources

Possible opportunities for Funders to work together to fund a comprehensive VAWG delivery model

- Do you think that UK Funding bodies (both statutory and independent trusts and foundations) could work better together to commission a comprehensive VAWG delivery model?
- How do you think this could be approached?
- What might be the benefits of this for your organisation?
- Is there anyone else that you think we should approach to interview?
- Would you consider taking part in a wider discussion to advance this opportunity?

Appendix 3 Questions for Commissioners

Background

- Who currently delivers VAWG services in your LA?
- What is the balance between generic/specialist VAGW providers?
- Were survivors included and if so how? (determine if tokenistic or co-production of commissioning remits/scope etc).

VAWG commissioning structure

- Was a combined large single tender used or was a mixed model of smaller scale tenders available? (large ones are problematic for smaller local providers as they lack capacity/critical mass to deliver everything).
- How was the decision made regarding the remit/scope of the tender specification?
- Was the role of locally based specialist organisations recognised in this process?
- What do you see as the role/benefit of specialist organisations in delivering VAWG services?
- Was the most recent round of commissioning informed by a gender specific or gender neutral approach?

Commissioning process

- What were the most important considerations in commissioning VAWG services? And how can we improve specialist services ability to respond to these?
- How involved were local VAWG services in informing the process?
- Could local VAWG services do anything differently to better meet the commissioners' requirements?
- Please can you help us to better understand how the value for money issue is addressed whilst ensuring quality is maintained?
- What could Providers and potentially charitable funders do to help with that?
- What national or local issues/guidance impacted on last/most recent round of commissioning? E.g. NICE guidance/standard?
- What organisations were involved in the commissioning process – how collaborative was this process?
- So an integrated funding model across LA/ CCG for example (although could be other combined budgets and commissioners) or other organisations that were just involved in helping to shape the service model.

- What are the barriers to this process and how can these be overcome?
- What sort of evidence/evaluations/impact is most useful/compelling when commissioning VAWG services?
- What do you see as best practice in commissioning VAWG services?
- Is there anything the charitable funding sector can do to support this process?