Planning for the future

Quality statement

We expect providers, commissioners and system leaders live up to this statement:

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

What this quality statement means

- People are supported to make informed choices about their care and plan their future care while they have the capacity to do so.
- People who may be approaching the end of their life are identified (including those with protected characteristics under the Equality Act and people whose circumstances may make them vulnerable). This information is shared with other services and staff.
- People's decisions and what matters to them are delivered through personalised care plans that are shared with others who may need to be informed.
- When people want to express their wishes about cardiopulmonary resuscitation, they are supported to do so and are able to change their mind if they wish.

- When any treatment is changed or withdrawn, professionals communicate and manage this openly and sensitively so that people have a comfortable and dignified death.
- When people's future care preferences are for greater independence and fewer care interventions that are likely to benefit them, professionals work together to support them to achieve their goals.

I statements

I statements reflect what people have said matters to them.

- I can get information and advice that is accurate, up to date and provided in a way that I can understand.
- I am in control of planning my care and support. If I need help with this, people who know and care about me are involved.
- I am supported to plan ahead for important changes in my life that I can anticipate.

Subtopics this quality statement covers

- DNACPR/ReSPECT
- End of life care
- Complex care needs
- Palliative care
- Decision making

Related regulations

Regulated Activities Regulations 2014

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect

Also consider

- Regulation 11: Need for consent

Best practice guidance

We expect providers to be aware of and follow the following best practice guidance.

Universal Principles for Advance Care Planning (ACP) (NHS England)

DNACPR/ReSPECT

CPR Decisions, DNACPR and ReSPECT (Resuscitation Council UK)

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions (NHS)

End of life care

Care of dying adults in the last days of life (NICE guidance [NG31])

Palliative and end of life care (Office for Health Improvement and Disparities Guidance)

End of life care for adults (NICE guidance [QS13])

Care of dying adults in the last days of life (NICE guidance [QS144])

End of life care for adults: service delivery (NICE guidance [NG142])

End of life care for infants, children and young people with life-limiting conditions (NICE guidance [NG61])

Palliative care

Palliative care - general issues (NICE guidance)

Complex care needs

Care and support of people growing older with learning disabilities (NICE guidance [NG96])

Dementia: assessment, management and support for people living with dementia and their carers (NICE guidance [NG97])

Social work with adults experiencing complex needs (NICE guidance [NG216])

Decision making

Decision-making and mental capacity (NICE Guidance [NG108])