

An example of care planning in action

Mrs Smith attended her care planning consultation with a practice nurse. The results of her annual review tests had already been shared with her by post, following an appointment with the healthcare assistant three weeks earlier. She had used the opportunity to think about these and talk to her husband about them. They were pleased that most of the results were in the target range except her blood pressure and weight. She had made a note of these in the 'issues for discussion' section of the 'your results explained' leaflet containing the test results.

The practice nurse discussed the results with Mrs Smith and clarified that there were no other specific concerns or questions. She noted that Mrs Smith was a smoker but was not considering giving up and was aware of the potential risks. The nurse explained that Mrs Smith could get in touch at any time if she changed her mind and wanted support to give up smoking.

Mrs Smith decided that her current priorities and goals were; better blood pressure control and to lose a stone in weight. She elected to self-monitor her blood pressure and to see the GP after two months if it remained above target levels.

It was jointly agreed that Mrs Smith would visit the nurse for her next care planning consultation in a year's time, but that she could contact the practice nurse in the meantime if she had any concerns.

Two months later

Her blood pressure readings were still high, so she made an appointment to see her GP and they agreed to start treatment. The GP established that Mrs Smith had become concerned about diarrhoea, and wondered whether this was due to the Metformin she had been taking. They agreed to try a reduction in dose and to check HbA1c in a couple of months.

The diarrhoea improved immediately. The combination of weight loss and reduced Metformin resulted in no change in HbA1c and Mrs Smith understood that she might need to try other tablets in the future. She continues to work in partnership with her GP to reach her blood pressure goal.

Contact us

If you would like more information about your diabetes, please contact your care planning team on:

you and your
DIABETES

Care planning for your **diabetes**

The purpose of this leaflet is to explain our care planning process to you and how it can help you in the management of your diabetes.

What is care planning?

Care planning is a process that allows you to be actively involved in deciding, agreeing and owning how your diabetes is managed.

What does care planning involve?

The care planning process is linked to your yearly diabetes check-up and encourages you to think about what you might like to discuss once you have the results of your diabetes checks and measurements, for example:

Before your yearly diabetes appointment you will be asked to attend the surgery to have all of your checks and measurements completed. The results of these checks - which include your diabetes control, blood pressure, cholesterol and blood fats, kidney tests, weight and body mass index and smoking status - will be sent to you

before your yearly diabetes appointment. This gives you the chance to think about what the results mean to you and what you might like to discuss.

At your appointment with the healthcare professional you will be able to discuss the results, share stories about your health and wellbeing, set goals and create an action plan to help you cope with your diabetes. For example, if your weight has increased you may decide to agree a healthy eating plan.

Receiving care in this way

Care planning is not about making you do something that you don't feel comfortable with. It recognises that some people will want more control over their care than others.

