Newton

# Case studies

## Creating places that enable families and communities to thrive

# Contents

# FOREWORD

Since we were together at LGA last year, the scale and complexity of the challenges facing public services, and the pace of reform required to meet these challenges, have only intensified.

We are passionate about creating places that enable families and communities to thrive, supported by services which are connected, resident centric, and financially sustainable. We're proud of the client partnerships we've built and deepened in the last 12 months, which are all in some way moving toward this ambition. This is resulting in better outcomes for people and, in return, is saving local authorities millions of pounds.

These partnerships are:

- helping to deliver short-term improvement activity to rapidly move towards financial sustainability
- setting the strong digital and operating model foundations for long-term innovative change
- supporting leaders to shape and deliver bold ambitions for their place and communities.

Over the last year, we've been working to keep bringing the latest innovation to local government.

- We continue to expand the capability of Xantura's Oneview platform, working with local authority partners to build a holistic picture of the needs of individuals and families and using predictive analytics to enable early intervention. This is leading to the delivery of impactful prevention strategies, and resident centric service redesign. Our groundbreaking work to accurately predict carer breakdown is now supporting carers to feel more resilient, and in turn reducing demand for formal care and support. Our recent work with the Society of County Treasurers and the County Councils Network has shone a light on the four out of five instances where a child becomes looked after and the parent or parents also have a support need, which half the time is unsupported.
- Through our Social Investment Model we are developing new models of care, utilising public-private partnerships to finance the development of much needed care provision, such as dementia nursing care.

We're pleased to have also continued to invest in our research programmes, including:

- Conducting national research with the Society of County Treasurers and the County Councils Network to explore how local systems can move decisively towards an end-to-end model of prevention and reconnection that improves outcomes for children while strengthening long-term financial sustainability.
- Working with the charity Revolving Doors to understand the opportunity to better support individuals caught in the cycle of reoffending.
- Partnering with Partners in Care and Health to deliver the 'Future of Prevention' programme. Following its success, we are now working with Partners in Care and Health and The NHS Alliance to convene a new community of practice focused on maximising the impact of integrated neighbourhood teams.

This document covers some of our recent client and research partnerships across the breadth of local government - and the wider council and systems they operate within. You will see a range of examples, all bespoke and developed bottom-up within their unique context. Some cover the significant and immediate challenges of today, whilst others seek to reimagine public services for the future. However, all share a consistent outcome of supporting people and families to thrive in their communities.

**Danny Sperrin, Partner**

# Families First: keeping children in Bristol safe, stable, and connected to their families

**The challenge**

In 2025, Bristol City Council partnered with Newton to design and deliver Families First, a system-wide transformation programme. While designed to respond to the pressure that increased demand and rising costs were placing on the council, it placed outcomes for children and families at the heart of the programme. It was focussed on achieving two of the council's priority objectives: strengthening families and supporting them to succeed, and making sure vulnerable young people can thrive in safety and stability.

Families First sought to strengthen how teams work together; reduce siloed working; and improve the experience of children and families moving through services. It was also linked to the national Families First Partnership Programme, building on the implementation of Family Help in Bristol and bringing a consistent focus on family group decision-making.

**Designing and delivering lasting impact for children and young people**

Families First focused on seven connected areas, each shaped with frontline teams, and developing a partnership approach to preventative early help for children, young people, and families in South Bristol.

- Keeping families together with the right support, whenever it is safe to do so.
- Growing Bristol's fostering community so children in care can be closer to home, in a family setting.
- Supporting care arrangements to ensure children remain in stable and happy homes.
- Bringing children back to their communities and family-based settings from children's homes outside Bristol.
- Making sure children can grow up in a permanent, loving home outside of care wherever possible.
- Strengthening commissioning partnerships to achieve better outcomes for children, and better value for money for Bristol.

This was supported by programme-wide work on service culture, practice, team processes, and bringing enhanced data-led visibility.

> **"I think the level of visibility we have now is excellent... We have never had such a good understanding of our vacancies and matches."**
> Service Manager, Fostering

**Introducing new teams and roles focussing on proactive preventative support, permanence, and exiting care**

The programme identified that children aged 11 and over were most likely to enter care. Bristol children's services had established a dedicated team specifically for children at risk of family breakdown and the programme supported their practice model and processes. The Connecting Families Team demonstrated that earlier, more intensive support can have a very significant impact on the outcome for a child.

> **"Made a referral - consultation two days later and allocated right away... Regular reviews are taking place which has been really positive."**
> Social Worker

Previously, permanence could have been better consistently considered for all children, especially those settled in long-term care. Bristol children's services have introduced a dedicated Permanence Social Worker to provide specialist support, and over half of kinship fostering arrangements were identified as having potential to progress to Special Guardianship Orders, giving children greater stability and lifelong family connections.

13% of children in care in Bristol are cared for in an out of area residential placement, with many of the most vulnerable living hours away from their home and their network. Coming home planning has established structured weekly reviews and clearer shared ownership of transition planning, making this a routine expectation rather than an exceptional event, supporting more children to be closer to family, friends, and their communities.

To help more children in care live in stable, family environments close to their networks in Bristol, the programme helped Bristol children's services improve visibility of unused foster home beds. This, combined with new regular review meetings led by service leaders, now means over 20 additional children each year benefit from being supported by a Bristol City Council foster carer.

## OUTCOMES

Clear KPIs were defined, tracked, and quantified through the programme. This shows that Families First has resulted in families across Bristol achieving more positive outcomes across many parts of an interconnected system for children in care.

- **10%** more children living with Bristol City Council foster carers than at the start of 2025, against a backdrop of a 15% reduction in the previous five years.
- **Double** the number of children supported to move from children's homes into a family-based setting in 2025 compared to the previous two years.
- **100** families supported by the Connecting Families Team in the first 12-months, with **78%** remaining together.
- **150%** more children progressing towards a Special Guardianship Order from a Full Care Order every year.
- **8%** cost reduction to the council following a structured review of all children in children's homes to ensure the right support is in place with their provider.
- **£6.6m** financial impact delivered in year one, with **£20m** total projected over the first two years, and **£65m** over a five-year period.

> **"Understanding the model of care alongside the child's care plan allows professionals to align resources, achieve good outcomes and deliver value for money."**
> Design Lead

### Building capability and sustainability

Over the first year of the programme, Families First engaged more than 1,400 staff and delivered training to over 500, embedding significant changes in ways of working that delivered the impact. The work has moved into business as usual, with service leadership focusing on continuous improvement and further developing the next phase.

An important legacy of the programme is the capability and capacity built within Children and Education services to deliver future transformation. Looking forward, there are still significant ongoing challenges for Bristol to tackle, including the pressures presented by the high cost of homes. To continue the transformation journey, and deliver on its wider reform agenda, Bristol City Council has established a portfolio of four service-led change programmes across Children's and Education services.

# Timely, coordinated, effective and well communicated support for children with SEND

**Ensuring that all children and young people with SEND receive support which matches their needs, in the most inclusive setting possible to maximise their chance of positive educational and social development and long-term independence.**

### Laying the foundations and improving outcomes

In partnership with a large County Council, Newton worked alongside internal subject matter experts (including SEN Assessment, EarlyYears, Inclusion Services, and Business Intelligence specialists), parents and families, schools, and former teachers to design and deliver new structures, processes and ways of working that wouldbe adopted across the SENA service and the school system.

Throughout the programme we focused on two core strands:

1. Improving the SENA service - laying the foundations

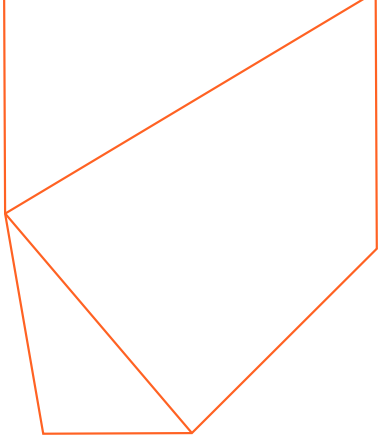
The SENA operating model was redesigned to enhance collaboration and efficiency by developing six work streams, restructuring teams around operational functions, creating a resourcing model to manage demand, and aligning key metrics and data for accountability and empowerment.

2. Improving outcomes

Alongside laying internal foundations, changes were developed to drive better outcomes for children by introducing tools and new processes to support high-quality decision-making. This included the 'Needs Descriptors' tool for consistent understanding of needs, a tool for Case Managers to improve visibility of consult results, and focused work in Early Years to create guidance for placements and transitions. There was also work to support Autism Outreach and Inclusion services with data driven decisions for timely interventions.

To strengthen relationships across the system, the Council engaged with numerous system partners, including schools and early years providers, parents and carers, and used consistent messaging and engagement approaches to improve relationships, confidence and accountability.

An Inclusive Practice Toolkit was created to provide information, guidance, and outline common expectations for inclusivity standards for mainstream settings across the County. Setting-specific planning processes were also developed to strengthen relationships with schools, offering high support and challenge to targeted schools and trusts facing higher than average SEND challenges.



**I think this is really, really good. It helps us get the parental engagement we need and sets us up to get the right outcomes for children."**

Assistant Director of Education, SEND and Commissioning

## OUTCOMES

### Improved outcomes

- One third of children, beyond early years, who would have been supported in specialist setting are now successfully supported in mainstream education.
- In the 2023/24 academic year, **44** early years children are now better supported in mainstream settings instead of specialist services, compared to baseline projections.
- 5-week reduction in the average time to complete needs assessments compared to the 2022 baseline.
- **66%** increase in the amount of Y6 phase transfers done before the deadline this year compared to last, up to 218 from 131 in 2023/24.

### Improved system collaboration

- **94%** of the surveyed SENA staff agreed that changes in their ways of working will lead to long-term benefits.
- In the first six-months alone, the Inclusive Practice Toolkit was viewed **4,500** times – indicating that it is a key resource used by partners across the system.
- In the first two-academic terms post launch, **17** schools or trusts went through the setting-specific planning process, with more keen to follow.

### Improved financial resilience

- By increasing the number of children receiving their ideal and most inclusive setting, the programme has resulted in over **£21.7m** of annualised financial benefit.

# Becoming a more financially resilient social landlord to deliver for residents, build new homes, and regenerate communities

**In the face of growing resident needs, rising sector expectations, and increasing operating costs, a housing association's transformation programme is allowing them to deliver against business priorities and improve financial performance, in turn enabling investment for the future.**

### Doing more with what we have - understanding the opportunities to improve

An in-depth assessment of the customer journey identified a large amount of re-active repair jobs requiring follow-up; a proportion of jobs that could be avoided; the ability to reduce the duration of voids; and the potential for housing officers to spend more time with residents.

There were also challenges with data availability, siloed teams lacking clear accountability, and competing priorities across teams stifling opportunities for collaboration.

Within repairs teams, jobs often exceeded their expected duration and planning inefficiencies led to unfulfilled utilisation. This highlighted an opportunity to improve the grip on performance of internal resource and reduce dependence on subcontracted labour.

As a result, they embarked on a strategic transformation programme to:

- Design ways of working and teams to be responsive and agile, and to anticipate and meet customer needs more effectively.
- Evolve the operating model to put customers at the heart.

### Empowering people and processes

This led to four priority areas:

1. Creating a more valued and visible frontline by spending more time with customers and in communities.
2. Moving people into quality homes as quickly as possible.
3. Improving the repairs service by looking at the information flow from customers through to trade teams, to support getting the repair fixed the first time around.
4. Ensuring an effective and efficient repairs service.

> **"This programme has given us a way to understand and manage our teams in a way we never had before.**
>
> **We have never seen a change implemented so well and we are confident we have only seen the start of the benefits it will deliver."**
>
> Repairs Director

**Transforming for the benefit of residents, today and tomorrow**

The programme has enabled the housing association to house people quicker, improve the quality and safety of their homes, enhance customer service, and spend more time in the community with their customers.

Across all the priority areas there were three key enablers: data visibility, high performing teams and collaboration. As a result, the financial benefit was combined with a better working culture and fundamentally a better outcome for customers:

## 19 DAYS

Void turnaround time has reduced by 19 days (and rising). As a result, people are now being housed faster and rental losses associated with empty properties are reduced.

## 37%

Housing officers are now able to spend 37% more time face-to-face with residents as a result of spending less time on administrative tasks. This is enabling a better understanding of resident needs and fostering stronger community engagement. Positive customer feedback has increased by 12%.

## 6%

Subcontracted spending on reactive repairs has decreased by 6%, reflecting more control over internal resources and less reliance on external labour. Further streamlining of processes has enabled operative efficiencies to be improved by 18%.

# ‘Connect and Prevent’ in Hertfordshire County Council

**The challenge**

Hertfordshire County Council have a high performing adult social care service; they are in the top 10% of current CQC scores. However, like many local authorities, they are facing increasing pressures with demand for support rising, driven by an ageing population, and residents increasingly presenting with more complex needs.

With this in mind, and with the strong ambition to improve outcomes for residents and build greater financial resilience, the council wanted to explore how they could improve and innovate their service, including by more deeply embedding a preventative approach to their practice.

In 2023, the Council started working in partnership with Newton to understand the key opportunities to achieve this, launching the Connect and Prevent programme.

**Enabling people to live independent lives**

From the outset, frontline staff and managers were at the heart of leading and co-designing the changes, ensuring ideas were shaped by those closest to residents. Residents and key partner organisations were also engaged throughout the process through co-production and hands-on workshops, helping to develop solutions that reflected local needs and priorities. This approach kept residents’ outcomes at the heart of every decision while building early and enduring support for change across the service and wider system.

Connect and Prevent was implemented through five interconnected workstreams, all grounded in collaboration between service areas, data-led insight, and continuous improvement.

- **Taking a proactive approach to prevention** by harnessing the power of advanced analytics and artificial intelligence to identify the people who are likely to need support in future, before they need it. The initial focus has been on unpaid carers at risk of breakdown, which was highlighted as a key focus area with over a third of cases identified as having proactive prevention potential during initial diagnostics. Early identification supports staff to manage tailored outreach to carers to provide support designed to strengthen their ability to continue caring, and is being delivered in partnership with Carers in Hertfordshire.
- **Enhancing community connections** across front door and assessment processes so that residents are connected to the right support at the right time with stronger links to community and voluntary services.
- **Increasing the reach and impact of the enablement service,** underpinned by a new digital app which supports three lead providers and frontline staff to strengthen their approach to goal setting, track resident progress, and accelerate discharge from reablement services, and prevent, reduce, and delay the need for long-term services where appropriate.
- **Promoting independence during transitions** by introducing a consistent, goal-based planning approach for working with young people moving from children’s to adult services. This is helping to remove the perceived “cliff edge” and helping those young people to maximise their independence.
- **Delivering and embedding goal-based practice** at every stage to help people with learning disabilities maximise their independence, including by supporting people to move into suitable and often more affordable support settings, where appropriate.

Alongside these workstreams, Newton has supported the council to introduce finance dashboards that unify operational and financial reporting, giving managers a clear, real-time view of the drivers behind costs and enable confident, data-led decision-making.

### Spotlight on: Identifying carers at risk using joined up data and AI

Unpaid carers play a vital role. Across Hertfordshire there are 92,000 unpaid carers, with 26% of the county's unpaid carer population caring for 50 hours or more. A survey conducted by a local carer support service found that as a result of caring:

- **52%** of carers said they felt more anxious
- **60%** of carers said they felt more stressed
- **1 in 3** carers said they have had or have been close to point of crisis.

To best support carers who might be at risk of reaching crisis point, the council needed a way to identify carers most at risk. The OneView platform is now being used to join up data from across services and bring visibility to previously unknown unpaid carers. It provides an in-depth and holistic understanding of their circumstances – including the nature of their caring relationship and risk factors. Using artificial intelligence, and with 65% precision, Hertfordshire can now identify these individuals. They are working with Carers Hertfordshire to proactively outreach and offer support – from practical advice to emotional wellbeing checks.

The results have been powerful. Hundreds of carers have been contacted and are being supported through the new service. For many, a conversation and timely support have helped them feel more resilient, allowing them to continue caring safely and confidently. This not only improves outcomes for residents but also reduces demand on statutory services.

## OUTCOMES

Connect and Prevent has delivered significant, measurable impacts and improvements across Hertfordshire's adult social care system by transforming outcomes for residents, empowering staff, and strengthening financial resilience. The council has become a thought leader in prevention, adopting new ways of working to innovate service delivery. The work has been shortlisted for industry awards and was recognised by winning bronze in the Health and Social Care category at the LGC Awards.

As of July 2026 – 10 months after workstreams transitioned to business as usual ownership:

**Improving carer resilience:**

- Carers supported through targeted prevention report on average a **27%** improvement in resilience and a **21%** increase in wellbeing.
- The carers identified and supported were found to be **66%** less likely to have reached a crisis point in the 12 months following the intervention and support.

**Older adults:**

- The percentage of older people accessing reablement has increased by **22%**, helping more residents regain independence.
- Residents accessing reablement are achieving independence on average **three days faster**.
- Reablement effectiveness has improved by **7%**, enabling better long-term outcomes.
- **5%** more assessments are now being completed at the front door, connecting more residents to the right support sooner.

**Working age adults:**

- Annual reviews for adults with learning disabilities now result in independence focused outcomes that are on average **35%** more independent.
- **234** individuals have already, or are currently receiving, focused support through progressive reviews.
- A consistent goal-based planning structure is now in place for people with learning disabilities across 0–25 and adult services, with **46** young people working towards structured independence goals.

Staff are also benefitting from clearer processes, supported by an improved data and performance infrastructure. Financially, the service is on track to achieve over its target of **£24.8 million in annualised savings.**

# A new operating model for 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.

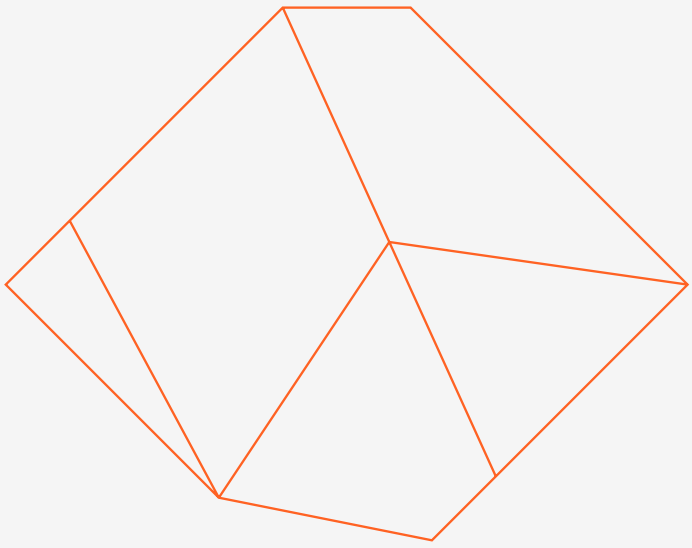
The publication of the Fuller Stocktake Report in 2022 provided an early vision for the reorientation of health and care in Birmingham towards more proactive, personalised services by building 'Integrated Neighbourhood Teams' (INTs).

### Designing the operating model

Birmingham's journey began with detailed analysis of service use across the system. By combining patient-level data from all partners in the 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.

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.




## OUTCOMES

### Impact and legacy

The new model was trialled across two Primary Care Networks 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. 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 have generated significant national attention, with visits from senior leaders from NHS England and sector membership bodies. This is helping to inform other health and care systems around the country looking to mobilise their own INTs.

> **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 new HomeFirst model of intermediate care in Leeds

**The HomeFirst programme**

Leeds Health and Care Partnership, which brings together health and care organisations in the city set out to transform the way that intermediate care is delivered.

The HomeFirst programme was developed 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.

The HomeFirst programme consisted of five interrelated projects which focued on maximising independence and ensuring that residents always achieve their best outcome.

**The five projects were:**

- **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 and Recovery Beds:** transforming bed-based intermediate care to improve outcomes and minimise length of stay in short-term beds.
- **System Visibility and 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 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

**Spotlight On: System visibility project**

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 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.

## OUTCOMES

The HomeFirst programme has seen many positive outcomes, but most importantly, residents of Leeds are receiving highly effective services and are supported in achieving significantly improved outcomes.

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.

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.

# Reducing homelessness in Maidstone

Xantura
A Newton Company

**Xantura helped to develop a risk alert system focusing on early intervention and proactive support to reduce homelessness in at-risk residents in Maidstone.**

### Increasing numbers of individuals going into interim and temporary accommodation

Like many other areas, Kent has been experiencing a significant increase in the number of individuals going into interim and temporary accommodation. Identifying and supporting individuals at risk of homelessness using an early intervention and prevention-focused approach is a priority for forward-thinking councils.

### Identifying individuals at risk of homelessness

An effective data solution is necessary to identify these at-risk individuals in need of proactive support. Xantura's OneView system reliably identifies an individual's circumstances and areas of financial risk. By identifying individuals at risk of becoming homeless, proactive support can be put in place to help prevent homelessness.

### Better outcomes for residents and the Council

The project has resulted in a **40%** reduction in homelessness as a result of risk alerts enabling proactive support. This has reduced the administrative burden for Council staff, with **61** days reinvested in working directly with vulnerable citizens, and a potential increase to 160 days with project expansion.

### Significantly higher rate of preventing homelessness:

- Households identified 3-6 months before reaching crisis point.
- A success rate of homelessness prevention reaching over 98% (compared to the national average of 56.3%).

### Improved partnerships:

- The Council's working relationships with partners have significantly strengthened, improving the operational delivery of the project and enabling teams to gain a holistic understanding of an individual's situation.
- Maidstone's largest provider of social housing experienced a fall in overall evictions from over 20 per year to under **5**, as a result of improved partnership working and data sharing.

### Cost savings:

- The project has resulted in **£225k** in actual cost savings, with potential savings of **£578k** if the Council had additional capacity.
- This represents an ROI of over **600%**.

**OneView has been proven to deliver immediate benefits to the client group with tangible examples of families who without the support they are now receiving were on a trajectory to presenting as homeless in the near future and who otherwise may not have come to our attention until a point which was too late for a successful intervention."**

John Littlemore, Head of Housing and Community Services, Maidstone Borough Council

**I wholeheartedly support the use of the OneView product and have seen a significant impact on our ability to prevent homelessness with its use. In addition, Xantura have proven to be an excellent partner with great attention to detail, responses to issues, and ongoing valuable relationships to ensure the project can continue to be delivered with excellence."**

Housing Advice Manager

# Improving financial inclusion and reducing debt in the London Borough of Barking and Dagenham

Xantura
A Newton Company

**Insight driven, targeted support enabled by Xantura for four months to vulnerable residents with debt using the Homes and Money Hub in the London Borough of Barking & Dagenham.**

**The cost-of-living crisis has further exacerbated financial exclusion and rising debt**

The direct effect of debt on residents is often detrimental. Personal debt is associated with physical ill-health, suicide, anxiety, stress, and clinical depression, independent of the effects of poverty. It can contribute to family breakdown and also has negative effects on labour market outcomes.

**Identifying people vulnerable to the negative effectives of debt**

Working with Barking & Dagenham and through the use of advance analytics, we built a predictive model that helps the authority identify people vulnerable to the negative effects of debt and offer them support before they reach crisis point. This insight-led service transformation has advanced the borough's data maturity and has driven a more joined up response across service silos.

**Significant increased engagement, increased debt collection and wider benefits to the health and wellbeing of vulnerable residents**

Taking a holistic view of debt, facilitated by Xantura's OneView system, allowed Homes and Money (HAM) Hub staff to identify vulnerable residents with debt and deliver support services. This has enabled Barking & Dagenham to be a leading authority in debt management, with increased debt collection and lower negative outcomes associated with overwhelming debt.

**[Barking & Dagenham] was ahead of the game in developing its OneView system to take a holistic view of all the factors that contribute to their residents' financial wellbeing. This is something that we in central government were just starting to think about. [Barking & Dagenham] has demonstrated its expertise and is now considered to be a vital stakeholder and critical friend to central government as we try to replicate their success."**

Deputy Director, Government Debt Management Function & FEDG Central Team, Cabinet Office

## OUTCOMES

INCREASED DEBT COLLECTION

**£75K**

additional (compared to counterfactual) reduction in debt over 4 months (annual projection £223k).

INCREASED DEBT COLLECTION

**69%**

Improved targeting of the cohort has the potential to lift the additional debt reduction by 69%.

SIGNIFICANT INCREASED ENGAGEMENT

**127**

different interventions delivered to vulnerable residents versus five interventions to a predefined counterfactual.

### Wider benefits

Significant, measurable impact on wider risk factors (13 out of 14 categories or risks), including for example:

- Double the number of people (60%) showing an improvement in emotional health and wellbeing compared to the counterfactual (29%).
- Four times the number of people (23%) showing an improvement in domestic abuse compared to the counterfactual (6%).

**Xantura's OneView offer is a unique combination of service transformation methodology and class-leading analytics and data management platform. The approach and platform are now central to the council's data maturity and wider transformation strategy. Equally impressive is Xantura's obvious passion to improve outcomes for our vulnerable residents."**

Pye Nyunt, Head of Insight and Innovation, Strategy and Participation

# Partner programmes

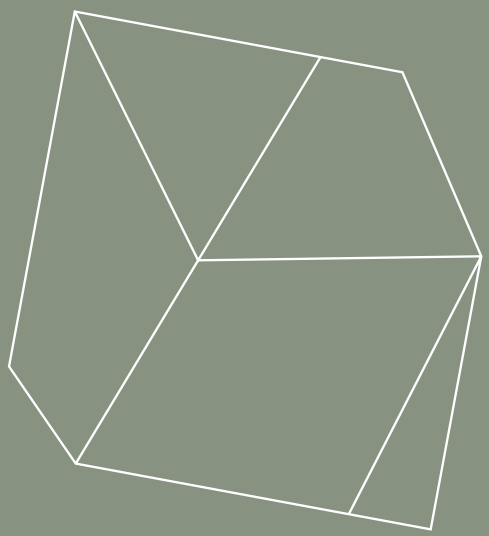
**Over the last year, we're pleased to have continued to invest in research and leadership programmes alongside a range of partners:**

- We have recently launched a new report with the Society of County Treasurers and the County Councils Network – 'From prevention to reconnection: working towards a multi-agency system that keeps more families together'. The programme explored how to, in the context of children's social care reform, prevent more children coming into care, and support more children to return to their family network.
- With Partners in Care and Health and NHS Alliance, we are running a national, sector-led community of practice to facilitate place teams to develop and accelerate models of on-the-ground delivery of Integrated Neighbourhood Teams.
- We're starting a new research programme in partnership with the County Councils Network, to identify the common factors contributing to homelessness within unitary authorities. The programme will support these authorities to gather rapid insights into their homelessness performance, and to identify specific opportunities for improvement.
- Following a successful community of practice, we're delivering the 'Future of Prevention Academy' with the LGA. The Academy is working towards the first large-scale national evidence base for proactive prevention in adult social care. DHSC are contributing through sponsoring development of an evaluation methodology.

**Below is a reminder of some of our previous research programmes:**

- The Future of Prevention: a delivery model and evaluation framework for proactive prevention in adult social care
- The Forgotten Story of Social Care: the case for improving outcomes for working age and lifelong disabled adults
- Finding a way home: how health and social care can optimise hospital flow and discharge this winter to improve outcomes and performance
- The Future of Adult Social Care
- The Future of Children's Social Care

We also continue to deliver a number of sector-led leadership programmes – these include the adult social care leadership programme 'ADASS Accelerate', the Future County Finance Leaders Programme in partnership with the Society of County Treasurers, and the London SEND Leadership Programme in partnership with LIIA and nasen.

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