

Strengthening the Hospital to Home Discharge Pathway in Somerset

For nearly 40 years, Agincare has partnered with local authorities and the NHS to meet the complex challenges of delivering sustainable, person-centred care. We understand the pressures you face every day; hospital capacity constraints, rising costs, workforce shortages, and the need to reach people in different types of settings.

This case study forms part of a 10-week rapid reablement project delivered in partnership with Somerset Council up until March 2026. It demonstrates how targeted, short-term reablement support can help individuals safely return home and rebuild independence following a hospital stay.

Through rapid mobilisation of care teams and intensive, person-centred support, Agincare's approach helps people regain essential daily living skills while reducing ongoing care needs and relieving pressure on hospital discharge pathways and wider social care services.

Flexible service model responding to urgent system pressures	✓
Targeted support delivered in areas with limited care coverage	✓
Reduced pressure on acute hospital beds and discharge team	✓
Significant reduction in long-term care needs	✓
Independence restored within 5 weeks through reablement	✓
Delivering reliable care in rural areas	✓
Block contract budgeting	✓

STATISTICS BREAKDOWN

220 PEOPLE DISCHARGED
AND SUPPORTED AT HOME

300 HOURS OF CARE
DELIVERED
EACH WEEK

**ALL INDIVIDUALS RETURNED TO INDEPENDENT
LIVING OR TRANSITIONED TO REDUCED CARE**



**OPERATING ON A WEEK-TO-
WEEK BASIS FOR FLEXIBILITY**



**CARE MOBILISED WITHIN
48 HOURS NOTICE**

16 DAYS AVERAGE CARE
DURATION PER PERSON



**SERVICE CONTINUITY
MAINTAINED**