## **Planning for the future**

### The focus of the CQC inspection will vary here depending on the type of service you provide. For some services, the CQC inspection focus may primarily focus on end of life care, but for other services it might be around how you manage complex care needs, support younger people’s transition into adult care services or assist them into work.

### Whatever way you support people to plan for their future, the CQC will expect those individuals are at the centre of this process. They should also be given the time to consider the options and make informed decisions.

### Recommendations checklist

These recommendations act as a checklist to help you consider what you could potentially evidence, but it’s not intended as a definitive list. We hope they help you reflect on what evidence you might wish to share with the CQC.

### Part 1: End of life care

|  | Yes | No | N/A | How we evidence | Action |
| --- | --- | --- | --- | --- | --- |
| We can evidence how we involve individuals in decisions around their end of life care and ensure our care respects their wishes. | [ ]  | [ ]  | [ ]  |       |       |
| We support people being cared for and their families to have honest conversations about death and dying in ways that meet their needs. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure end of life plans consider the person’s language, ability to communicate and capacity to ensure it’s as accessible to the people we support (and/or their family/advocates) as possible. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure that advance care plans, which record people’s preferences when they near the end of their lives, are in place, well documented and regularly reviewed. These include adaptable activities suiting someone’s changing needs and wishes. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure our advance care plans consider people’s protected equality characteristics. | [ ]  | [ ]  | [ ]  |       |       |
| Where appropriate, we involve the person’s family, friends, power of attorney and advocates to discuss decisions about their end of life care. | [ ]  | [ ]  | [ ]  |       |       |
| We offer innovative new approaches to end of life care (e.g., piloting different ways of offering support), drawing on best practice and external expertise where needed. | [ ]  | [ ]  | [ ]  |       |       |
| We provide opportunities for people’s religious beliefs and associated priorities to be respected and adhered to as part of their end of life care. | [ ]  | [ ]  | [ ]  |       |       |
| We provide opportunities for people nearing the end of their life to engage in adaptable activities that suit their changing needs and wishes. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure specialist equipment andmedicines are consistently available at short notice. | [ ]  | [ ]  | [ ]  |       |       |
| As people approach the end of their life, we regularly monitor those who need care and support and assist them with symptom and/or pain management. | [ ]  | [ ]  | [ ]  |       |       |
| We make sure our service is appropriately staffed to guarantee people at the end of life receive additional support and accompaniment. | [ ]  | [ ]  | [ ]  |       |       |
| We expand care during this difficult time to include support needed by family, friends and advocates of those at the end of their lives and following their passing. | [ ]  | [ ]  | [ ]  |       |       |
| After a person we support has passed, we ensure their body is cared for in a dignified and culturally sensitive way. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure all staff, including managers and leaders, are trained in appropriate levels of end of life care and resilience. | [ ]  | [ ]  | [ ]  |       |       |
| We regularly review our end of life care approach as part of staff supervisions and team meetings, and document what went well and plans for any areas of improvement. | [ ]  | [ ]  | [ ]  |       |       |
| We have close links with end of life care professionals to ensure the support reflects good and best practice. | [ ]  | [ ]  | [ ]  |       |       |
| We work closely with GPs, District Nurses, specialist Macmillan teams etc. to monitor people and have regular multi-disciplinary tram reviews of changing needs. | [ ]  | [ ]  | [ ]  |       |       |
| Where we have an end of life care programme, we use an expert external organisation to review this. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service, the people we support with dementia are given the opportunity to discuss advance care planning at diagnosis. This is in accordance with NICE Quality Standards. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service, the people we support who are likely to be approaching the end of their life are identified using a systematic approach. This is in accordance with NICE Quality Standards. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service, the people we support who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they’re nearing death, stabilising or recovering. This is in accordance with NICE Quality Standards. | [ ]  | [ ]  | [ ]  |       |       |

### Part 2: Other future planning

|  | Yes | No | N/A | How we evidence | Action |
| --- | --- | --- | --- | --- | --- |
| We can evidence how we support people to make important decisions about their life. | [ ]  | [ ]  | [ ]  |       |       |
| Our staff understand the importance of helping individuals to identify and achieve personal goals. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure our managers and staff have enough time themselves to research and identify the options available to people. | [ ]  | [ ]  | [ ]  |       |       |
| We provide the individuals we support with the time and information they need to make important decisions about their life. | [ ]  | [ ]  | [ ]  |       |       |
| We help the people we support to connect with specialist organisations and individuals who can further assist them to achieve personal goals and ambitions. | [ ]  | [ ]  | [ ]  |       |       |
| Where appropriate to the people we support, we will support their continued educational development. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service and the peoplewe support, we will help these individuals tofind employment. | [ ]  | [ ]  | [ ]  |       |       |
| Where appropriate to our service, we will respond to people’s additional needs when transitioning between different health or social care services (e.g., from child to adult care). | [ ]  | [ ]  | [ ]  |       |       |
| Where appropriate to the people we support, we will support any transition away from the care systems and their long-term independence. | [ ]  | [ ]  | [ ]  |       |       |
| We have clearly documented records covering an individual journey from initial discussions to significant life events. | [ ]  | [ ]  | [ ]  |       |       |

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| Resources to help**GO Online: Inspection toolkit**Learn more about how this is inspected via a short film, practical examples and resources [here](https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Good-and-outstanding-care/inspection-toolkit/Topic-focus.aspx?services=&kloe=responsive-1&topic=planning-for-the-future).**Recommendations checklists**Access the full range of all Recommendations Checklists, exclusively available to Skills for Care Registered Manager Members [here](https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Support-for-registered-managers/GO-guide-SAF.aspx).**Good and Outstanding care support**Skills for Care’s Good and Outstanding care resources include practical e-learning modules, guidance and seminars to support you to meet CQC expectations. Learn more about what is available [here](https://www.skillsforcare.org.uk/go). |