Newton

Xantura A Newton Company

Case Studies

Achieving the best outcomes for people and families by transforming organisations, systems, and places to deliver connected, resident-centric, and financially sustainable public services.

Contents

FOREWORD

Since we were together at NCAS last autumn, the pace of change and reform has not let up.

In that context, we're proud that our client partnerships are helping to create connected, resident centric, and financially sustainable services which deliver good outcomes. This means thousands of adults and children are living more independent and autonomous lives connected to their families and communities. This is saving the state millions of pounds.

These partnerships are developing ever more innovative models of service delivery, creating real cause for continued optimism:

- Our work with Xantura is accelerating, providing novel insights into the range of need families and individuals experience in a place. This is leading to the delivery of innovative and effective prevention strategies, and resident centric service redesign.
- We are bringing further innovation in developing new models of care, utilising public-private partnerships to finance the development of new and much needed care provision, such as dementia nursing care and extra care housing.

Over the last year, we're pleased to have also continued to invest in our research programmes, including:

- Working alongside CCN to examine the implications of LGR on people services.
- 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 NHS Providers to convene a new community of practice focussed on maximising the impact of integrated neighbourhood teams.

This document covers some of our recent client and research partnerships across the breadth of adult social care, children's safeguarding, SEND, housing, and integrated health and social care - 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 look to support assurance and quality improvement journeys. Others seek to reimagine public services for the future, centred around proactive prevention and early intervention, enabled by digital and AI.

However, all share a consistent outcome of achieving brilliant life outcomes for individuals, families, and communities, while being more resident centric, connected, and financially resilient and sustainable.

Steve Knight

Partner, Head of Local Government

Building brilliant outcomes for children and young people in London

This London Borough children's services were already in a position of strength, with a 'Good' Ofsted rating and delivering great outcomes for the children and young people of the borough. As a directorate, they wanted to build on this and further improve outcomes.

Understanding the opportunities to improve

We worked in partnership with the Borough covering the entirety of children's safeguarding and part of its services support children with special educational needs and disabilities (SEND).

Initially, 121 staff participated in workshops to review 199 cases; 30,000 lines of data were studied; 42 staff participated in live studies; and 86 participants responded to surveys to understand the environment for change and the opportunities to improve.

Designing and delivering lasting change

Together, we developed these findings into four key focus areas. We focused on creating sustainable change by engaging staff and families at every stage of the programme and developing lasting internal change capability.

1. Internal fostering:

In order to increase the capacity of the award winning internal fostering service and maximise how it supports children in care, the foster carer recruitment process was transformed, from the website and marketing activity to creating a simplified application process. New technology, governance, and processes ensure every candidate is progressed and bespoke additional support is provided for those who need it.

2. Moving to Adulthood:

To achieve brilliant life outcomes for young people with SEND as they move to adulthood, three separate assessment processes were consolidated into a single coherent approach with families, complemented by new strengths-based, citizen-led collaborative ways of working with young people. A pilot team was created to work with young people and test these different ways of working. As a result, a business case was developed across two directorates, and the Health and Adults and Children's Services directorates went on to work together to implement a new service.

3. Safe outcomes across Child in Need, Child Protection and Edge of Care:

To achieve the outcomes defined in plans in the most timely way, to support children to thrive at home, and to achieve safe permanence for children in care as soon as possible, a new practice toolkit was designed to help practitioners. Regular group case discussions promote learning, quality assurance and collaboration, and a new dashboard helps every practitioner and manager in supporting children in a more efficient way. A workforce modelling tool matches capacity to demand and highlights opportunities to redeploy resources to enable a more resilient and stable service moving forward.

4. Prevention:

Through working with schools, a new offer across children's services to deliver brilliant outcomes for adolescents was explored. The pilot resulted in the Council implementing the Family Assessment and Safeguarding System model with named leaders linked to schools to continue to build relationships.

OUTCOMES

Two years after the programme first started, the Borough has:

- Tackled process delays and drift to deliver statutory CIN (two weeks) and CP (eight weeks) outcome plans faster.
- Achieved permanence out of care **18** weeks faster by tackling drift and delay, where that is the plan for a child.
- Implemented a new service that has enabled **181** individuals with SEND to seamlessly transition to adulthood by remaining closer to home, in turn reducing costs by an average of **41%.**
- More than doubled the rate of recruitment of foster carers to the internal service.
- Supported **32%** more children to exit care through special guardianship orders or adoption, avoiding long-term permanence in care.

As a result the programme has delivered **£7.2m** in financial benefit.

Building capability and sustainability

To sustain the improvements, from the start there was a clear focus through the programme on building digital, operational, and financial capability. Every single member of staff in the council's children's services department was given access to at least one type of training and professional development support. As a result, teams now feel more empowered to support children and families with the best possible data, tools and systems, measuring the success at every level.

A comprehensive benefits tracking mechanism was also developed which enables the service to measure the financial impact.

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

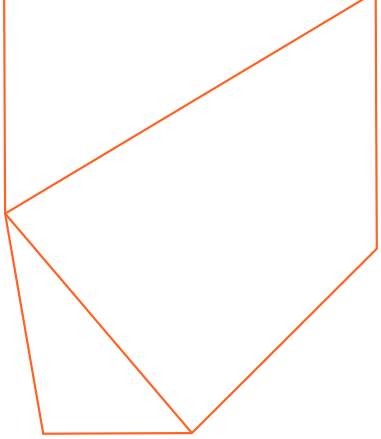
The SENA operating model was redesigned to enhance collaboration and efficiency by developing six work streams, restructuring teams around operational functions, creating a resourcing model to manage demand, and aligning key metrics and data for accountability and empowerment.

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%.

Preventing carer breakdown in a County Council

The challenge

Like many local authorities, this council has been facing significant pressures in the delivery of adult social care. Demand for support is rising, driven by an ageing population, increasing complexity of need, and they are specifically seeing a growing number of unpaid carers reaching crisis point. Despite a strong ambition to innovate and become more preventative, the adult social care service in this county was stuck in a cycle of reacting to presenting demand.

In 2023, the Council commissioned Newton to conduct a diagnostic review which showed that they could improve outcomes for residents, an opportunity worth £24.8m in annualised savings. One aspect of this involved taking a targeted approach to preventing carer breakdown.

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

Unpaid carers play a vital role. In this council there are 92,000 carers, and 2% of the county's population care 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 a carer breakdown.

When caring arrangements break down there can be profound consequences for both the carer and the person they're caring for.

To best support carers and avoid breakdown, the council needed a way to identify carers most at risk. Xantura's OneView platform is 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 advanced analytics and machine learning, and with 65% precision in predicting a future carer breakdown, the council can now intervene early to ensure that carers are being supported. Outreach is delivered through a local carer support service, and ranges from practical advice to emotional wellbeing checks.

OUTCOMES

The results have been powerful. Hundreds of carers have been contacted and are being supported through the new service. This is resulting in a 27% improvement in feelings of resilience and a 25% increase in wellbeing.

For many, a conversation and timely support have helped them feel more resilient, allowing them to continue caring safely and confidently, potentially delaying or avoiding a breakdown. This not only improves outcomes for residents but also reduces demand on statutory services.

The wider adult social care transformation programme, of which this was part of, has enabled this County Council to support more residents to maintain, and regain independence. For example, residents receiving reablement are achieving independence on average three days faster, and annual reviews for adults with learning disabilities now result in outcomes that are 24% more independent. Staff are also benefitting from clearer processes, supported by an improved data and performance infrastructure. Financially, the service is on track to achieve £24.8 million in savings.

The council has become a thought leader in prevention, adopting new ways of thinking and working that directly align with its strategic priorities: supporting those most in need, and innovating service delivery to make the best use of scarce resources.

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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.

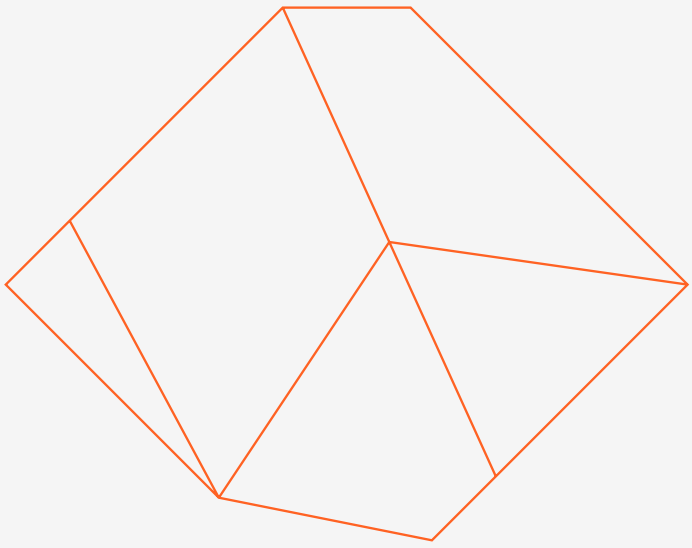
The publication of the Fuller Stocktake Report in 2022 provided an early vision for the reorientation of health and care in Birmingham towards more proactive, personalised services by building 'Integrated Neighbourhood Teams' (INTs).

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.

‘Empowering Lewisham’: An evidence-based approach to adult social care delivery and council change

Providing consistent, fair access to outstanding tailored adult social care and support for residents in need while becoming more financially sustainable.

Achieving ambitions for residents while becoming more financially sustainable

Lewisham Borough Council’s adult social care service aims to provide consistent, fair access to outstanding tailored care and support for their residents in need. At the same time, like many other authorities, it is facing significant financial pressure. Over the past three years, Lewisham’s community services expenditure has increased by approximately £10m. Therefore, they decided to embark on the Empowering Lewisham programme with the objective of identifying opportunities to achieve their ambitions for residents while becoming more financially sustainable.

Identifying opportunities to achieve their ambition

The Empowering Lewisham programme started with a comprehensive, evidence-based diagnostic.

The diagnostic involved engaging with over 100 practitioners from 12 disciplines to review more than 100 active cases in multi-disciplinary team review workshops, to understand the opportunities to achieve more independent outcomes for people. This was supported by analysis of millions of data points from the case management system, to understand baselines, trends, patterns, and variation.

Considerable time was also spent directly at the frontline with staff, shadowing activity and ways of working, to develop an understanding of processes and barriers, as well as the team culture and environment for change.

Delivering and sustaining the change

Based on the findings from the diagnostic, a plan was created to transform practice, processes, and ways of working across adult social care. This involved supporting frontline practitioners with better practice and processes; improving the efficiency and effectiveness of enablement services; and redesigning progression and next steps for adults with learning disabilities.

Enabling lasting change

The programme has embedded a more evidence-based approach to service delivery and change, and the focus on achieving the most ideal outcomes for individuals is driving continuous improvement across the service. This was supported by a structured programme of learning and development for staff, including several colleagues who were seconded, full time, to form a joint programme team. By upskilling these individuals, the Council has been able to take core learnings from ‘Empowering Lewisham’ and apply these across other change programmes. They have also been able to establish consistent governance which ensures alignment in approach and continuous improvement.

OUTCOMES

52

fewer people require long-term residential or nursing support and approximately 4,000 fewer hours of commissioned care are required each week, as residents are living more independently.

315

additional people are benefitting from the enablement service each year, and the number of individuals being delayed leaving the service has reduced by half.

LESS THAN HALF

of residents go straight to a long-term placement on discharge from an acute hospital.

12

individuals with learning disabilities have moved to more independent settings and a further 19 are living more independently in their existing setting, because staff have been working with them in a tailored way to maximise what they are able to do for themselves.

£8.6M

The Empowering Lewisham programme has, and continues to achieve, better outcomes for residents. It is also on track to deliver in excess of £8.6m in annualised financial benefit.

Reducing homelessness in Maidstone

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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
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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 our partnerships work with the sector.

We're currently working on a research programme with the Society of County Treasurers and the County Councils Network exploring how, in the context of children's social care reform, local area partners can best work together to move towards an end-to-end system of preventative and rehabilitative services that keep children with their families.

With Partners in Care and Health and NHS Providers, we are also bringing together our skills and experience to offer 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.

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 life long disabled adults
- Analysing the impact of Local Government Reorganisation on people services
- 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
- Future of children's services
- Demand and capacity of homes for children in care
- Unlocking prevention in Integrated Care systems

We also continue to deliver the 'ADASS Accelerate' social care leadership programme and our 'Children's Change Leadership Programme' (CCLP). We have also recently launched 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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CONTACT US

Steve Knight
Partner

E: stephen.knight@newtonimpact.com

Ruth Morgan
Partner

E: ruth.morgan@newtonimpact.com

Danny Sperrin
Partner

E: daniel.sperrin@newtonimpact.com

Wajid Shafiq
CEO - Xantura

E: wajid.shafiq@xantura.com

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