Newton

Delivering meaningful impact across health and care

CASE STUDIES

Contents

FOREWORD

Health and care systems remain under profound and sustained financial, operational and structural pressure. Newton works in partnership with trusts and systems to navigate the intense challenge and complexity that this presents, delivering immediate, measurable impact and designing the operating models that will sustain performance over the long term and transform the way that health and care is delivered.

Our work, which spans urgent and emergency care, integrated neighbourhood teams, and unplanned and planned care optimisation, is underpinned by data, AI, and digital capabilities that help our clients extract greater value from their investments and deliver more sustainable change.

The case studies here reflect the breadth of that work. Every example is different in context, but all share a common goal of achieving consistently improved outcomes for individuals, a better experience for staff, and a more financially sustainable future for the health and care system.

The team and I are delighted to welcome you here at ConfedExpo.

Robin Vickers
Partner, Health and Integration

Care Closer to Home in Manchester

The challenge

Manchester, like many health and care systems nationally, has been facing sustained pressure across its urgent and emergency care (UEC) pathway. Despite the dedication of staff, residents were not always receiving the most appropriate support or achieving the most independent outcomes.

In 2024, an assessment carried out by Newton found that many hospital admissions could have been safely managed in the community, and that almost a third of discharges were happening to non ideal settings, resulting in an avoidable dependency on long term care. Frontline teams also lacked timely access to data and visibility of community options, contributing to inconsistent decisions and variation in health and care outcomes. These challenges were compounded by fragmented system working, complex access routes into community services and a digital infrastructure that made staff decision making difficult.

With Manchester Foundation Trust placed in NHS England's Tier 1 for challenging UEC performance, it became clear that the city needed a more unified and integrated approach; one that would shift care closer to home, strengthen community provision, and ensure people receive the right support in the most appropriate setting at the right time.

Impact

Manchester's Care Closer to Home programme is helping the system make tangible progress toward its long-term vision: a UEC system that keeps people well, prevents avoidable escalation, and supports residents to remain independent closer to home. By strengthening community services, improving access routes, and reshaping pathways that previously defaulted to hospital, the city is now delivering care in a way that better aligns with its strategic priorities of improving outcomes and promoting independence, whilst working as one to build a sustainable, person-centred health and care system.

Frontline teams across Manchester are increasingly able to make treatment decisions that put independence first, supported by clearer processes, better data visibility, and stronger relationships between partners. As a result, residents are experiencing a more responsive system that intervenes earlier, reduces time spent in hospital, and ensures people return to their own homes as quickly as possible – if not immediately.

The programme has helped to cultivate a more collaborative culture across Manchester's health and care system. Partners are now working with a clearer shared purpose, supported by improved visibility of performance and a stronger collective understanding of where change is needed. This has laid the foundations for a future UEC model that is more integrated and better aligned to what Manchester wants for its residents: care that is compassionate, community-focused, and helps people live independently for longer. This is explicitly aligned to the NHS 10 year plan and the UK Government's national ambition of shifting care 'from acute to community'.

Optimising services to deliver better outcomes for residents

To make meaningful improvements at pace, Manchester focused first on strengthening the services already in place, simplifying how people move through urgent and emergency care today, while reinvesting the capacity released into community services that will shape the city's future UEC model. This approach has allowed partners to improve flow, reduce unnecessary hospital use, and expand the support available closer to home, creating the foundations for a longer term shift toward prevention, independence and better outcomes for residents.

The Care Closer to Home programme is built around a set of interconnected projects that work together to improve how decisions are made, reduce delays, and ensure people can access the right help at the right time:

- **Right Patient, Right Place -** Staff now use clear, shared decision making frameworks to guide residents to the most appropriate setting of care, ensuring people are safely supported in the community whenever hospital isn't needed. This improves early assessment at the front door, reduces unnecessary admissions and strengthens performance against 4 and 12 hour standards.

- **Reducing Days Away From Home -** Ward teams now prioritise a "home first" approach, reducing delays in tests, reviews and discharge activities so residents spend only the time they truly need in hospital. Close coordination between acute, community and council teams accelerates safe discharge, lowers acute occupancy and creates space to reinvest resources into community alternatives.

- **Short Term Services & Discharge -** Short-term home-based and community bedded services now operate with clearer processes and faster acceptance, allowing residents who no longer need hospital care to move quickly into the right support. This reduces reliance on long-term care, helps people regain independence sooner, and supports the city's long-term shift towards sustainable community provision.

- **System Visibility & Active Leadership -** Leaders and frontline teams now use a single shared view of performance to spot pressures early, manage flow consistently and take coordinated action. Regular cross system forums reinforce shared accountability, embed evidence based decision making and support continuous improvement across the UEC pathway. This collective approach strengthens both day to day operations and the system's long term resilience.

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OUTCOMES

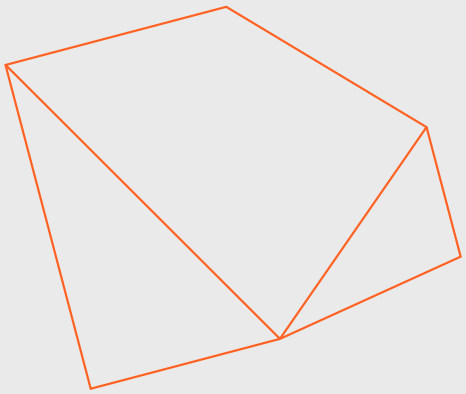
The Care Closer to Home programme is already delivering meaningful progress towards Manchester's ambition for a more responsive, community led UEC system that keeps residents well and independent for longer. People are spending less time in hospital, front-door pressures are easing, and more residents are returning home sooner with the right support. These changes are contributing to stronger performance on ambulance handovers and 4 and 12 hour waits, while also reducing unnecessary bed occupancy, helping Manchester Royal Infirmary to remove corridor care and close escalation wards.

Outside of the acute setting, the programme has also delivered significant reduction in Manchester City Council spend on both home based and bed based long term placements through avoiding unnecessary hospital admissions that cause deconditioning, appropriate pathway decision making on discharge from hospital, and increased use of reablement services to enable returns to more independent settings.

As of January 2026, after 12 months, the Care Closer to Home programme has resulted in:

- Reduction in bed demand by **130** beds, of which **94** beds have been closed and the ED queue for an admitted bed has been reduced by **25%**
- **66%** reduction in 30-60 minute ambulance handovers
- **98%** reduction in 60+ minute ambulance handovers
- **14%** improvement in 4 hour performance in December 2025 vs. 2024 baseline
- **9.2** hours reduction in the time spent waiting in the emergency department for admitted patients
- **35** fewer people per day waiting in hospital without a reason, meaning people are returning home more quickly
- **30%** reduction in patients spending longer than 3 weeks in the MRI
- **10%** reduction in average length of stay (including a 25% reduction in length of stay for patients returning home without ongoing social care)

The programme is also creating the headroom needed to reinvest in community services, supporting Manchester's long term shift towards earlier, preventative care. Perhaps most importantly, the programme leaves behind a stronger, more unified system. Partners now share consistent decision making approaches, a single view of performance, and a more collaborative culture. These foundations give Manchester the capability and confidence to scale the model across more localities, continue shifting activity closer to home, and sustain the improvements already achieved.



HomeFirst - a new model of intermediate care in Leeds

The challenge

Across the country, health and care systems are facing a range of challenges in the delivery of intermediate care due to rising demand, driven in part by an aging population with increasingly complex health conditions.

In Autumn 2022, the Leeds Health and Care Partnership, which brings together health and care organisations in the city, commissioned Newton to conduct an initial review to help identify how the system could improve the delivery of intermediate care for the residents of Leeds. The review showed that whilst thousands of people from across Leeds were receiving great health and care, there were a number of challenges in the system related to patient flow and the transfer of people into intermediate care, which meant that individuals were not always achieving their best outcome.

Impact

Based on this evidence, the Leeds Health and Care Partnership, supported by Newton, set out to transform the way that intermediate care is delivered in Leeds through the HomeFirst programme, which aims to achieve a person-centred, home-first model of intermediate care that is joined up and promotes independence.

By working together in a true partnership, system partners have delivered a new model of intermediate care within existing workforce, funding and organisational arrangements. Fundamental to the success of the HomeFirst programme has been building on the culture and relationships across partners in the system, embedding a culture of collaborative decision making and service delivery.

As a result of the changes made, the HomeFirst programme sees more residents achieving their best outcome whilst simultaneously relieving seasonal pressures on the acute and unlocking significant financial benefit within the system.

The HomeFirst programme

The HomeFirst programme consists of five interrelated projects which focus on maximising independence and ensure that residents always achieve their best outcome.

The five projects are:

- **Active Recovery at Home:** redesigning the home-based intermediate care offer to maximise capacity and deliver the best outcomes for people accessing these services.
- **Enhanced Care at Home:** transforming preventive services to avoid escalations in need with a specific focus on avoidable acute hospital admissions.
- **Rehab & Recovery Beds:** transforming bed-based intermediate care to improve outcomes and minimise length of stay in short-term beds.
- **System Visibility & Active Leadership:** making use of the wealth of data in the system to produce system and service level dashboards, while establishing the right cross-partner governance to use these for effective decision-making.
- **Transfers of Care:** redesigning the discharge model to minimise discharge delays and ensure the system achieves the most independent outcomes for people leaving hospital.

The new ways of working have been designed, trialled, iterated and scaled by experts including frontline staff and operational managers from across the system.

The benefits have been huge, both for staff and for the patients. For the patients, it means that they're seen in a more timely manner and prioritised, appropriately. The referrals are triaged immediately, so there's no delay, and from a staff perspective it means that we're receiving the right patients who are right for our service."

Occupational Therapy Clinical Lead

OUTCOMES

The HomeFirst programme has seen many positive outcomes, from seasonal pressures on the acute hospital being relieved, to a reduction of the system's reliance on long-term care. Most importantly, residents of Leeds are receiving highly effective services and are supported in achieving significantly improved outcomes.

As of September 2024, the programme is having the following impact on outcomes across intermediate care in Leeds:

- **169** more people able to go home after their time in intermediate care rather than a long-term bedded setting each year
- **8.2** day reduction in the average length of stay in short-term beds
- **421** more people going directly home after their stay in hospital each year
- **786** fewer adults admitted to hospital each year
- **31%** reduction in length of stay for complex patients with no current reason to reside
- **522** additional people benefitting from reablement each year
- The effectiveness of the home-based reablement offer has increased by **8%** (in terms of long-term home care hours following the service), with a **19%** increase in the proportion of people leaving the service fully independent
- **33%** decrease in readmission rates after receiving home-based reablement
- This performance translates to **£23.7m** per annum of equivalent financial benefit to the system. These benefits are spread across system partners and are a combination of cost-out, future cost avoidance, or investment in quality.

Embedding and sustaining the changes is an important component of the work allowing for long term change that can be maintained by teams. There is more to do to deliver the full vision of the programme and ensure that Leeds Health and Care Partnership is able to support the changing needs of the population in years to come, but the impact and approach of HomeFirst delivers a strong foundation to build from.

System Visibility

Before the HomeFirst programme, system partners in Leeds regularly met to discuss system performance, but the lack of a unified data source meant these meetings were often inefficient and unfocused. Each partner organisation produced a lot of data, but without a single version of the truth, efforts were duplicated, and trust was eroded. Leeds needed a way to consolidate their data and a leadership model to ensure decisions were evidence-based at every stage.

The introduction of the system visibility dashboard addressed this need by bringing existing data into a single, regularly updated platform. This dashboard supports decision-making at all levels, providing patient-identifiable data for joint case management at the team level and highlighting areas needing additional support at the service and system levels. This tool, combined with the Active Leadership framework, enables partner organisations to review data collectively and take coordinated action to resolve issues.

For the first time, heads of service from all health and care organisations in Leeds can effectively review system pressures and delays, allowing for timely, cross-organisational actions to relieve pressure before it escalates. The team has been able to identify the hidden delays further down the system which were often driving some of the delays to discharge, which would otherwise go unnoticed. The System Visibility tool and Active Leadership approach has transformed how Leeds manages system performance, fostering collaboration and enabling more effective, data-driven decision-making.

> **"What the dashboard has given us is one version of the truth so we can actually focus on what we need to do for the people of Leeds to improve their outcomes and we're doing it together. So rather than having a culture where we don't necessarily trust each other, and we don't necessarily trust each other's data, we've not got real agreement and consensus and can move forward, taking actions together collaboratively."**
>
> Nicola Nicholson, Associate Director of Strategies and Programmes, West Yorkshire ICB

> **"The beauty of HomeFirst is that it has brought people together through a partnership and *TeamLeeds* approach to look at all the key transitional points where people move from the community to hospital, from hospital to home, and from hospital to community care beds. It feels so much more joined-up now because we have had so much commitment to doing this as a system rather than individual organisations."**
>
> Sam Prince, Executive Director of Operations, Leeds Community Healthcare NHS Trust

> **"I need to get back my mobility because I used to go out quite a lot before I were ill. They've been great, really great. I've picked up now, and I'm doing alright."**
>
> Person being supported at home by Active Recovery

Improving Lives - launching a single point of access model in Coventry

The challenge

Coventry, one of four places within the Coventry and Warwickshire Integrated Care System, like much of the country, found its urgent health and care services under significant pressure meaning that the residents of Coventry were not always receiving an optimum service or the best possible outcome.

In response to this, in 2023 a place-based partnership consisting of Coventry City Council, University Hospital Coventry & Warwickshire, Coventry & Warwickshire Partnership Trust and other system partners including PCNs and the West Midland Ambulance Service began working on the Improving Lives programme with support from Newton.

The programme builds on the findings from an assessment of Coventry's urgent health and care services which found significant opportunities to improve along the entire pathway. The assessment, led by Newton, found that there was a tendency to make hospital conveyance the default option for people with urgent need. The drivers of this were identified as lack of awareness of services available in the community, paired with fragmented and unnavigable services in which frontline and clinical staff had low confidence. There was a clear opportunity to come together across Coventry to unlock organisational boundaries, improve relationships across the system, and create a more integrated model of care.

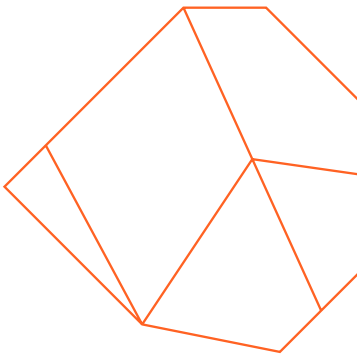
Impact

The Improving Lives programme is about fundamentally changing the way in which people with urgent need in Coventry are supported. By implementing a new model for the system, the programme has enhanced the visibility and awareness of available services in the community, enabling better decision-making and more effective use of resources across all system partners. Health and care is now tailored to a patient's specific needs rather than being constrained by the limitations of current service offerings.

A new, integrated model for the system

At the heart of the Improving Lives programme is a single, local integrated team which is fully equipped to respond in a coordinated way to urgent health and care needs across the city. This group is split into three locally integrated teams, with the capability to support all of its residents needs, ensuring that decisions are made based on individual need rather than the services available. This includes providing urgent response services which are tailored to the needs of each patient, proactive discharge planning for patients admitted to hospital, through to step-down, community-based services providing ongoing support in the community or at home. This team has one urgent health and care caseload, reducing duplication across multiple organisations, enabling the best use of skillsets and resources, and ensuring that a person's urgent needs are responded to in a tailored, coordinated way.

> **"With an aligned workforce and collaborative leadership we can unblock things that have previously been unfathomable. This programme has a voice and allows us to do things that the workforce have been wanting to do for years."**
>
> Integration Lead, Coventry and Warwickshire Partnership Trust



Enablers of the new model

This is an ambitious, complex model which requires robust supporting mechanisms and tools to be in place in order to realise its potential and become sustainable. The partnership has embedded the following key enablers:

- **Hospital visibility and accountability:** really embedding the basics through well-defined roles, responsibilities and accountabilities across the hospital pathway, and providing front-line staff and leaders with live visibility of data to drive the right behaviour and evidence-based decision-making.
- **Pull model:** commencing the discharge process as soon as someone is admitted to hospital, led by the local integrated team which has deep knowledge of and connections with services in the community and is able to actively pull residents out of hospital.
- **Workforce and leadership**: integration at all levels across the three main organisations, with a single leadership structure to help hundreds of staff work collectively in the new model.
- **Digital and data:** building a single intermediate care record system with shared access to holistic care plans for patients and enabling effective resource planning. Creating a suite of dashboards providing live visibility of activity across the urgent care pathway to enable evidence-based decisions, both at a patient level by frontline staff, as well as at a system level by executive leadership.

The new model has been designed, trialled and iterated, with involvement from across the health and care system, including PCNs and the ambulance trust, in the design of interfaces with the local integrated team, ensuring a more streamlined service for residents.

OUTCOMES

The Improving Lives programme has seen many positive outcomes, from the creation of a locally integrated model that effectively supports residents, the introduction of a pull model which allows patients who are being discharged from hospital to have their care plan before they're medically optimised, and improvements to the visibility of the services within the system. Most importantly, the experience of the residents in Coventry has improved significantly with a personalised approach to health and care supporting them in achieving the best outcomes.

As of January 2025, the programme is having the following impact on outcomes across the UEC pathway in Coventry:

- **18%** reduction in older adult admissions to base wards with people being better supported by primary care or the urgent community services
- **20%** reduction in P0 patient length of stay
- **50%** reduction in the number of people moving to a long-term bedded setting
- Reduced demand for short-term bedded care from **85** beds to **39** beds, with this group having more independent outcomes in their own homes
- Successfully moved **158** members of staff from eight different services into one new organisation
- Built a care record that hosts a case load of **700+** people and connects community, adult social care, and acute data
- This performance translates to ~**£17m** annual financial benefit for Coventry.

Integrated Neighbourhood Teams in Birmingham

Understanding the challenge

Like much of the country, Birmingham's health and care services were under significant pressure from rising demand. As a result, residents were not always achieving their best outcomes whilst the financial position of the health and care system was becoming increasingly unsustainable.

The scale of this challenge nationally has received a great deal of focus in recent years, with widespread agreement that the shift towards more preventative health and care services is essential in helping people live longer, healthier lives and in ensuring the performance and sustainability of the health and care system.

The publication of the Fuller Stocktake Report in 2022 provided an early vision for the reorientation of health and care towards more proactive, personalised services by building 'Integrated Neighbourhood Teams' (INTs). It also highlighted the need for local systems to drive the change themselves, requiring primary, secondary, social care and voluntary services to work together to design and deliver an impactful new model of care for their population. The challenges presented by integrated ways of working are well known, alongside the difficulty with proving the impact of preventative services within a timeframe that supports significant and recurrent investment. However, the approach taken by Birmingham has led to hugely positive results in a relatively short space of time, generating significant national interest and providing a proven model for other systems to adapt and adopt for their own contexts.

What did we do?

Birmingham's journey towards impactful INTs began with detailed analysis of service use across the system. By combining patient-level data from all partners in Birmingham and Solihull Integrated Care System, it found that 57% of services were being used by the top 5% of service users. Having identified this high frequency user cohort, further analysis, including multi-disciplinary case reviews, enabled system partners to further understand the impact of delivering preventative interventions to these individuals.

This evidence was then used to co-design a new operating model for Birmingham's INTs, including the membership of the team, the services they would provide and new ways of working. Four interventions were found to match 75% of the needs of the target cohort, including community mental health, social prescribing, structured medication reviews and social care assessments. This understanding of the specific needs and volume of the target cohort was central to the design of the new team.

> **This genuinely gives us the chance to make a fundamental difference to people for the long term."**
>
> CEO, Birmingham Community Healthcare NHS Foundation Trust

A single Primary Care Network (PCN) INT consists of:

1. **INT Coordinator:** A skilled admin who ensures appropriate information gathering and smooth running of INT meetings, remaining action-focussed.
2. **Neighbourhood Expert:** A social prescriber or voluntary sector representative who supports the whole team in building knowledge of available interventions and links into, for example, social care community coordinators.
3. **GP:** A named GP from the PCN, who attends both weekly meetings and has delegated responsibility for any clinical decision-making by the INT.
4. **Four Key Workers (Occupational Therapist, Social Worker, Community Trust Rep, Mental Health Trust Rep):** Contribute their professional perspective about cases discussed. Act as the key point of contact for specific residents supported by the INT.

The new model was trialled across two PCNs in east and west Birmingham, where activities and an agreed set of KPIs were closely monitored to allow the model to be iterated and optimised.

Scaled up, there is an opportunity for 20,000 people in the city to be supported by INTs, preventing at least 15% of the 850,000 contacts with health and care services each year.

OUTCOMES

Impact and legacy

Results from the two pilots showed a significant stabilisation in service use for individuals receiving an intervention from the INTs. This included:

- A **32%** reduction in primary care appointments
- A **15%** reduction in A&E attendances.

Residents supported by the pilot reported an overwhelmingly positive experience – with an average feedback rating of **4.3** out of 5.

The work and its early impact has generated significant national attention, with visits from senior leaders from NHS England and health sector membership bodies such as NHS Providers and NHS Confederation, and is helping to inform other health and care systems around the country looking to mobilise their own INTs.

Our role

Newton played a central role in the diagnostic, design and set up of the two INT pilots. At the heart of this was the alignment of leaders across health and care system partners, using the data and evidence to enable them to proceed with confidence in realising their joint vision for the residents of Birmingham.

Over 200 members of staff across the system were involved in the design process from social care, primary care, the acute, community and mental health providers, the voluntary sector and the Integrated Care Board. Not only did this ensure that the design of the new teams and services benefited from the full breadth and depth of clinical and operational experience within the system, but also helped to build the belief, commitment and new integrated ways of working that would ensure the effectiveness and sustainability of the new model.

Working as One - UEC transformation in Gloucestershire

The challenge

Like much of the country, Gloucestershire's hospitals are under significant pressure, with demand forecast to continue increasing due to an ageing population. Delivering urgent and emergency care (UEC) services which are equipped to deal with the demands of today and the future is critical.

Committed to evidence-based improvement of UEC services, One Gloucestershire commissioned Newton to undertake a detailed pathway review, covering delivery of care in the community, hospital arrivals, during hospital stays, and intermediate care journeys post discharge. The review found a number of challenges including lengthy ambulance handovers, long waits for acute beds, and challenges in discharging residents resulting in lengthy stays. Disconnected services and lack of awareness of referral pathways meant that residents often were not supported to stay in their homes and communities.

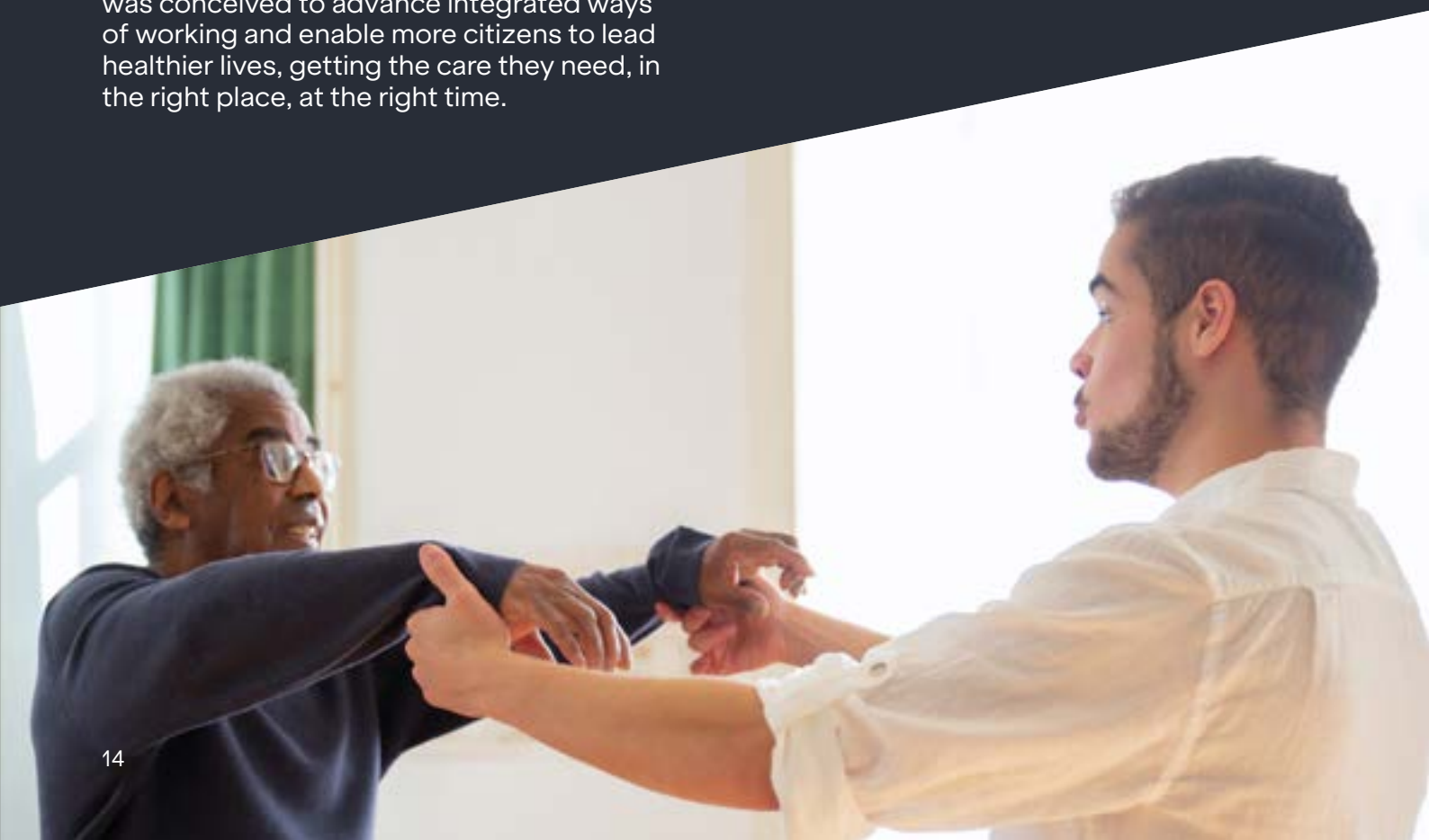
Fundamentally, there was mismatch between demand for care and capacity in the system. Aligning around a vision for citizens and clear evidence of where the most impactful change would be, the Working as One programme was conceived to advance integrated ways of working and enable more citizens to lead healthier lives, getting the care they need, in the right place, at the right time.

The impact

Working as One is an example of a system-wide partnership aligning around a vision for its population. It works in a truly joined-up way across a hugely complex change programme to deliver improved outcomes for the individuals in its care.

The improvements in flow have seen the hospital occupancy reduce from over 105% to the low 90s. This has been achieved in a period where demand has been rising, and the system has undergone some significant reconfigurations of its bed base, as well as consolidating most ambulance conveyances at a single site. Improvements to discharge have seen the NCTR queue reduce, without using additional beds in the community, and the system is now using fewer beds than before.

This is enabling better outcomes for patients, and the acute trust has seen impact on their delay related harm and mortality outcomes. Ultimately, people are spending fewer nights in a bed that isn't their own, and are achieving more independent outcomes than they were previously.



The Working as One approach

In the programme there has been a deliberate effort to start small, for example with one ward or team, before scaling more widely – with the hospital flow improvements now spreading across both medicine and surgery specialities, and the intermediate care improvements rolling out across all community hospitals and locality-based reablement teams.

Working as One focused on transforming three areas around UEC which together would lead to improved outcomes for people, better experience for staff, and financial system benefit:

- **Community urgent response and front door:** Better use of services in the community – with effective referral routes to support the right people to stay at home and improved ways of working at the hospital front door that help more people return home that day.
- **Hospital flow and decision making:** Reduced time for people in hospital through better co-ordination of health and care teams and a collaborative discharge hub supporting the most complex patients quickly to their ideal next step.
- **Intermediate care and access to care packages:** Improved availability, flow and outcomes through rehabilitative care in the community. Increased intermediate care capacity to smooth discharge from hospital (or step-up from community) into care in the most suitable location. Better availability of long-term care packages reducing delays in onward progression.

OUTCOMES

To date, the programme has achieved the following:

- **21%** reduction in emergency length of stay
- **50%** reduction in length of stay in short stay units
- Acute medical unit now supports as many people with **40** beds as it did with 60
- Hospital occupancy reduced from over 105% to the low **90s**
- The improvements on discharge have seen the NCTR queue reduce by **80** people

This performance translates to **£27m** operational value for the system. As well as investing in the occupancy improvement, operational savings have allowed the system to sustain a planned **40** bed reduction via acute reconfiguration and using **50** fewer P2 beds than previous years, all while absorbing increased front door pressure.

Providing insight to the elective challenge

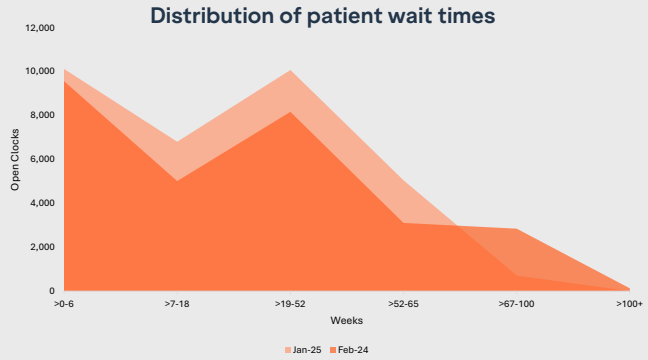
The elective challenge

Waiting times for elective care have been under pressure for a long time, but COVID-19 caused a dramatic escalation. At the height of the pandemic, many routine and elective procedures were paused to prioritise emergency care and respond to the urgent needs of patients with COVID-19. As a result, a substantial backlog accumulated. By 2024, the elective waiting list in England had grown to over 7.5 million with nearly 1 in 8 of the UK population on an elective waiting list.

To meet this challenge the government and NHS England have launched several initiatives.

- **Elective recovery plans:** targeted investment in staff, facilities, and technology, including surgical hubs and community diagnostic centres, to increase capacity and efficiency.
- **Use of the independent sector:** collaborations with private healthcare providers to increase the volume of elective procedures.
- **Prioritisation and triage:** systems to ensure those in greatest clinical need or who have been waiting longest are treated first.
- **Digital innovation:** expansion of virtual consultations and digital tools to streamline patient pathways and reduce administrative delays.

However, the situation remains challenging. Although the number of people waiting the longest has reduced, the profile of people waiting has shifted and the overall list size remains largely unchanged.



In January 2025, the NHS published a new ambition to reform elective services and increase the percentage of patients treated within 18 weeks to 65% by March 2026, with a further increase to 92% by March 2029.

To meet this challenge, one large multi-site acute teaching trust asked Newton to help by bringing an innovative dynamic flow-based approach to the development of their recovery plan; a task they knew would be incredibly challenging. Newton's rigorous, data-led approach has provided the trust with the insight they need to meet the challenge.

Working together to understand the challenge

Newton, alongside the trust's operational, clinical and BI teams, were able to provide a level of insight that enabled the trust to understand:

- the areas with the greatest opportunity to improve and how to access them – by speciality, point in the pathway, operational planning guidance, and operational delivery lever;
- the relative potential for each opportunity to impact performance for prioritisation;
- the requirement for dynamic solutions and to recognise the knock-on impact of improvements across the pathway;

and to forecast the required performance trajectory, including clock start / stop requirements to meet targets, and highlighting delivery risks for further consideration.

Bringing a flow-based approach to elective recovery

The Newton team were able to bring the sophisticated, dynamic flow-based approaches that have been so critical to solving Urgent and Emergency Care (UEC) flow across systems and apply the same technology, processes and predictive based thinking to elective recovery.

This involved:

Pathway Deep Dives - operational

With agreed speciality and Points of Delivery (POD) areas, Newton worked alongside data validators to review cases and processes to further understand patient pathways and the opportunities to improve elective care performance.

Static Data Analysis

Combining publicly available and trust-provided data to analyse how the trust's performance compared nationally and identified focus areas within the trust.

Dynamic Analysis

With the basis of data analysis and case studies examined, a dive further into the data to identify the specific improvements that could be implemented, creating a dynamic view of how the waitlist is changing over time.

Scenario Modelling

Utilising the patient pathways identified from the case studies and the dynamic analysis, modelling how the suggested improvements would drive better 18-week performance and simulating how this would impact waiting lists at different parts of the patient pathway.

We showed that:

Over **55%** of people with open clocks were waiting for a first outpatient appointment, and over **75%** of patients have their clocks stopped in their first outpatient appointment.

Up to **40%** patients would have benefitted from a 'straight to test' pathway, improving patient experience and RTT performance.

Providing actionable insights

Through the deployment of technology and approaches that have been so critical to solving complex UEC flow optimisations and applying them alongside a deep understanding of elective care, Newton was able to surface actionable insight for the clinical, operational and leadership teams. This allowed the trust to build an optimised recovery plan that will dramatically reduce the numbers waiting for care over the next three years and contribute to achieving the 65% target by 2026, and 92% targets by 2029.

We are really excited to be able to wrap this insight alongside Newton's fee guarantee model to make a meaningful contribution to helping NHS trusts reduce the numbers of people waiting for care, enabling them to deliver better outcomes at a lower cost.

Improving theatre productivity in West Hertfordshire

The challenge

Across the country there are over 7 million patients on waiting lists for elective care; the backlogs existed before the COVID-19 pandemic, but the impact of the pandemic has compounded the problem and more people than ever are waiting for surgery.

In January 2023, Newton and West Hertfordshire Teaching Hospital NHS Foundation Trust (WHTH) started a programme of work to improve the effectiveness of their operating theatres. At the start of the programme the Trust had 5,500 patients waiting for surgery, with many of these people having been waiting for well over a year. The Trust had limited visibility over how theatres were operating, meaning that surgeries were often being cancelled on the day and it was difficult to have grip on the situation.

WHTH needed to improve their theatre effectiveness to ensure that they were providing the best standard of care for their patients.

A clinically and data-led approach to improving theatre productivity

The programme, co-designed by Newton and WHTH, has embraced a clinically-led change approach from the outset, empowering clinicians and the teams around them to design and own the solutions to improve theatre performance. To kickstart this, 105 staff across the division (clinicians, theatre staff, waiting list coordinators, divisional management and more) took part in workshops to set a clear vision for the programme.

Key principles underpinning this vision were:

- Calm, efficient surgeries with smooth patient flow minimising delays. Multi-disciplinary teams working together to create a fantastic patient experience.
- Every operating list is at full capacity, to ensure prompt finishes without finishing early.
- Prompt starts and smooth turnarounds, with a standardised process to call for the next patient and lists reviewed ahead of the day to prevent order changes.

An on-the-day process for theatres has been agreed by all involved in the process, from those booking the surgeries to the surgeons, to prevent delays, ensuring that surgeries start sooner and turnarounds between surgeries are efficient. A separate booking process ensures that the lists created will have the right number of patients, helping them to run to time and enabling full utilisation of valuable theatre time.

These changes have been enabled by a newly implemented theatre performance tool.

With this clinically led approach, this time I really think we will be able to make a change together."

Clinician, West Hertfordshire Teaching Hospitals Trust

We've seen what worked: Clinical engagement, visibility of data, commitment to action - we need to do more of this."

CEO, West Hertfordshire Teaching Hospitals Trust

The theatre performance tool

The theatre performance tool which has been implemented as part of this programme of work is providing WHTH with greater visibility than ever before. The theatre management software provides two main views:

- **Booking view –** enabling improved forward-looking visibility of how full lists are and providing confidence that a list will be well utilised. This is encouraging ownership of lists, and allows for flexibility in booking.
- **Reporting view –** showing how theatres have been utilised and where cancellations have occurred, allowing clinicians, theatre staff and management to continuously identify blockages and ensure they are addressed going forwards.

The tool also provides easy use of surgeon-specific median operation times to ensure lists can be optimally used.

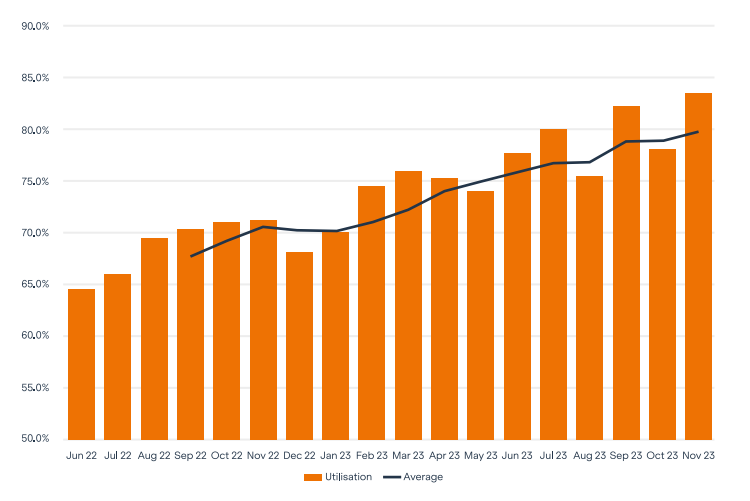
Since implementing the tool, lists are better planned, theatres are more utilised and patients are not waiting so long for surgery. In addition, staff are enabled to have better grip on services and can work proactively to ensure that the new processes are being followed.

THE IMPACT

- **40%** reduction in late starts
- **20%** reduction in time to turnaround between cases
- An additional **3,000** cases per year, reducing the impact of industrial action.

Operating theatre utilisation

- A **22%** increase in trust-wide utilisation across all elective activity.



Neighbourhoods Delivery Hub

The Neighbourhoods Delivery Hub is a participant-led Community of Practice delivered in partnership with The NHS Alliance, Partners in Care and Health and Newton. It brings together Place-based partnerships to develop and accelerate on-the-ground delivery of Integrated Neighbourhood Teams.

The challenge of neighbourhood health delivery

Integrated Neighbourhood Teams (INTs) are a pivotal element in the shift towards neighbourhood health, a concept central to the government's 10 Year Health Plan. With NHS and local government budgets under sustained pressure, and the challenges of an ageing population resulting in an increase in demand on services, the case for change has never been stronger. By bringing together health, local government, VCSE and community partners, neighbourhood health aims to support people earlier, closer to home and in more joined up ways.

However the shift towards neighbourhood-led health and care is ambitious, and delivery is complex. Systems face challenges in defining what an effective neighbourhood model looks like in practice, aligning partners around shared goals, connecting data between systems, finding budget to support new models and delivering change alongside day to day operational pressures.

Why neighbourhood health matters for systems

Delivered successfully, neighbourhood models aren't simply a new way of organising services; they represent a shift in how we think about health, care and community. They enable earlier intervention, better coordination of services, and a stronger focus on resident-centric care.

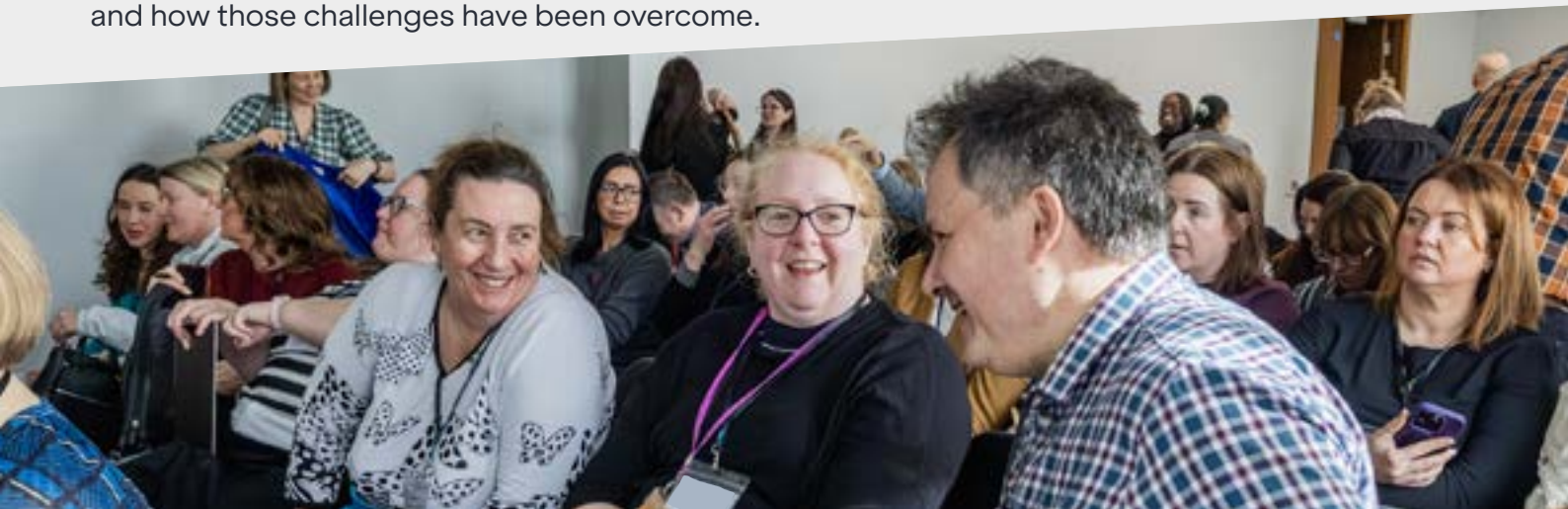
At a system-wide level, successful neighbourhood health models underpin wider priorities such as improved outcomes for communities, financial sustainability and workforce resilience. Building the confidence and capability to not only design but successfully implement INTs at scale is a strategic imperative across the country, requiring new relationships across multiple organisations, new ways of working and, in many cases, a cultural shift that takes time, collaboration and persistence.

For system leaders, this means making decisions about where to focus effort and existing resources, how to align partners, and how to deliver change in a way that is both realistic and sustainable.

Introducing the Neighbourhoods Delivery Hub

Bringing people together enables leaders across the sector to learn from one another, share what works, and move faster and more confidently towards delivering INTs in their own local contexts than any one Place could alone.

This is the rationale behind the Neighbourhoods Delivery Hub. The collective insight, evidence and practical experience generated through the Hub will be synthesised into a national output; an evidence-base designed to help any health and care system accelerate and scale up the design and delivery of their INT model, drawing on what has already worked, where others have struggled, and how those challenges have been overcome.



A community-led approach to accelerating INT delivery

The Neighbourhoods Delivery Hub was established to bring together leaders from across health, social care and the voluntary sector to accelerate the delivery of INTs. Participants include leaders from 21 Places across the country and the Hub operates as a Community of Practice, meaning it is participant-led and grounded in co-creation, shared learning and collaboration.

The Neighbourhoods Delivery Hub brings participants together through a structured programme combining in-person collaboration and ongoing virtual engagement. This approach is designed to sustain momentum between sessions, enable continuous peer learning, and support teams to translate insight into practical delivery in their own systems.

The format is specifically curated to support participants by moving beyond traditional learning programmes to combine three elements:

- **Cross system learning:** Participants learn directly from peers facing similar challenges through presentations, workshops and solution marketplaces, accelerating learning and reducing duplication of effort across systems. Regular webinars also bring in external subject matter experts for deep-dive sessions on specific topics.
- **Development support:** Practical frameworks, tools and structured approaches support teams to progress from ideas to action. Each Place is also paired with a Newton buddy who provides continuity, support and facilitation throughout their journey, while a shared Whatsapp group builds sense of community between sessions.
- **Live implementation:** The focus is firmly on supporting delivery in real time, helping teams apply learning immediately rather than treating it as a theoretical exercise. Every participating system will leave the Hub with a completed implementation plan, grounded in peer learning, in tested approaches and in their own local context.

Building confidence, capability and momentum

The Community of Practice regularly brings together over 70 leaders from across health and care, creating space to step back from day-to-day pressures and work through some of the most complex challenges associated with implementing neighbourhood teams in their systems.

Participants consistently highlight the value of learning alongside peers navigating the same terrain. Hearing directly from other Places has helped teams identify where approaches can be adapted and applied locally, with one participant noting it has

> **“brought to life the approaches taken by others and where we might be able to incorporate these into our local implementation plans.”**

The Hub has also become a valuable source of perspective for those implementing INTs. Participants have appreciated the

> **“reassurance that others have experienced similar challenges and discussion around mitigating strategies to those challenges.”**

This shared experience, combined with structured discussion, is helping to build confidence and resilience among leaders, giving them greater clarity and assurance as they move forward.

This is reflected in the data: **76% of participants report feeling more confident about the INT journey ahead of them since joining the Community of Practice.**

This feeling is increasingly translating into tangible progress, with participating systems developing robust implementation plans and moving forward with increased clarity on how to deliver neighbourhood models locally. These models will be shared alongside insights and learnings from the Community of Practice as part of a national output in Autumn 2026.

Balancing act: supporting finance leaders to deliver on short- and long-term priorities - a summary

The Balancing Act report was produced by the HFMA and Newton in 2025, following engagement with over 40 Chief Finance Officers and finance leaders from across England. It sets out how finance leaders can stabilise today's finances while building foundations for a sustainable health system tomorrow, anchored in a three-horizon model for change.

The challenge

During the last few years, the NHS has faced one of its most precarious financial positions in recent history. At the time of initiating this engagement for the Balancing Act report, the 2023/24 system deficit of £1.4bn had improved only partially, with integrated care system plans for 2025/26 initially projecting a combined shortfall of £6.6bn. At the same time, performance against key targets, including the 18-week elective standard, emergency department waits, and mental health access, remained well below acceptable levels.

NHS England's March 2025 financial reset called for major focus on both immediate grip and longer-term structural change. Yet the intensity of in-year demands - agreeing control totals, managing running cost reductions, and absorbing the disruption of NHS England's abolition - left finance leaders with little or no capacity to engage meaningfully with multi-year transformation.

> **"It's not just do we have financial headroom, it's do we have the time to stop and think?"**

Impact

Together, HFMA and Newton undertook a series of engagements with finance leaders to understand their sentiments and experiences of developing multi-year plans for long-term financial sustainability and improved outcomes, at the same time as operationalising current plans and delivering on a tight financial plan for the current year. Through a number of forums and roundtables, a consistent set of challenges and opportunities was surfaced.

Whilst discussions repeatedly centred around three themes: thinking across multiple change horizons; system and patient value; leading with hope and optimism, there was one main clear and shared ambition: a health and care system that delivers long-term financial sustainability and better outcomes for patients, while meeting the pressures of today. Finance leaders are increasingly recognised not just as controllers of the budget, but as designers of system change; able to harness evidence, model multi-year value, and broker collaboration across organisations with competing incentives.

Delivered well, the shift finance leaders are being asked to lead is not simply a financial exercise. It represents a fundamental change in how the NHS thinks about value; moving from a focus on unit costs and in-year savings toward a broader understanding of what care delivers for patients and communities over time. This is directly aligned with the three big shifts at the heart of the government's 10-Year Health Plan: from analogue to digital, hospitals to communities, and sickness to prevention.

Delivering change across multiple horizons

Together with practical tools and frameworks designed to support finance leaders in enacting the report's three central themes, the report also sets out a three-horizon model that helps leaders to reflect on where they are currently operating and where they need to build capacity.

- **Horizon 1:** Improvement – making what exists today as productive and efficient as possible.
- **Horizon 2:** Building blocks for the future – designing, testing and scaling new service delivery models. These are reliant on technology and by nature disrupt the current state, creating a step change in value.
- **Horizon 3:** Fundamental system redesign – with new service delivery models in place comes the opportunity for a new operating model to include revised governance, financial reform, new leadership and accountability.

THREE HORIZON MODEL

OUTCOMES

The report brings together a wealth of positive thinking, practical tools and best practice from finance leaders across England, whilst the case studies gathered illustrate how multi-horizon thinking can help leaders make progress against the complex challenge of balancing short- and long-term priorities for their system.

Delve into this suite of materials sharing some of the methods and mindsets being applied across the country by scanning the QR code or by visiting newtonimpact.com and searching "Balancing Act".

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