Winter Planning 2024

Shared Care Plans

- **Current Situation**: With COVID-19 still present and winter illnesses, there will be an increase of unwell patients in the community.
- **Objective**: Manage resources effectively to reduce pressure on the healthcare system and care for our most vulnerable patients as close to home as possible.

Shared Care Plans
Designed for patients with chronic and complex health and social needs who are at higher risk of needing urgent care.

Types of Plans:
- Acute Plans
- Personalised Care Plans (PCP)

These plans are available on Health Connect South and can be shared widely across health services in the South Island. Last winter, an average of 4614 Acute Plans were viewed per month.

We encourage general practices to use shared care plans to facilitate the sharing of crucial information about their patients' complex health needs. Please consider creating an Acute Plan to highlight important information about patients' vulnerabilities, comorbidities, and care needs to other clinicians.

How do shared care plans work?

A patient and their Family Practice team make a plan together.

The plan is then kept electronically in Health Connect South.

The patient's healthcare team can see the plan.

Pegasus™

Acute Plan

- Consider completing an Acute Plan for patients with complex or specific health needs that are at moderate to high risk of requiring acute service input over the next 12 months.
- Can support decision making regarding the need for admission, investigations, and the appropriate setting for acute and/or ongoing care.
- Consider only including information that would be useful to acute care teams. This could include, patient preferences, baseline functions, clinical risks, other formal or informal supports currently in place and reference to any other care plans that are relevant for that patients care.
- Use this time to review and amend existing plans to ensure the information captured in the plan is still relevant and up to date.

Personalised Care Plan (PCP)

- Aims to support patients to work with care teams to coordinate care around their needs and priorities, making goals and actions visible to other clinical teams.
- Focuses on a subset of the patient's health care or can be created across a range of different conditions.
- A care plan which focuses on 'What matters to them, rather than what is the matter with them'.

Which patients to consider

- Vulnerable patients who might present acutely to emergency services.
- Those who are at risk of serious infections with COVID-19.
- Those with a complex or chronic health or social need.
- Those with a large package of care/ service input already in place who rely on formal supports to live well at home.
- Patients who you have developed an action plan with, if their health was to deteriorate due to their chronic health condition.

Benefits of using the plans

- A single place for key information to be shared across health services that can be kept up-to-date and relevant to the patient.
- Enables secure information sharing between hospital, primary and some community care providers.
- Simple to complete and amend, can assist in streamlining patient care.
- It provides guidance to clinicians who are unfamiliar with the patient. For ambulance teams and ED staff this can potentially improve safety and efficiency when working with patients during an acute episode.
- Encourages a patient centred approach when discussing their goals and actions within a PCP.
- A way to support and advocate for people who do not have support people with them e.g. if there was visitor restriction at hospital.
- The plans are used across other South Island regions.

For more information

For more information about the plans visit the Shared Care Planning page on the CCN website.

The Canterbury Shared Care Planning team is available to provide further information or education and can be contacted via emailing info@sharedcareplanning.health.nz

Webinar
There is a webinar now available for clinicians that can be viewed here(youtube.com).

Handout
You can view and download the handout here(ccn.health.nz).