The HOUSE Journal

The newsletter for the Year of Care Community of Practice

Issue 29
Resources

Welcome to The HOUSE Journal

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In this edition of the newsletter, we focus on sharing some new and updated resources which teams may find useful for personalised care and support planning in primary care and via neighbourhood teams.

These include a new toolkit and resources to help neighbourhood teams implement personalised care and support planning for the proactive care group.

The resources and report share lessons and learning from our pilot programme about how to deliver patient centred approaches to those with complex needs in a community setting.

Year of Care resources now available on our website

Year of Care resources have been available via a secure password protected area on our website however we are delighted to confirm they are now freely accessible to all.

Please visit https://www.yearofcare.co.uk/year-of-care-document-library/ for access to resources and tools that support practice teams to set up and think though each stage of the personalised care and support planning process.

This **poster** outlines the focus of each section within the library. Resources include materials to get started and promote the Year of Care approach, reflective resources for practitioners, preparation materials for patients and tools to support your local evaluation.

Updated Year of Care Patient Preparation letters available

To support the move towards digital Year of Care have developed a new range of preparation letters for patients that are easier to read on electronic devices. They include the latest clinical updates and can be sent digitally via email, text or the NHS app *or* printed in black and white for those who wish to have them posted. Please note that letters sent electronically should be in PDF format to retain the correct layout.

We suggest at the initial information gathering visit the health care assistant or nurse associate asks about people's preferences for how they receive their preparation letter which includes their results. This should be documented in the patient record to ensure the patient receives these documents by their preferred method once the results are back from the lab and have been reviewed by an appropriate clinician.

Letters are now available for the following combinations of long term conditions

Moderately or severely frail:

- COPD CVD*
- CVD*
- Diabetes
- Diabetes COPD

Not frail or mildly frail:

- COPD CVD*
- CVD*
- Diabetes
- Diabetes COPD
- Prevention (can be used for people with any one of the following conditions not included above: hypertension, RA, gout, mental health, non-diabetic hyperglycaemia, health checks)

*Please note CVD includes CHD, PAD, CKD, TIA, Stroke, AF

Proactive Care toolkit

We have developed a resource to support teams and organisations in the design and delivery of personalised, proactive care in line with the hospital to community shift outlined in the new 10 year health plan. This **resource** outlines how the approach can work and curates key learning from work with two neighbourhood health teams in North Cumbria (Keswick and Solway PCN and Carlisle Healthcare PCN).

It is based on using the Year of Care approach to personalised care and support planning to deliver coordinated, preventative healthcare to people with frailty and multiple long-term conditions, who are beginning to have more functional difficulties. The resource shares key learning, practical advice and tools from the successful implementation of the pilot proactive care programme.

If you are in the North East North Cumbria ICB area and would like to learn more about the pilot programme that informed the development of the toolkit, join our lunch and learn session

7 October 2025 1:00pm – 1:30pm

'Proactive care: Developing a personalised proactive care toolkit with PCNs in North Cumbria'

Please book via the Boost learning academy at this link:

https://boost.org.uk/learning-academy/

New patient case study – meet Kathleen!

Year of Care have developed a new **case study** based on Kathleen, a person living with long term conditions in the North East of England whose GP practice introduced the Year of Care approach around ten years ago.

In this case study Kathleen tells us how care and support planning works for her, and how it has changed the way she receives support from the practice for her long term conditions.

Kathleen describes how she now has more coordinated care and she understands things better. Receiving her results before her appointments helps Kathleen to feel more prepared, and, because her review includes all her long term conditions she feels like she knows what to do.