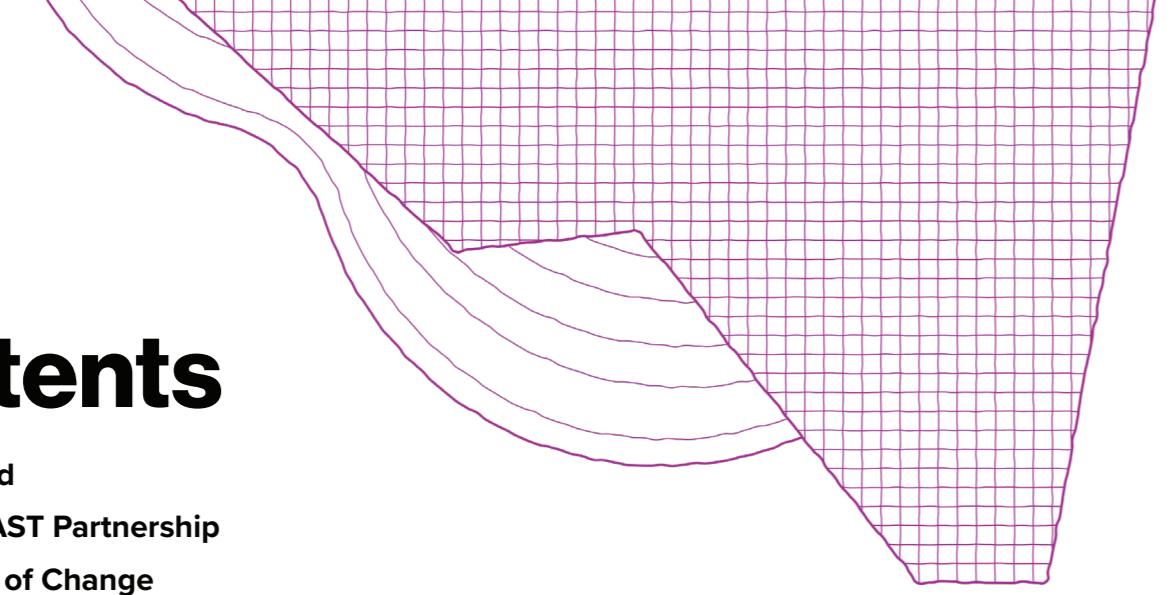


MAST

Multi-Agency-Support-Team

Impact Report 2025





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MAST (Multi Agency Support Team) is an award winning service first mobilised in 2020 and now works across Airedale General Hospital and Bradford Royal Infirmary.

Delivered in partnership between five local charities, MAST is based across both hospitals. The team delivers interventions and health messaging in emergency departments and on some wards to support the system around identified pressure points; alcohol use, mental health, frailty, and social isolation. By identifying patients who would benefit from additional support at all stages of their admissions, from triage to the ward, MAST is able to engage with patients early to take a preventative approach as well as supporting frequent attenders, supporting safer discharges and reducing readmissions.

After discharge patients may be referred to the Community MAST team to for ongoing support. Identifying and removing barriers for ongoing treatment, ensuring needs are met, signposting and referrals to other services and help in accessing long-term treatment.

Forward

MAST (Multi-Agency Support Team) across Bradford district is a truly impressive collaboration, making a profound difference for people accessing hospital services at Bradford Royal Infirmary and Airedale General Hospital. Its model embodies the highest ideals of collaborative, holistic support and is operated through a joint contract by our Voluntary, Community and Social Enterprise Sector (VCSE).

What distinguishes MAST is the way in which its peer support workers and specialist VCSE support organisations come together. Rather than seeing frequent attenders or those with complex needs purely through the lens of clinical symptoms, MAST recognises the fullness of people's lives — the mental health struggles, issues around alcohol use, social vulnerability, frailty, and often co-occurring social determinants. The service doesn't just respond in hospital: it reaches into the community, following up after discharge, helping to bridge the gaps that so often lead to readmissions.

In each hospital's emergency department, MAST provides timely, non-clinical interventions: signposting, referrals, holistic support, and brief interventions that can de-escalate crises, reduce patient distress, and ensure people get to the right support more quickly. By focusing on frequent attenders, MAST eases pressure on A&E resources, enabling staff to concentrate attention where it's most acutely needed.

Another strength is MAST's partnership structure. With different organisations bringing complementary expertise—mental health (The Cellar Trust), alcohol support (Project 6), frailty help (Carers' Resource), specialist social prescribing (HALE & Keighley Healthy Living)—the service is able to offer tailored support that feels relevant and personalised.

Moreover, its outcomes speak volumes. For example, in one year, over 85% of patients reported they did not return to A&E with the same issue.

Finally, MAST also demonstrates an excellent balance of compassion with system-level thinking: reducing emergency department burden, improving discharge and follow-up, enhancing patient experience, and helping ensure that crisis doesn't become the only route to care. I'm a proud supporter and commissioner of MAST across Bradford district.

Iain MacBeath

Strategic Director, Adult Social Care, Health & Housing for Bradford Council and Director of Integration for Bradford District Community NHS Trust

The MAST Partnership

This report highlights the real and lasting impact that MAST has achieved over the past year.

While it focuses on the most recent 12 months, it also reflects on the ethical collaboration and the strength of the voluntary sector that have shaped MAST over the past five years.

We are proud to be part of a vibrant, agile, and deeply rooted network of community organisations. Through partnerships built on shared purpose and trust, the voluntary and statutory sectors can deliver meaningful outcomes and impact for the communities we serve.

We are community rooted

Our deep roots within local communities remain one of our greatest strengths. Through this foundation of trust and connection, we have built strong community relationships and delivered person-centred support that has a visible and lasting impact.

We are uniquely positioned to bridge the gap between statutory services and the voluntary and community sector, helping to create accessible pathways for people who might otherwise struggle to engage with support.

This grounding in local knowledge and community trust has been central to the system change that MAST represents. While our partners have a long history of delivering community-based initiatives, working alongside medical teams through MAST has strengthened social prescribing pathways and deepened understanding of the complex challenges faced by hospital trusts and the people they serve.

We are a partnership

Together, the MAST partners have a proven track record of delivering services that improve health and wellbeing across our communities.

By reducing duplication and improving communication between partners, MAST has created a smoother, more coordinated experience for individuals who might previously have been passed between organisations. It has strengthened our collective ability to reach people earlier, preventing crises and promoting positive, sustainable change.

We have also seen tangible benefits from shared approaches, including joint training and reflective practice. These initiatives have enhanced staff wellbeing, supported professional development, and fostered a shared learning culture across organisations.

We are reducing readmissions

The benefits of MAST are clear. Together, we have developed a holistic and responsive model of care that combines the specialist expertise of NHS colleagues with the flexibility, creativity, and community reach of the voluntary sector. The result is support that feels both professional and human, clinical and compassionate.

Of course, collaboration is not without challenges. Differences in organisational culture, funding structures, and systems can create complexity, and navigating NHS processes can sometimes feel slow for smaller, more agile charities. Ensuring that voluntary sector voices are heard at a strategic level requires ongoing commitment and advocacy.

We remain committed to bridging gaps between systems and sectors, ensuring that every person can access the right support, at the right time, in the right way.

The MAST Partners



Theory of Change



Team Structure and Delivery

MAST (Multi Agency Support Team) brings together specialist workers from the five partner organisations, each contributing unique expertise in addressing the key social factors that often lead to frequent hospital attendance.

By supporting patients both before discharge and in the community, MAST provides continuity of care; offering consistent, person-centred support that helps remove real-world barriers to improved wellbeing.

The Cellar Trust Mental health

Project 6 Alcohol use

Carers' Resource Frailty

HALE Keighley Healthy Living Social prescribing

The team work collaboratively to achieve the following system outcomes:

- Reducing the number of hospital readmissions in 30 days after discharge.
- Identifying and overcoming barriers to engaging with community-based services
- Supporting active engagement in long term community-based support to promote improved wellbeing and reduce hospital admissions.

In the hospital

Within the hospital setting, MAST receives referrals from a range of sources, including clinical teams, ALPS, social workers, BEST, and Virtual Wards.

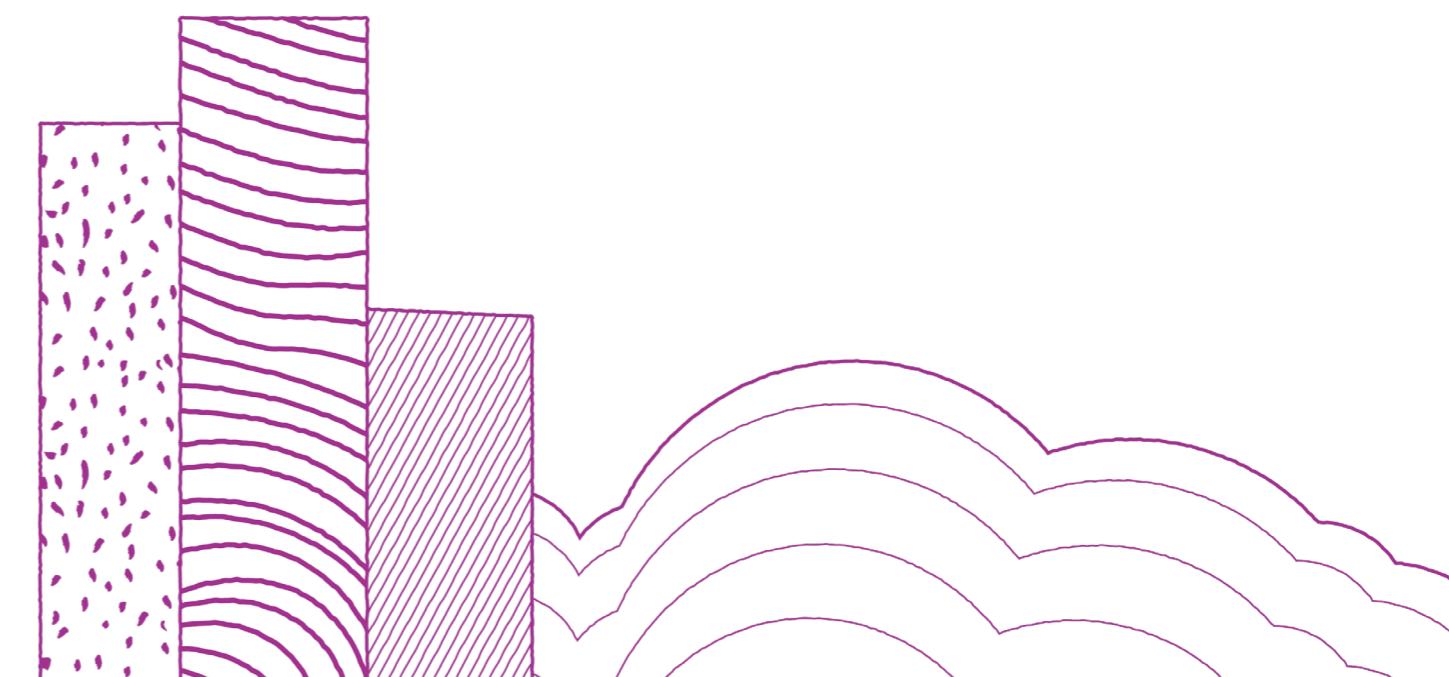
The team works alongside these services to provide wrap-around, multi-agency support for patients.

MAST also contributes to hospital multidisciplinary meetings, where frequent attenders are discussed, ensuring that plans are in place to help individuals manage their needs effectively without recurring hospital visits.

Each referred patient is screened and assessed by a MAST worker according to their main area of need; alcohol use, mental health, frailty, or social prescribing. During this contact, MAST staff deliver evidence-based interventions and, where appropriate, make referrals to community-based support for continued care after discharge.

In the community

Following discharge, the Community MAST Team continues support for patients who have accepted a community referral. The team conducts a comprehensive assessment of need, helping individuals understand and overcome the barriers that may prevent them from engaging in long-term support or treatment.



Outcomes and Impact

This year MAST screened and assessed 3232 patients (1565 BRI & 1667 AGH) and delivered 5866 interventions in hospital.

As patients make repeated visits to hospital, the 3232 patients included some repeat attenders. Patients receive an average of 2.1 Interventions.

In the community

MAST worked with 1100 individual.



Delivering 2132 sessions.



And made 1346 referrals into mainstream services



The service received an average rating 4.9 / 5 form the patients we worked with.



After discharge from the community caseload, we complete a 3 month follow up. One question we ask is 'since we last spoke have you had any hospital admissions due to the area we supported you in?' In the last 3 months

86%

of people contacted said that they had not had any readmissions to hospital since MAST support in the community.

Feeling able to cope

Before the start of support, 43% of people reported that they felt unable to manage their own wellbeing, and only 25% reported that they felt able to do so.

After receiving community support, the percentage of people that feel able to manage their own wellbeing has increased to 69%.

43%-69%

When asked at the start of support whether the person knew about statutory and community services available to them, 65% answered they were not aware or unsure of these services.

After receiving MAST support, 90% of people knew about community services available to them and how to access them.

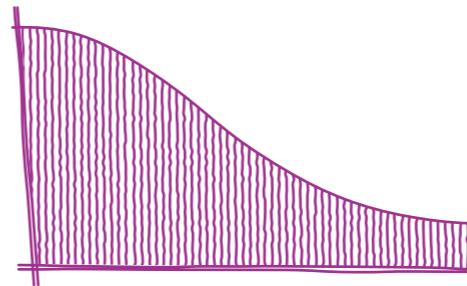
Before accessing MAST community support, 41% of people expressed they were able to seek support independently.

This figure increased to 84% after receiving MAST support.

Feeling able to manage in a crisis

Before accessing MAST community support, 39% of people expressed they had the tools they needed to manage their distress in a crisis.

This figure increased to 83% after receiving MAST support.



People who feel supported by, and connected with their community are more likely to maintain improvements to their wellbeing and less likely to re-attend hospital. The percentage of people feeling disconnected and unsupported after working with MAST has decreased from 51% to 12%, and the percentage of people feeling supported and connected has increased from 24% to 65%.

Promoting improved mental health

In 24-25, the percentage of people who felt they could deal with problems well has increased from 9% before accessing MAST to 68% after accessing MAST services with only 4% of people expressing that they could rarely or never deal with problems well since receiving MAST support.



Return on Investment

As well as improving outcomes for patients, MAST provides significant savings through reduction in readmittance.

In 2021 we calculated a potential cost saving £1,501,644 for 453 worked with reducing admission.

Since 2021 the service has grown. If 946 people identified as frequent attenders reduce their hospital readmissions by 1 in a 12-month period, based on our previous calculations, we estimate the potential cost saving from the MAST team to be

£3,161,481.64

Based on:

- £406 cost of patient admission per day
- £2458 cost of admission via emergency services
- 4.39 days average length of stay for a patient we work with

86% of the 1100 patients we supported in the community did not return to hospital in 3 months = 946

76% of patients we work with come in through emergency services (76% of 946) = 719

Saving on reduced admissions via emergency services - £2458 x 719 = £1,767,302

Saving on length of stay - 3.39 LOS (4.39 – initial night included above) x £406 admission cost per day = £1,376.34

£1,376.34 x 719 = £989,588.46

Total: £2,756,890.46

24% of patients we work with come in through general admission services (24% of 946) = 227

Saving on length of stay - 4.39 LOS x £406 admission cost = £1,782.34

£1,782.34 x 227 = 404,591.18

Total saving per year: £3,161,481.64

Case Studies

Our ward cares for some of the most complex and vulnerable individuals in the hospital patients struggling with both mental health difficulties and alcohol use, often alongside mobility issues and long-standing physical health problems. Many of these patients face significant barriers to accessing community support because of their physical or psychological limitations. The input from MAST bridges those gaps and provides essential continuity of care that simply would not exist without the team.

The team is noted for its compassion, expertise, and consistency and the impact that has on our patients. I feel MAST's involvement not only improves patient outcomes but also helps reduce hospital readmissions, support safer discharges, and enhances patients' engagement with recovery and long-term support services. For many of our patients, MAST represents hope, a compassionate and understanding connection that helps them take steps towards stability and wellbeing.

From a staff perspective, the team's guidance, accessibility, and willingness to collaborate has been invaluable. MAST help us manage highly complex situations safely and confidently, and your presence on the ward contributes enormously to staff morale and patient safety. Without the additional support MAST provide it would be extremely difficult to meet the holistic needs of our patients, and the level of care we can provide would inevitably suffer.

Susan Holmes

Registered Nurse, Gastrology, Ward 16 BRI

Luke

The best support I have ever had.... the positivity shown towards me and the non-judgemental approach is really what helped me to make the changes.

Luke was referred to MAST by the ALPS team when he was admitted for suicidal ideation. He is a young man in his mid-twenties and has been living with his partner of three years. He has struggled to manage his mental health for a number of years and this has become progressively worse. Luke had been in work but was currently off sick and this was causing some financial issues.

During the intervention with the MAST worker in the hospital, the Luke described how he felt that he was unable to go to work because of his poor mental health but was finding the lack of structure and routine difficult to manage. He recognised that he is socially isolated. When his partner was at work he found being in his home on his own a particular challenge. He reported that he felt lonely at times and couldn't see a future for himself, feeling most days that he was existing rather than living.

Luke accepted support upon discharge with Keighley Healthy Living and was very keen to engage with some of the groups and activities delivered by the organisation. The first session was arranged the same week following discharge.

Luke attended the first session with his partner and given that it was a nice day made the decision to sit outside in the garden. During the session the patient explained that he found it difficult responding with eye contact, he shared with the MAST worker about events that had led to him being admitted to hospital.

He was taking antidepressant medication but did not feel that this was having a significant impact.

During the initial session the MAST ensured he had the contact details for Safe Spaces and First Response and worker explored onward referrals to Keighley Pathways for help and advice around benefits. The worker was also able to make a referral to Carers' Resource for his partner who was struggling to manage her caring role. He consented to both referrals this and was offered an appointment to meet alongside an advisor within a couple of days. He was also sent some information from Carers' Resource and were added to a waiting list to be offered face to face support.

He attended all four session at Keighley Healthy Living and has described this as a great step in supporting him to get out of the house and feel comfortable at being around people. In the 3 months following discharge Luke had not required any further hospital admissions.

Following MAST intervention Luke also agreed to an onward referral to Mental Health Connect where he is having 1:1 support to help ensure he feels able to cope in the event that he feels that his mental health is deteriorating. Luke has engaged with every session and says that he has looked forward to coming to each session, feeling comfortable enough to attend all subsequent appointment on his own. He has had the confidence to take part in groups and has attended different social activities. He has also taken part in an exercise and cooking programme specifically aimed at men.

Cam

Cam had struggled with her alcohol intake for several years and it was impacting her physical and mental health, relationships with family, and led to a number of admissions to hospital. Cam was referred to the MAST worker, to provide community support after being discharged.

She had tried accessing support in the past but had not had good experiences, which made her reluctant to accept support initially. Cam mostly stayed in her bedroom while at home, did not access the community much, and had needed time off work due to being hospitalised for alcohol use.

MAST delivered six alcohol support sessions with Cam which were a combination of home visits and telephone calls. In the first session, Cam appreciated being listened to and said it was

'the first time someone had really understood what I was saying.'

The MAST worker and Cam wrote a support plan together, which included alcohol reduction and onward referrals for mental health support and social prescribing, to address her isolation and lack of connection. Cam invited her father to one of the sessions so he could better understand her situation. Support sessions were arranged around the Cam's preferences and around her working pattern.

After the six sessions with MAST, Cam had reduced her alcohol intake and said she felt more aware now of how to reduce safely and will work on further reductions herself. She was feeling better at work and had applied for another job, was more engaged with her local community and spending more time out of her bedroom. She also felt that family tensions had been significantly improved.

MAST

Multi-Agency-Support-Team

MAST is a partnership of five voluntary sector organisations. For more information about the partnership, please contact us at info@project6.org.uk

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