

Bridge Back Home project impact review

MARCH 2025

always possible

CONTEXT

The Bridge Back Home (BBH) service is delivered by Bridge Support, providing community-based support to help individuals transition safely from hospital to home. Initially commissioned by Oxleas NHS Foundation Trust and now by the Royal Borough of Greenwich, the service is funded through non-recurrent allocations from the Market Sustainability and Improvement Fund and the Adult Social Care Discharge Fund. Current funding is due to expire at the end of March 2025.



The aims of the Bridge Back Home project are multifaceted, primarily focusing on supporting residents of the Borough of Greenwich with mental health challenges to leave hospital and live independently.

Service offer:

Supporting discharge alongside clinical, Home Treatment, and mental health liaison teams

intensive social care support to individuals in crisis

up to 12wks support at home

BBH aims to provide ongoing support at home for up to 12 weeks to give clients the best opportunity for recovery.

improve patient experience

reduce hospital readmissions

RESEARCH METHODOLOGY

Louis Childs and Richard Freeman from independent consultancy always possible led a review of the BBH programme between January and March 2025. A structured, multi-phased approach was used to evaluate the impact and effectiveness of BBH.

This included:

PHASE ONE: DATA COLLECTION

surveys sent to stakeholders to gather feedback on impact and effectiveness

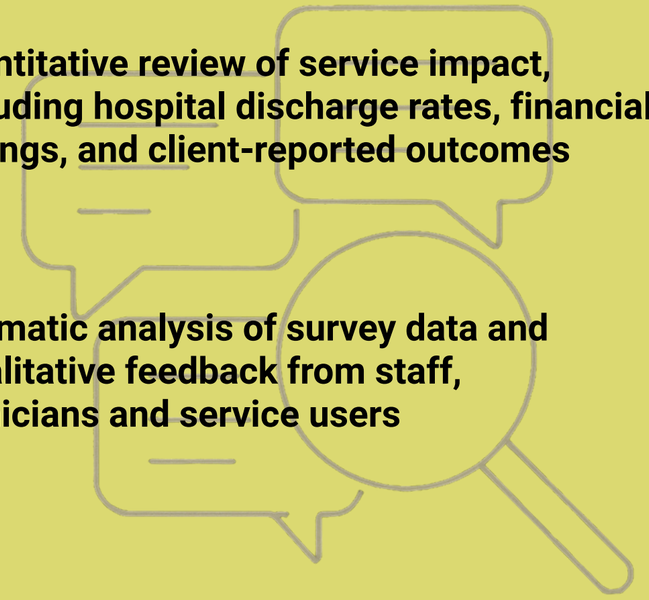
user interviews conducted with BBH service users

review of existing data and evaluation reports

PHASE TWO: DATA ANALYSIS

quantitative review of service impact, including hospital discharge rates, financial savings, and client-reported outcomes

thematic analysis of survey data and qualitative feedback from staff, clinicians and service users



PHASE THREE: DEVELOPMENT OF RECOMMENDATIONS

mapping findings against BBH objectives to assess success in reducing hospital stays and improving independent living outcomes

identifying key areas for improvement and sustainable growth strategies

preparing a counter-narrative to address any challenges in demonstrating the preventative impact of the service

REVIEW OBJECTIVE

Objective:

To evaluate the impact of the **Bridge Back Home** service in reducing unnecessary hospital stays, improving patient experience and supporting independent living.

Key aims:

- assess how BBH helps individuals transition from hospital to home
- measure patient satisfaction and long-term well-being outcomes
- identify financial and system-wide benefits of reducing hospital admissions
- inform future service development and funding decisions

This review will cover the period from April 1st 2021 to 30th September 2024



SUMMARY OF OUR FINDINGS

Following objective analysis, we have concluded that Bridge Back Home is delivering proven, **cost-effective**, and **life-changing support** to individuals with mental health challenges.

By preventing unnecessary hospital stays and **empowering individuals** to live independently, BBH is not only **enhancing patient well-being** but also generating **significant financial savings** for the healthcare system.

For the period of evaluation from April 1st 2021 to 30th September 2024, BBH has **successfully discharged 912 service users into independent living**, achieving an 85% success rate.

The service has prevented unnecessary hospital stays, **reduced pressure on emergency services**, and saved the healthcare system up to **£8.7 million** in avoided inpatient care costs. Feedback from clients highlights the personal and social benefits of BBH's support, with **95% expressing satisfaction** with the service and its impact on their quality of life.

BBH has demonstrated its value, but **continued investment** and strategic scaling are **essential to sustain** and expand this impact. By strengthening data collection, securing long-term funding, and broadening service delivery, BBH can continue to **transform lives** and drive systemic improvements in mental health care.

912
successful discharges

£8.7M
saved in avoided inpatient costs

95%
satisfaction rate from service users

INTRODUCTION: BRIDGE BACK HOME

THE CHALLENGE:
Breaking the cycle of hospitalisation

Many individuals experiencing a mental health crisis remain in hospital longer than medically necessary due to social, financial and housing barriers.

These prolonged stays can negatively impact recovery, increase the likelihood of relapse and contribute to systemic inefficiencies. BBH was established to bridge this gap by providing holistic, person-centred support, enduring that individuals receive the non-clinical assistance they need to transition home successfully.



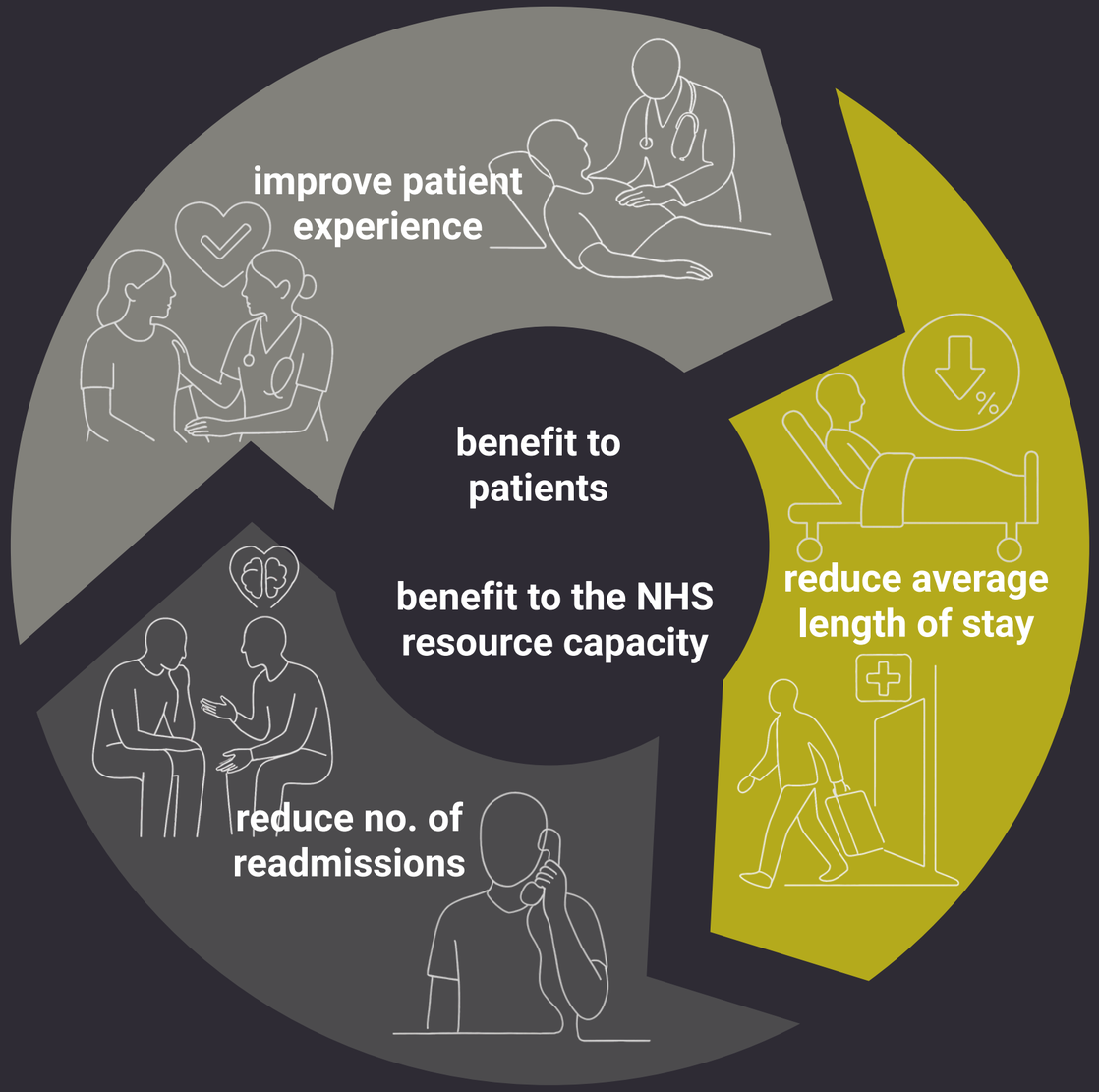
HOW THE SERVICE IS FUNDED

The service was funded through the **Market Sustainability and Improvement Fund 2023-2024** and the **Adult Social Care Discharge fund via RBG from July 2023**.

- **Funding until March 31st, 2024:** £330,000 per annum
- **Funding increase request:** An additional £27,000 was awarded, bringing the total to **£357,000** to meet the London Living Wage from April 2024
- **Funding expiry:** March 31st 2025
- **Current status:** Funding is non-recurrent, requiring sustainable long-term investment to ensure continuity of service



BRIDGE BACK HOME: THREE OBJECTIVES



PRACTICAL SUPPORT: ENABLING INDEPENDENCE

Bridge Back Home provides hands-on, practical support to help individuals transition successfully from hospital to independent living.

This includes:

SUPPORT TO APPOINTMENTS



GP / hospital
dentist
probation
job interview
WDP / DWP
Police

(BBH do not act as appropriate adult)

FINANCIAL & ADMINISTRATIVE SUPPORT

benefit forms
freedom pass applications
job applications
essential bills
(gas, electricity, water)



HOUSING ASSISTANCE



rent
council tax
housing benefits
bills
repairs / cleaning
hoarding
anti-social behaviour
issues

PRACTICAL SUPPORT: ENABLING INDEPENDENCE

SOCIAL AND EMOTIONAL SUPPORT



One-to-one check-ins and emotional support to help clients rebuild confidence and stability

SIGNPOSTING TO COMMUNITY SERVICES

UK MEN'S SHEDS

Recovery College

HER CENTRE®

WDP

Connecting clients with organisations and services e.g. victim support, befriending services and local FE college courses

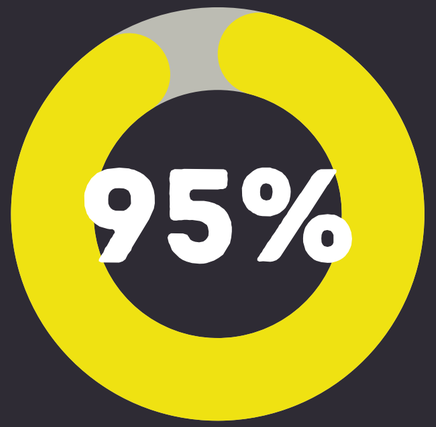
FACILITATING COMMUNITY ACTIVITIES



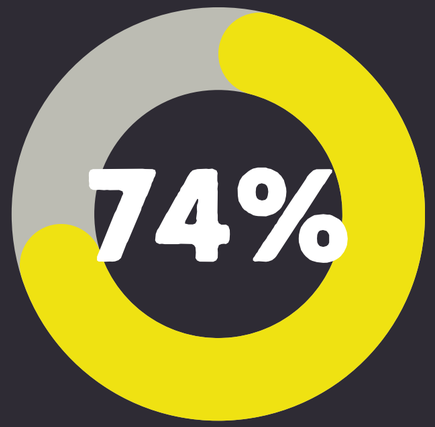
Encouraging participation in exercise, swimming, cinema outings and social lunches to develop sense of inclusion and well-being

IMPROVING PATIENT EXPERIENCE

BBH empowers service users by addressing their unique barriers to independent living.
Survey results show:



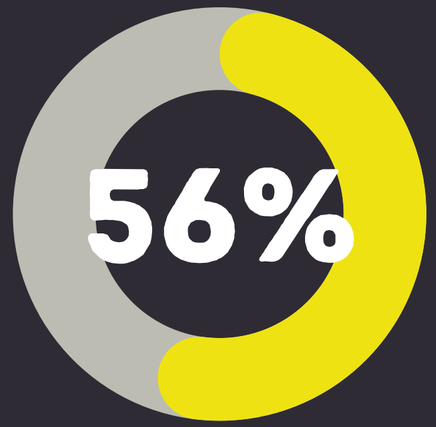
satisfaction rate among clients



reported improved mood after receiving support



noted an enhanced quality of life



saw improvements in mental health



reported increased ability to self-manage their condition

All above based on 32% of clients discharged between February - June 2024

IMPROVING PATIENT EXPERIENCE

BBH provides **tailored interventions** to meet each client's unique needs, ensuring they receive the appropriate level of assistance. The service plays a crucial role in supporting emotional well-being by offering **continuous reassurance**, guidance and **practical support**, that enables clients to regain confidence and stability.

It also helps individuals navigate complex bureaucratic systems, assisting with benefits applications, housing support and financial stability. By **encouraging social engagement** and participation in community activities, BBH fosters integration and resilience, helping **reduce social isolation**.

Furthermore, BBH takes a **proactive approach to crisis prevention**, identifying potential triggers early and working with clients to develop strategies that prevent hospital readmission.



CASE STUDY

USER A



HOUSING SUPPORT | **WEEKLY APPOINTMENTS** | **GUIDANCE & SUPPORT**

User A accessed Bridge Support in 2023 after experiencing multiple challenges including workplace bullying, financial exploitation and burnout. These issues, combined with long-standing mental health difficulties, led to job loss and isolation.

Seeking an alternative to traditional talking therapy with long waiting lists, ***User A*** decided to reach out for support. ***User A's*** involvement with the project began with an introductory course designed to assess whether the service was a good fit. The service offered guidance and practical support.

When ***User A*** encountered a housing crisis, a BBH staff member provided access to a list of private landlords willing to rent to those on Universal Credit, and worked with them to secure a new property.

User A reported that the intervention allowed them to see beyond their immediate difficulties and consider future work opportunities at a pace suitable for their condition. The consistent weekly meetings were cited as key in preventing further deterioration of mental health and reducing the need for emergency intervention.

> ***I looked online to see if there was anywhere for support... and that's when I came across bridge support. Weirdly, I got through to support in another location, but they brought me back to bridge support Greenwich, who I then contacted. And I'm so glad I did the best thing I ever did, and I'd be in a lot worse situation now, if it wasn't for them.***

> ***I definitely can see a future. Even with my mental health challenges, I can see that it doesn't have to define me and to have full control over me***



CASE STUDY

USER B



FACE-TO-FACE SESSIONS | WEEKLY APPOINTMENTS | LEARNING & TRAINING

User B came into contact with BBH in May 2022 following a suicide attempt. Initially referred by the Home Treatment Team, their support journey began after receiving support for poor mental health at Oxleas House. ***User B*** had experienced significant challenges with social isolation, communication difficulties and severe anxiety.

After the initial crisis, ***User B's*** support worker visited during their stay at Oxleas and identified areas for support, particularly in social skills and confidence.

> ***"It literally helped in all areas, but I'd say probably more my social skills, really, because I'd stopped talking, I'd pretty much stopped eating, and just felt completely lost..."***



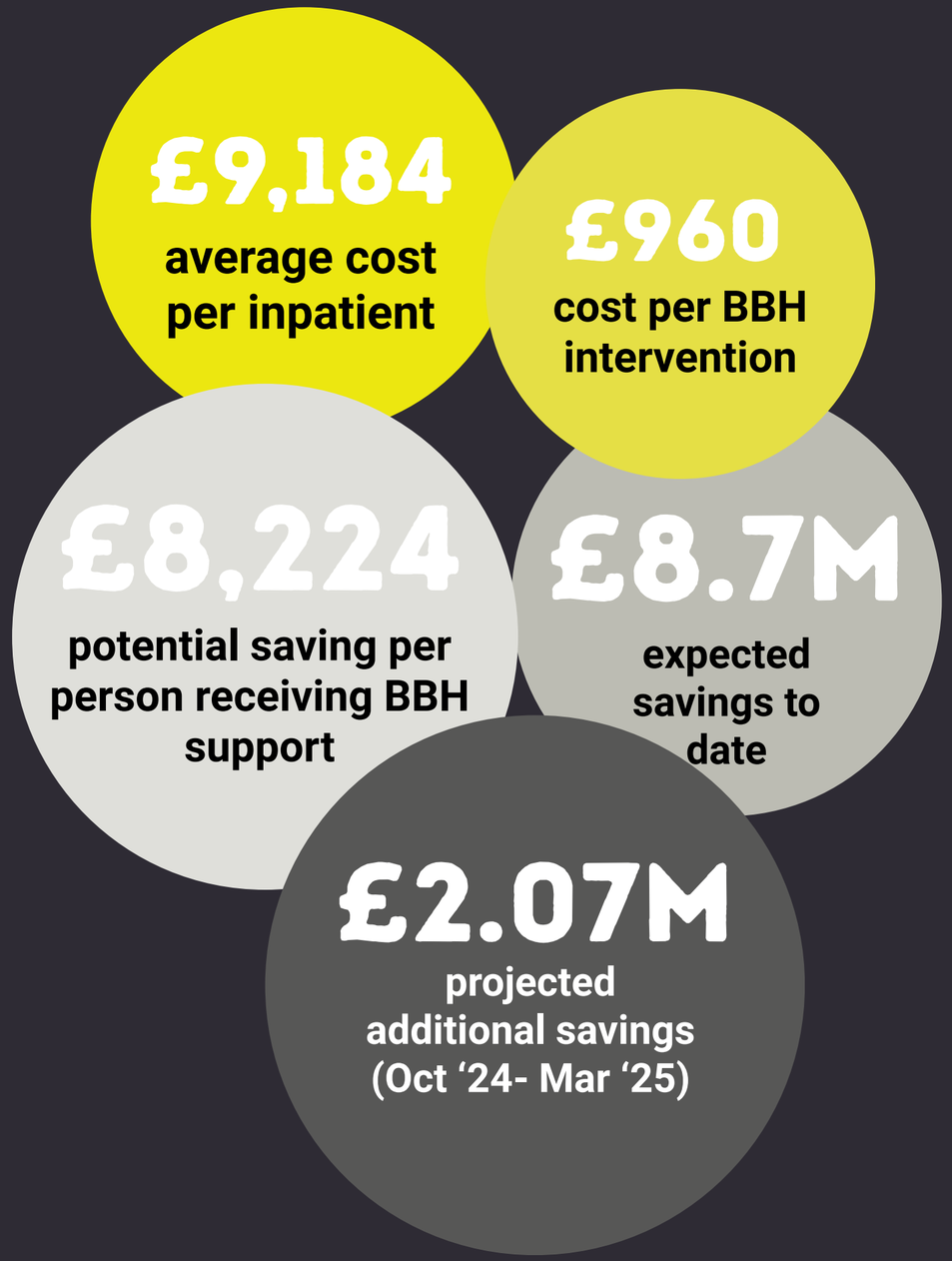
The support plan centred on regular, face-to-face sessions once they had left hospital. Beginning with short walks and gradually building in duration and complexity — from 10-minute strolls to café visits, and eventually bus journeys and other public outings. This approach aimed to rebuild confidence and strengthen communication.

User B also joined the Bridge Recovery College, complementing the practical work with additional peer support. They highlighted that weekly contact with a support worker provided both structure and a reliable point of contact during periods of heightened anxiety.

Over time, the intervention led to noticeable improvements in ***User B's*** communication and social confidence. The continuity of support — including a transition into longer-term therapy and participation in the recovery college as both a learner and peer trainer — helped to reinforce their progress.

> ***"Within two weeks... they offered weekly support where I would physically see them... if I needed them, or I wanted to query something... I had something that was more regular, which is what I needed."***

FINANCIAL AND SYSTEM-WIDE BENEFITS



The financial case for BBH is clear. The average cost of an inpatient stay is **£9,184** per patient, while the cost of BBH intervention is £960 per client. This represents a potential cost saving of **£8,224** per person receiving BBH support.

To date, BBH expected to have generated **£8.7 million** in savings by preventing prolonged hospital stays. These savings **directly benefit** the wider health and social care system by **freeing up clinical capacity** and reducing strain on emergency services.

With projections indicating an additional **£2.07 million** in savings between October 2024 and March 2025, BBH continues to demonstrate its economic value and cost-effectiveness.

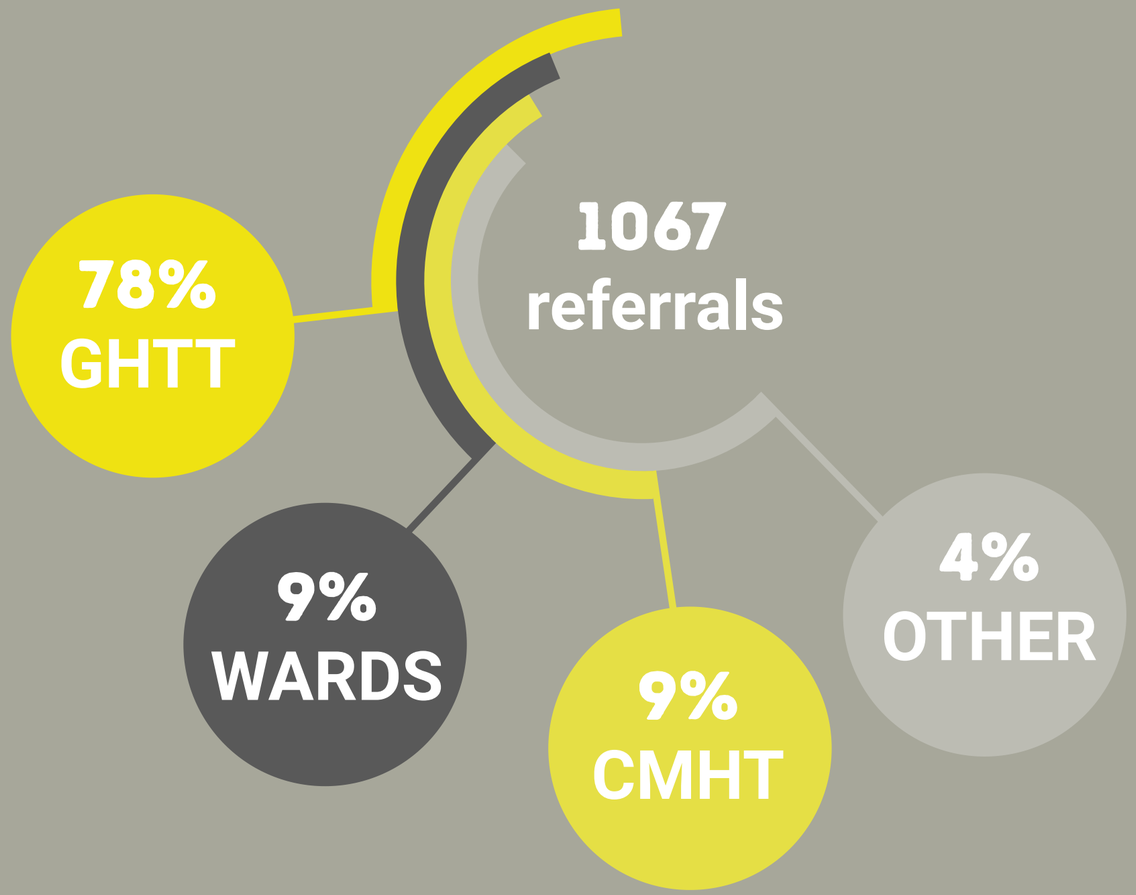
REDUCING HOSPITAL ADMISSIONS & LENGTH OF STAY

BBH has significantly reduced unnecessary hospital stays by providing the right support at the right time. **The service has facilitated 912 successful discharges from the Bridge Back Home service to independence**, ensuring individuals can safely reintegrate into their communities with the necessary practical and emotional support.

By addressing key social factors that contribute to prolonged hospitalisation — such as housing insecurity, financial instability, and lack of community connections — **BBH has helped reduce pressure on inpatient services.**

Since 1st July 2023, **no readmissions** have been reported for clients supported by BBH, suggesting a significant impact of the service in preventing relapse and crisis in the last six months of the evaluation period.

The ability of BBH to provide structured, responsive, and ongoing support has been demonstrable in reducing the demand for emergency mental health services.



referrals to service

MEASURING THE PREVENTATIVE IMPACT OF BRIDGE BACK HOME

Challenges in measuring prevention
Measuring the preventative impact of the BBH service presents challenges, as much of the available data focuses on hospital discharge rather than crisis prevention.

Preventing hospital admissions is inherently more difficult to track, as it involves identifying individuals who might have required inpatient care had they not received early intervention. Without a clear system for measuring these outcomes, the full scope of the service's benefits may not be fully captured.

Role of Home Treatment Team referrals (HTT)
Referrals from the HTT serve as a key touchpoint in evaluating crisis intervention. These referrals provide insight into individuals who require support before their situation escalates to the point of hospitalisation.

However, relying solely on these referrals may not fully capture the benefits of the service, as individuals who have already been admitted and reached crisis point would also benefit from the service. Increasing the referrals from wards is something the Bridge Support team have been working on.



MEASURING THE PREVENTATIVE IMPACT OF BRIDGE BACK HOME

To better demonstrate the full value of the service, additional metrics should be developed to measure the effectiveness of early intervention.

RECOMMENDATIONS



Strengthening data collection methods to track individuals who avoid crisis due to Bridge Back Home support will be essential.



Working closely with Home Treatment Teams to refine referral tracking and outcomes could provide deeper insights into the service's preventative impact.

Further refinement of evaluation methods is required to fully capture the value of crisis prevention and early intervention. By **improving data collection** and measurement strategies, Bridge Back Home can continue to **demonstrate** its **impact** in reducing hospital stays and preventing mental health crises, ultimately strengthening its role as a key component of community-based mental health support.

SERVICE USER TESTIMONIALS

I didn't know how I would cope when I left the hospital, but BBH made the transition manageable. The support with my finances and housing was life-changing

The Bridge Back Home service gave me hope again. They were always there, checking in, making sure I was okay. I can't thank them enough for the kindness they have shown

I would like to say how much the Bridge team have helped me so much. My support worker has been a moral support for me in all ways when I have been so low and had no one else to talk to

BBH isn't just a service; it's a lifeline. The support team helped me regain control over my life and avoid another hospital stay

Bridge Back Home made sure I had everything I needed to transition home. They even helped me sort out my benefits and get back on track with my finances

PROFESSIONAL TESTIMONIALS

There have been tremendous satisfactory feedbacks from our patients. Many of our patients had been granted both temporary accommodations and permanent accommodation, moved from debilitating houses to a better place, and successfully sorted out their financial situations

— Greenwich Home Treatment Team Staff Member

Your team has always been there to support our patients around their social needs, which is usually either a trigger for relapses or a perpetuating factor for their illness. Without BBH, it would have been extremely difficult to discharge and move patients on effectively

— Consultant Psychiatrist, Greenwich Home Treatment Team

Since Bridge Back Home has been supporting HTT, I have found the quality of holistic care being offered to service users improving significantly

— Mental Health Social Worker, Greenwich Home Treatment Team

DESIGNING AN HIGH IMPACT PERSON-CENTRED SERVICE

service design approach

A person centred service must be shaped around real user needs. This demands a co-design approach, involving stakeholders at every level to build shared ownership and ensure alignment with lived experiences.

Using systems thinking helps organisations engage stakeholders across the entire service spectrum, ensuring a joined-up, holistic approach. When users are at the centre of design, services become more effective, sustainable, and responsive to change.

iterative development & learning

A test-and-learn mindset is key to continuous improvement. By experimenting, refining, and iterating based on real-time feedback, organisations can adapt more effectively.

Working in the open — through transparent communication and shared learning — supports collaboration and drives innovation. Prioritising user needs over assumptions keeps services relevant and resilient.







DESIGNING AN HIGH IMPACT PERSON-CENTRED SERVICE

building the foundations for success

By embedding these principles, organisations can build sustainable services that meet user needs and drive system-wide improvement.

Person-centred services grow from the right blend of organisational culture, robust service design, and iterative learning.



organisational culture

A strong organisational culture underpins impactful services. This means fostering trust, empowering teams, and promoting transparency.

Organisations that encourage open dialogue and challenge convention are better equipped to evolve. When teams feel confident questioning assumptions and proposing ideas, services are more likely to respond to real-world needs.



KEY DEPENDENCIES FOR SCALING

For the BBH service to scale effectively, several key factors must be addressed. One of the primary enablers of scaling is the **strength of relationships** with ward teams.

The recent increase in ward referrals demonstrates the **effectiveness of** these **partnerships** and highlights the potential for further expansion. **Strong collaboration** with ward teams will be crucial in ensuring the sustainability and continued impact of the service. However, scaling beyond the current framework is challenging.

The Housing Department in Greenwich has a core focus on reducing homelessness, which may make it more difficult to establish meaningful partnerships with other teams that do not directly align with this priority. Engaging new stakeholders and building trust with a wider range of teams will require a strategic approach.

> ***Test it. Fix the problems. Change the design. Test it again. Tweak it again. And so on for as long as you provide the service. Suddenly, the most important question isn't 'how do we get this right first time?' it's 'how do we make this better by next Friday?'***

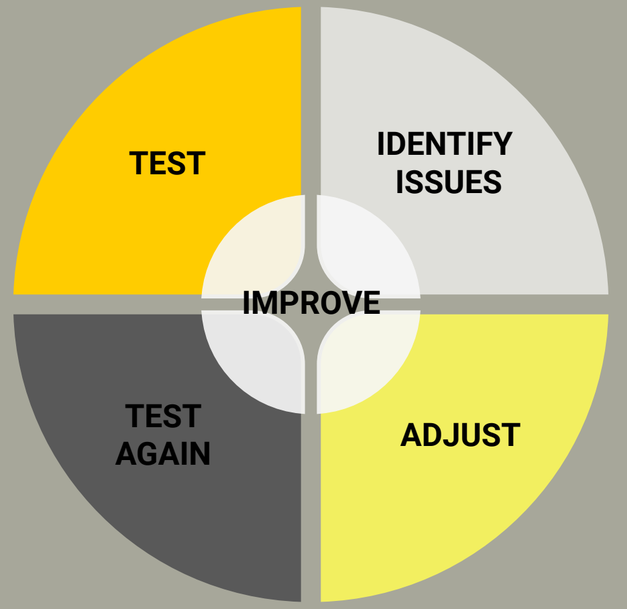
Rt Hon Pat McFadden MP, Minister for Intergovernmental Relations of the UK

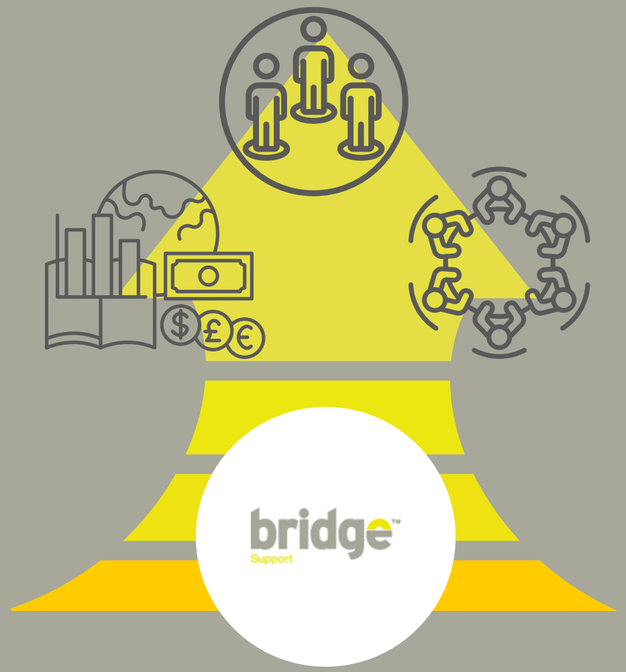


INNOVATING BRIDGE BACK HOME: WHERE NEXT?

Continuous improvement

Innovation is a continuous process of refinement. As Pat McFadden suggests, a ‘start-up culture’ in public services is not about getting everything right the first time. It’s about **testing**, fixing issues, **adjusting**, and testing again—ultimately leading to bigger, **longer-lasting rewards**.
The emphasis moves away from initial perfection and towards meaningful, week-by-week improvements. This **iterative approach** allows the service to evolve in response to **real-world challenges** and insights.





Scaling the service

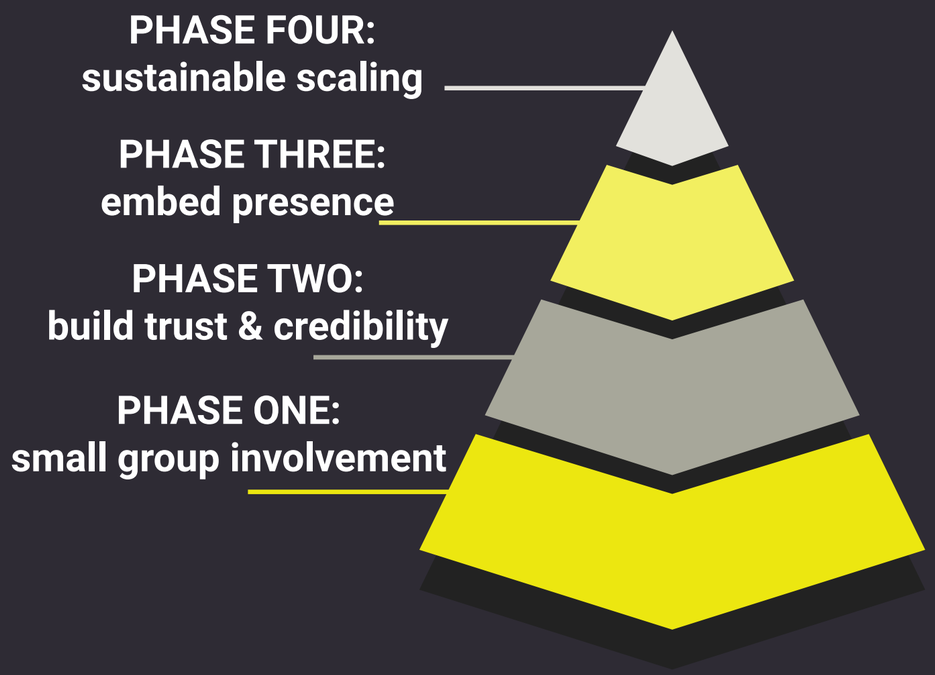
Bridge Back Home is currently running as a pilot, with **potential for wider rollout**. Scaling successfully depends on key factors like **funding**, **operational capacity**, and **stakeholder engagement**. A clear understanding of these dependencies is crucial to ensure growth is both sustainable and maintains the service’s quality and impact.

INNOVATING BRIDGE BACK HOME: WHERE NEXT?

Key relationships and challenges

A strong relationship with ward teams has been central to the service's success, reflected in the recent rise in ward referrals. However, expanding beyond these teams presents challenges. For instance, Greenwich's Housing Department prioritises reducing homelessness, making collaboration harder with teams whose priorities differ.



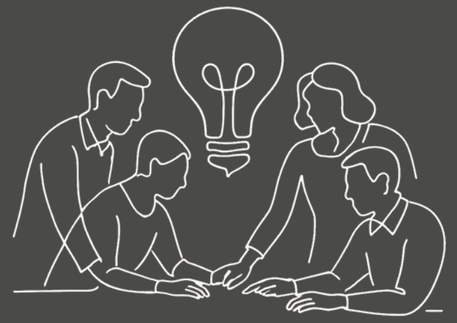


Test and learn approach

A measured, **phased approach** is vital for building trust and embedding the service effectively. Starting small (but not too small) ensures visibility and credibility without risking being overlooked. Involving a small group of staff initially helps **build trust**, **demonstrate value**, and lay the foundations for long-term scaling. Embedding a consistent presence on wards and with key teams will be critical to sustaining the service's impact. Through **continuous iteration** and **strong, strategic relationships**, the BBH service can grow in a **scalable** and **sustainable** way, ensuring more individuals benefit from its support.

RECOMMENDATIONS

REFINING DATA COLLECTION & IMPACT MEASUREMENT



Develop metrics to track crisis prevention and early intervention impact

Collaborate with Home Treatment Teams to assess the likelihood of hospitalisation without BBH support

SECURING SUSTAINABLE FUNDING



Engage with NHS Trusts, local authorities, and social care commissioners to establish longer-term financial backing

Explore integration into standard mental health service commissioning pathways.

EXPANDING THE SERVICE



Consider replication of BBH in other boroughs or NHS Trusts

Pilot new models of intervention such as expanded out-of-hours support

CONCLUSION

Bridge Back Home is delivering **proven**, **cost-effective** and **life-changing support** to individuals with mental health challenges.

By preventing unnecessary hospital stays and empowering individuals to live independently, BBH is not only **enhancing patient well-being** but also generating significant financial savings for the healthcare system.

The service has **demonstrated its value**, but **continued investment** and **strategic scaling** are needed to ensure its long-term sustainability.

By strengthening data collection, **securing funding** and **expanding service delivery**, BBH can continue to transform lives and drive systemic improvements in mental health care.



APPENDIX 1

Community-led health support models in the UK – wider evidence of benefits

Community-led health support models are non-clinical interventions that mobilise community resources and peer support to improve health and well-being.

In the UK, approaches such as social prescribing, peer support networks, recovery colleges, and community mental health hubs have shown improved patient outcomes, enhanced well-being, and reduced strain on clinical services. This summary outlines different models, case examples, and key considerations.

1. Social prescribing

Social prescribing links patients — often via a link worker in GP practices — to local non-medical services (for example, exercise classes, social clubs, welfare advice, or volunteering). This approach improves psychosocial health and reduces unnecessary use of clinical services by addressing loneliness, lifestyle, and other social issues.

- ***Improved well-being:*** In one large pilot, 83% of patients reported a positive improvement in at least one well-being outcome within a few months of engaging with social prescribing.^1
- ***Reduced healthcare usage:*** Evaluations in areas such as Rotherham and Kirklees demonstrated significant reductions in hospital admissions, A&E attendances, and GP appointments after patients engaged with social prescribing.^2,3
- ***Resource savings:*** The Rotherham programme, for example, reported an estimated reduction in hospital costs and a promising return on investment.^4
- ***Case example: Rotherham*** - this flagship service supported over 1,600 patients, with tangible improvements in well-being and reduced service use.^1,4

2. Peer Support Networks

Peer support involves individuals with lived experience of a health problem supporting each other, either one-to-one or in groups. Examples include mental health peer groups and support groups for chronic illnesses.

- ***Enhanced mental health and recovery:*** A major review covering hundreds of studies found robust evidence that peer support aids recovery from mental illness, reduces depression, and improves self-confidence.^5
- **Improved self-management and social connectedness:** Evaluations of programmes such as Mind’s "Side by Side" reported that participants experienced increased hope, confidence, and social connections.^6

APPENDIX CONT...

- ***Reduced reliance on formal services:*** Evidence suggests that effective peer support can result in fewer visits to health professionals and reduced pressure on clinical services.^6
- ***Case example: peer support in mental health*** - initiatives such as “Auntie Pam’s” in Kirklees and mutual aid groups in addiction recovery demonstrate positive outcomes through shared experiences and practical support.^5

3. Recovery Colleges

Recovery Colleges are educational programmes run by NHS mental health trusts in partnership with patients, focusing on teaching skills for self-management and recovery.

- ***Personal recovery and quality of life:*** Data show that participants report improved quality of life, increased hope, and a reduction in self-stigma after attending courses.^7
- ***Reduced clinical service use:*** Studies, such as one from Sussex Recovery College, found that participants experienced fewer psychiatric hospitalisations and reduced service contacts after enrolment.^7
- ***Cost savings:*** The reduction in service use may result in significant cost savings per participant over time.^7
- ***Case example: Nottingham Recovery College -*** this established college has reported that participants felt more empowered and experienced a decline in crisis service usage following their courses.^7

4. Community Mental Health Hubs

Community mental health hubs or wellbeing hubs provide a one-stop shop for mental health support in a local area. They integrate services across the NHS, local authorities, and the voluntary sector.

- ***Earlier access and prevention:*** In Lambeth, the Living Well Network Hub handled over 1,200 referrals within its first few years, with many referrals coming from individuals not previously known to specialist mental health services.^8
- ***Reduced pressure on secondary care:*** Models in Lambeth and Wirral have shown reductions in referrals to secondary mental health teams and fewer A&E attendances as crises are managed at the community level.^8
- ***Improved patient outcomes:*** Users report being treated “as a person, not just a patient” with improvements in overall well-being and social functioning.^9
- ***Resource and cost efficiency:*** Integrating services has allowed local authorities to reallocate funds from expensive acute care to community support, with estimates of around 20% cost savings compared to previous spending.^8
- ***Case example: Lambeth Living Well Network*** - this hub demonstrated a significant reduction in secondary care referrals and effective reinvestment of savings into community care services.^8,9

APPENDIX CONT...

Challenges and implementation considerations
While the benefits of these community-led models are clear, several challenges must be addressed to ensure their success:

- ***Sustainable funding and scaling: m***any programmes begin as pilots and require robust, long-term funding. Demonstrating cost-effectiveness is key to securing ongoing investment.^10
- ***Integration with traditional services:*** successful models need clear referral pathways and collaboration with clinical services. Building trust between GPs and community programmes is essential.^10
- ***Training and quality assurance:*** even non-clinical roles require training and supervision to ensure high-quality support. Guidelines and ongoing support for community volunteers are crucial.^5
- ***Measuring outcomes:*** traditional health metrics may not fully capture improvements in well-being, social connectedness, and empowerment. Developing appropriate evaluation methods remains a priority.^10
- ***Community capacity and equity:*** these models depend on the availability of community resources. Ensuring equitable access in deprived or rural areas may require additional community development initiatives.^10
- ***Cultural change:*** transitioning to community-led care involves significant shifts in mindset among traditional health professionals. Clear communication and co-production with service users can facilitate this change.^10

Footnotes

1. Public Health England – *Health Matters: Community-centred approaches*.
2. Rotherham Social Prescribing Pilot – Evaluation by Sheffield Hallam University.
3. National Academy for Social Prescribing – Impact case studies (e.g. Kirklees).
4. Economic analysis of the Rotherham programme – NHS England reports.
5. NIHR review of peer support in mental health – UCL/KCL 2024.
6. Mind charity – *Side by Side* peer support programme evaluation.
7. Sussex Recovery College study – Published in the Journal of Mental Health.
8. Lambeth Living Well Network – Local Government Association case report.
9. Community mental health hubs – Outcomes reported from Lambeth and Wirral initiatives.
10. General challenges and implementation considerations – Public Health England and other national reports.