How different groups of people with long-term conditions experience unequal access, support or outcomes and how a thematic delivery/commissioning model fits

Outline of proposed engagement project:

Our proposed research project will focus on revealing and highlighting the inequalities experienced by people living with long-term health conditions across diverse communities in Rochdale. Through our consortium, the research is uniquely positioned to capture insight across multiple communities simultaneously, enabling comparison and deeper understanding of inequalities between groups. It will also capture how VCSE organisations working collaboratively at a neighbourhood level can identify needs, coordinate provision, and create joined-up responses to health inequalities. These insights will form the evidence base to propose a shift towards a thematic commissioning model, moving away from traditional approaches that emphasise co-delivery of similar services, towards a coordinated thematic model aligned around shared health and wellbeing outcomes.

From analysing our baseline data, we know that 25% of our service users we hold data on report a long-term health condition. These include a long-term physical condition, a disability or mobility issue, a heart or circulatory condition, a mental health condition, or addiction issues. Therefore, we propose using this as a lens through which to research community health inequalities (access, support, outcomes) across the consortium. We'll use a community sample from each of our members (that have capacity to participate) to ensure a diverse representation of the demographic we serve across Rochdale (in terms of their health condition, ethnicity, age, postcode, gender).

Our proposed research will benefit our communities by producing a robust, evidence-based insights report and equity analysis which can be referenced in their own impact reporting. The consortium will gain evidence to support our collaborative model, a stronger negotiating position with commissioners, and a reduced reporting burden. Our service users will have their voices fed into system change without being extracted repeatedly by multiple organisations.

Project Aims

1. Test a thematic insights model by using our existing database to aggregate demographic and health data across multiple centres and reported against different themes.

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2. Generate actionable health inequalities insights - it will explore inequalities in access to, experience of, and ability to manage long-term health conditions across diverse communities in Rochdale. It will examine how these inequalities are shaped by socioeconomic factors, ethnicity, age, and other structural determinants.
3. Understand commissioning barriers by exploring with NHS and local commissioners what would need to change for them to commission under a thematic model (multi-service system) rather than a single-service model. Consortium insight showing commissioning model doesn't require co-delivery, but it does require intentional infrastructure.

Ethical considerations:

We will need to ensure participants clearly understand this is a research project, not a clinical service/direct support and how their information will be used /that providing it will not directly improve their care. We'll ensure participation is clearly voluntary and is separate from service provision, and that they can withdraw from the research at any point. This should remove any feelings of obligation to take part. Likewise, to limit emotional distress because of discussing barriers, health struggles and potentially negative experiences, we will avoid overly intrusive questioning and have a signposting plan in place for further support.

Although we will strive to represent the diverse communities of our consortium, we need to be aware of missing certain groups and over-representing others and therefore reinforcing stereotypes or drawing incorrect conclusions. We will be very transparent about what groups have/haven't been included/represented and avoid overgeneralising our findings by group/demographic.

RE data collection and GDPR, we will not share any names or identifiable data outside of our shared CRM as per our data sharing agreement.

Outline of data intelligence and insights we expect to generate from our project and how we plan to do this:

Insights Report

We will produce a comprehensive insights report bringing together all data and insights gathered through the research as follows:

Combine quantitative and qualitative data, including:

- Demographic breakdowns of participants
- Thematic analysis of lived experience (focus groups)
- Structured insight statements identifying key patterns of inequality

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Present findings on:

- How different population groups experience long-term health conditions
- Barriers to accessing services and support
- Differences in experience of care and engagement with services
- Wider social and structural determinants of health

Include data visualisation outputs and dashboard-style analysis, exploring trends across:

- Neighbourhoods / geography
- Age groups
- Ethnic communities
- Condition types and needs

Translate data into clear insight statements, highlighting:

- Key health inequalities identified
- Root causes and contributing factors
- Groups most affected
- Implications for service design and commissioning

This should demonstrate how our collaborative consortium model enables deeper and more representative insight than traditional single-service approaches, by capturing intelligence across multiple community organisations through one aligned topic and a single point of accountability.

Commissioning Proposal Document

A proposal outlining how our consortium could be commissioned under a single health and wellbeing theme (with distinct, separate services across members), including costings, governance, and reporting templates.

Methodology and Activities:

This research is underpinned by an interpretivist approach, focusing on understanding the lived experiences of individuals with long-term health conditions and how they perceive and navigate health inequalities. This is complemented by a structured, applied approach to identifying patterns across different population groups, enabling insights to inform commissioning design. We are:

- Collecting structured data (quantitative demographics, qualitative themes)
- Looking for patterns across groups
- Producing evidence for commissioners

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1. Data Deep-Dive: Who they are (demographic data)

Anonymised data. Analysis of our existing CRM to examine our demographic data. We will subscribe to Microsoft Power BI to build interactive dashboards and reports using our raw data submitted to the CRM quarterly. We'll also use mapping software to create different ways to present the data against each other to provide new insights through a thematic lens on demographics/health inequalities across the consortium and communities.

We will analyse the data with an equity focus by completing an equity analysis (a systematic, process to evaluate how services affect different groups of people).

2. Community Insight Focus Groups: What do they experience

8 x facilitated focus groups overall: structured as two focus groups with service users across different centres in the consortium per quarter. The focus groups will be made up of service users reporting a long-term health condition.

Our research questions will be along the lines of:

Barriers: What makes it difficult for you to manage your condition day-to-day?
Access: Have you experienced any challenges accessing health or support services? If so, what?
Understanding: Do you feel that services understand your needs? Why or why not?
Trust: How comfortable do you feel using health services or asking for help?
Improvements: What would make it easier for you to access support or manage your condition?
Hidden barriers: Is there anything that stops you seeking help that people might not realise?

To collect this qualitative insight data we'll use Excel – both for raw data and to tag themes. We'll also complete another equity analysis to create core insight statements based on patterns/themes arising from research.

3. Consortium Reflection Session

One facilitated session with consortium members to reflect on the experience and practical realities of operating as a collaborative network. To explore:

- What does "collaboration" mean when services remain independent in delivery?
- What infrastructure (data sharing, reporting, governance, communication) is needed to make the model work without forcing organisations to compromise their distinctiveness?
- What would need to change-internally and externally-for this model to be sustainable and credible to funders and commissioners?

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4. Commissioner Interviews

A semi-structured interview each with key stakeholders such as NHS place-based teams and Rochdale Borough Council commissioners. These will explore attitudes towards thematic commissioning, barriers to adoption, and what evidence commissioners would need to see.

- Can a single aggregated report meet NHS reporting requirements while reflecting the diversity of provision?
- What governance is needed?
- What would a "lead partner" model look like, where one centre holds the contract and sub-contracts others?
- How do we price this to be viable for the consortium while remaining competitive for commissioners?
- Would you accept a single budget line for a coherent thematic programme rather than line-by-line service costs?
- What assurance would you need around delivery?
- What flexibility would you allow in-year to respond to emerging community needs?

Support identified to help make the project a success?

Training will be needed for the Strategic Community Development Lead and Burnside's Manager around using Microsoft Power BI, also on how to effectively story tell/ effectively visualise data with both raw quantitative data and rich qualitative data, and how to conduct systematic analysis of case studies/conversations/open ended questions – (essentially how to complement our quantitative data collection with the community insight).

Budget:

Please provide an estimated breakdown of how you will spend the funding		
Item	**Breakdown (how you have worked out your costings)**	**Amount Requested**
Facilitator focus group	Facilitator for each focus group at £270 x 8 = £2,400 (mid-range)	£2160
Facilitator	Facilitator for Consortium Reflection focus group at £270	£270

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PowerBi	Microsoft Power BI for 1 year = £129	£129
PowerB i training	Cost per staff member	£79
Data visualisation/storytelling training		£349
Total amount requested		£2988

Appendix: Background to the Commissioning Challenge

Current commissioning practice presents significant barriers for grassroots organisations:

- Single organisations are expected to hold large contracts they lack the capacity to deliver.
- Consortia are typically required to co-deliver identical services, losing the specificity, cultural competence, and community trust that individual centres offer.
- Reporting is siloed, meaning insights from different communities are rarely aggregated into a meaningful strategic picture.

Our Alternative Model

We propose a different approach: multiple organisations, each doing what they do best, funnelling distinct services under a unified health and wellbeing theme. Can a consortium of grassroots centres, operating under a unified health and wellbeing theme but delivering distinct services be commissioned a contract rather than a single-organisation or a co-delivery model? And what would it take for NHS and public health commissioners to fund this way?

This collaborative consortium model offers:

- Shared insight-gathering infrastructure and single point of accountability
- Reduced reporting burden on individual centres
- A collective voice to strategic partners
- Preservation of a person-centred approach and community trust

The research project is designed with testing this model in mind and to provide evidence to support its adoption by commissioners.

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