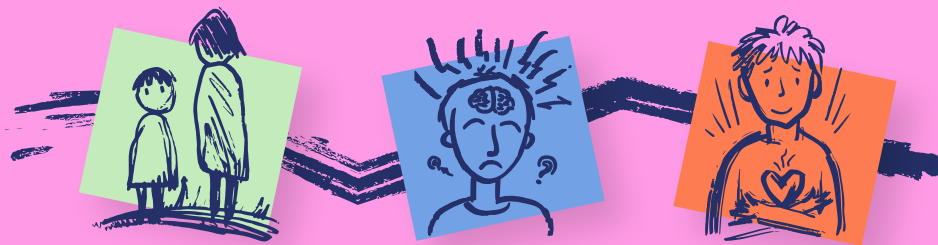


CREATING THE CONDITIONS FOR PEOPLE TO COME HOME AND STAY HOME

Bringing together health, social care, housing and community support in a way that works around the person, not the system.



At Catalyst Care Group, we have always believed that supporting someone to leave hospital is not a moment in time.

It is a process.

One that is often complex, sometimes fragile, and always shaped by relationships, trust and the conditions we create around a person.

Too often, discharge is treated as an endpoint. In practice, it is where the real work begins.

If we are serious about reducing unnecessary hospital stays and supporting people to live meaningful lives in their communities, then support cannot start at discharge. It has to start before it and continue beyond it.



That is why we developed our Bridging Support model.

A rights based, person-led approach, shaped through working alongside commissioners, clinical teams and families who are navigating some of the most complex transitions in the system.

Bridging Support

Our focus is to create the conditions for safe, sustainable transitions.

Not just moving someone out of hospital, but supporting them into a life that reflects who they are and what matters to them.

We do this by bringing together health, social care, housing and community support into one coordinated pathway, starting early, maintaining continuity, and deploying experienced transition teams.

Across our work, we have supported over 450 discharges and admission avoidance pathways, with a consistent focus on stability, reduced readmissions, and improved quality of life outcomes.

The Approach

We work within existing governance structures, alongside hospital teams, commissioners and providers, allowing us to deploy quickly and build relationships from day one.



Ward

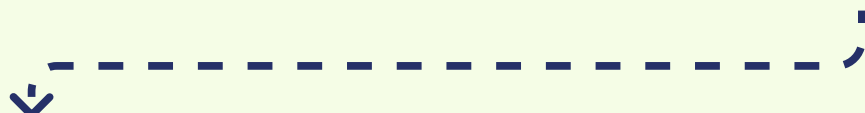
We begin by understanding the person properly. What matters to them, what a good life looks like, and how support should be shaped around that.



We work as part of the system, identifying and shaping housing options that meet the person's needs.



In-Reach



Transition

We stay close during the move, supporting both the person and the team, responding to risk in real time.



Support is front loaded and then gradually reduced as stability grows.



Discharge

Complex Discharge Processes in Practice



Josh's Transition

- Josh had been in hospital for a long time, with previous discharge attempts that had not held.
- Rather than rushing, we took time to understand him properly and worked alongside the clinical team to build a realistic and sustainable plan.
- Housing was shaped around his needs, and a consistent team was built with a focus on relationships as well as skills.
- We remained closely involved during transition, supporting the new team and responding to emerging risks.
- As stability grew, we stepped back gradually.
- Josh now lives in his own home with a team who understands him.



Lisa's Transition

- Lisa had also experienced a long hospital stay with high levels of perceived risk.
- We worked alongside commissioners and clinical teams to strengthen existing plans, focusing on coordination and continuity.
- Time on the ward helped ensure the transition felt like a continuation rather than a sudden change.
- Housing and team development were carefully shaped around Lisa.
- We remained involved through stabilisation before stepping back.
- Lisa now lives in the community with support aligned to her needs.

Working Together

We have designed this model intentionally to create the right conditions for people to move forward and remain in their communities.

If this reflects the challenges you are working through, we would welcome a conversation about how we can support.

CONTACT US 

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