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ReSPECT

Recommended Summary Plan for Emergency Care and Treatment

Policy for use across all providers in Lincolnshire

Approved by: ICS Clinical Policies Group.

Date approved: 16/12/2025

Organisations policy is applicable to:

- NHS Lincolnshire Integrated Care System.

Organisation and job title of lead author / reviewer:

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Title and organisation of Executive Sponsor (if required):

- Not applicable.

Organisation and title of person responsible for review of document:

- Ageing Well Programme Lead, Lincolnshire ICB.

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Target audience:

- All health and care staff across the Lincolnshire Integrated Care System.

Distributed via:

- Email, Website, Intranet and Board Portal.

ReSPECT :: Lincolnshire Palliative and End of Life

ReSPECT - supporting emergency care that aligns with what matters most

Version Control Sheet

Version	Section / Paragraph / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		New Policy	October 2018	Dr Adam Brown, Consultant in Palliative Medicine
2	1; 1.2; 1.3; 2.14; 1.28-1.33; 4.7-4.9; Glossary, Appendices: 1-6	Version 2.5. Updated with new guidelines and additional information, resources and hyperlinks.	July 2022	ReSPECT Clinical Reference Group
3	Changes have been made to each section of the policy, in line with the new ICS policy template.	Version 3.0. Updated to reflect latest national guidelines, resources and local processes. Added to new ICS policy template.	November 2025	ReSPECT Clinical Reference Group

Policy Document Statement

The Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) process creates personalised recommendations for a person's clinical care and treatment in a future emergency, in which they may be unable to make or express choices.

Background Statement

ReSPECT recommendations are created through conversations between a person, the people important to them, and health and social care staff, to understand what matters to them and what is realistic in terms of their care and treatment.

A single ReSPECT form and policy are in place to support the increased movement of people and staff between different care settings across the Lincolnshire ICS.

Key words

ReSPECT, Recommended Summary Plan for Emergency Care and Treatment, Escalation, ReSPECT Conversation, Advance Care Planning, DNACPR, Resuscitation, Person, Personalisation, Best Interests.

Responsibilities

Key responsibilities for staff groups in relation to delivering the policy's objectives.

Group:	Responsibility:
The person	The person should keep their ReSPECT plan with them and ensure that it is stored in an easily identifiable place which is immediately available to health and social care staff in an emergency, whether the person is in their usual place of residence or being cared for elsewhere.
Person's family / informal carers	The person's family and informal carers should support the person during the ReSPECT conversation, enabling the person to feel comfortable and at ease.
Health and social care staff (non-registered)	Non-registered health and social care staff should support the person, contribute and in some cases initiate the ReSPECT conversation, document outcomes form the conversation and seek sign-off of the ReSPECT form.
Health and social care staff (registered)	Registered health and care staff should support the person, contribute and in some cases initiate the ReSPECT conversation. Document and sign-off the person's ReSPECT form. Ensure the ReSPECT form is sent to the person's GP practice to be attached to their clinical record.
Person's GP Practice	The GP Practice should ensure that the latest ReSPECT form is attached to the person's clinical record.
Provider organisations	Provider organisations are required to comply with the content of this policy. Provider organisations are also required to undertake audits and quality checks of the ReSPECT process within their organisations.
All staff in scope	All staff within the scope of this policy are responsible for familiarising themselves with the content of this policy and adhering to the process described within it.

Training

The Lincolnshire ReSPECT Training & Education package identifies three tiers of training - each level targets a different type of responsibility for ReSPECT, as follows:

- **Tier 1**: awareness of ReSPECT for all staff
- **Tier 2**: how to action and care for a person with a ReSPECT form in place
- **Tier 3**: having and documenting a ReSPECT conversation

See Appendix 3 of this policy for further details on the Lincolnshire ReSPECT training matrix and resource materials.

Dissemination

This policy will be shared with partners across the Integrated Care System through the following:

- dissemination across Lincolnshire Integrated Care System (ICS) via Communication Teams in each partner organisation, including primary care
- via partner organisation websites including Intranet
- via Lincolnshire ReSPECT Clinical Reference Group and ReSPECT Community of Practice
- Local Medical Council
- Primary Care Network Alliance
- Ageing Well Programme governance, e.g. Frailty Leadership Group, PEOL Leadership Group.

Resource implications

Tools to support compliance with this policy:

- Undertake ReSPECT conversations in line with the process described in this policy.
- Document ReSPECT conversations using the ReSPECT form (See Appendix 4).
- Complete relevant ReSPECT training modules, as described in the ReSPECT training matrix (See Appendix 3).
- Undertake ReSPECT audits using the Lincolnshire ReSPECT audit tool (See Appendix 5)

Consultation

The following organisations were consulted during the development and review of this document:

- East Midlands Ambulance Service
- Lincolnshire Care Association (LinCA)
- Lincolnshire County Council
- Lincolnshire Community Health Services
- Lincolnshire Medical Committee
- Primary Care Network Alliance
- Lincolnshire Partnership NHS Foundation Trust
- NHS Lincolnshire Integrated Care Board
- St Barnabas Lincolnshire Hospice
- United Lincolnshire Teaching Hospitals NHS Trust
- LIVES
- Marie Curie
- Lincolnshire Hospital Circle Group

Monitoring

It is the responsibility of the individual organisation to take ownership of monitoring compliance with this policy, with the outcomes reportable through their internal governance processes.

Data relating to implementation of ReSPECT forms is captured via the Lincolnshire ReSPECT data dashboard which enables partners to map variation and target areas for improvement.

Equality Statement

As part of our ongoing commitment to promoting equality, valuing diversity and protecting human rights, Lincolnshire ICS is committed to eliminating discrimination against any individual (individual means employees, person's, services users and carers) on the grounds of gender, gender reassignment, disability, age, race, ethnicity, sexual orientation, socio-economic status, language, religion or beliefs, marriage or civil partnerships, pregnancy and maternity, appearance, nationality or culture.

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1. Introduction

This policy describes the process that should be followed to comply with the ReSPECT principles, in line with the latest guidance published by the Resuscitation Council UK.

This policy complies with legislation, standards, guidelines, codes of conduct and other relevant document listed in the References section.

2. Purpose

The purpose of this policy is to standardise the approach to implementing ReSPECT across Lincolnshire for people of all ages (adults, children and young people).

The policy seeks to promote more high-quality ReSPECT conversations between people (and their families / informal carers) with health and social care workforce (registered and non-registered staff), leading to shared decision making (when possible), better advance planning, good communication and documentation, and better overall care and care outcomes.

3. Context

Advance decision making about care and medical treatment involves collaboration between a person and health and social care staff.

In an emergency, it is vital that staff have a clear understanding of any identified limitations in an individual's treatment, wishes and preferences.

The ReSPECT form acts as a summary document for any key information that could influence emergency care at a time when a person may not be able to express their wishes.

4. Objectives

- To ensure high quality ReSPECT conversations take place.
- To ensure that ReSPECT conversations are clearly recorded in a ReSPECT form.
- To create personalised recommendations for a person's care and treatment.
- To protect the person's wishes and preferences and support health and social care staff in making these complex recommendations in an emergency.

5. Scope

Individuals

5.1 This policy is intended for anyone but will have increasing relevance for people who have complex health needs, people who are at risk of sudden deterioration or cardiac arrest, and those people who are likely to be nearing the end of their lives.

5.2 It is important to recognise that some people will want to record their care and treatment preferences for other reasons that are not described in this policy.

Organisations

5.3 This policy applies to all health and social care staff (registered and non-registered) working within or represented by the organisations in the scope of this policy, as described below:

- East Midlands Ambulance Service
- Lincolnshire Care Association (LinCA)
- Lincolnshire County Council
- Lincolnshire Community Health Services
- Lincolnshire Medical Committee
- Lincolnshire Partnership NHS Foundation Trust
- LIVES
- Marie Curie
- NHS Lincolnshire Integrated Care Board
- St Barnabas Lincolnshire Hospice
- The Lincoln Hospital Circle Group
- United Lincolnshire Teaching Hospitals NHS Trust
- Primary Care Network Alliance

6. Compliance

6.1 The Mental Capacity Act 2025

The Mental Capacity Act (MCA) applies to people aged 16 years and over and is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment (See section 7.12 of this policy for Children and Young People aged 0-18 including Gillick Competence).

In supporting an individual to make a decision consideration should be given to the questions below. All information relevant to the decision must be explained to the individual, including risks, benefits and consequences. It must include the information likely to be important to the individual. This will require a balance to be struck between giving enough information to make an informed decision and too much information or detail which could be confusing:

1. Has the individual been provided with all the relevant information needed to make the decision in question including benefits, risks and consequences?

2. Could the information be explained or presented in a way that is easier for the individual to understand?

3. Are there times of day when the individual's understanding is better or locations where they feel more at ease?

4. Can the decision be put off until the circumstances are right for the individual concerned?

5. Can anyone else help or support the individual to make choices or express a view, such as an independent advocate, family or someone to assist communication?

For Children under 16, the decision-making approach is governed at common law by Gillick competence, derived from Lord Fraser's judgment in Gillick v West Norfolk and Wisbech AHA [1986] AC 112. Such competence to make decisions is intended to reflect a child's increasing development to maturity. The test is whether the child has sufficient understanding and intelligence to enable them fully to understand what is involved in a proposed intervention to consent to it. The necessary degree of a child's understanding will vary accordingly to the particular matter and is thereby decision and child specific.

See Section 8. Definitions - Advance Decision to Refuse Treatment (ADRT) of this policy for further details on eligibility for a legally binding ADRT.

6.2 European Convention on Human Rights

The following sections of the European Convention on Human Rights are relevant to this policy:

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14)

6.3 Case law

In addition, this policy takes heed of, and is compliant with, Tracey v Cambridge University Hospitals NHS Foundation Trust 2014 and Winspear v City Hospitals Sunderland NHS Foundation Trust 2015.

The Winspear judgment ratifies the Tracey judgment and expands to someone lacking the capacity to participate in the making of the recommendations, requiring instead consultation (where practicable and appropriate) with those interested in their welfare, especially a Lasting Power of Attorney for Health and Welfare, Court Appointed Deputy or close family member.

6.4 The Mental Health Act

Where a person is detained under the Mental Health Act, the provisions of this act only apply to decisions about psychiatric treatment for a psychiatric condition. Capacity legislation applies to all other decisions. Therefore, for individuals detained under the Mental Health Act decisions about any other aspect of care such as other forms of life sustaining treatment should be made regarding the Mental Capacity Act. Detention under the Mental Health Act would not nullify decisions documented on a ReSPECT form, ADRT or advance care plan written about non-psychiatric conditions.

6.5 Martha's Rule

The principles of Martha's Rule may prompt a ReSPECT conversation.

Martha's Rule recognises that those who know the person best may be the first to notice changes that could be an early sign of deterioration, and the importance of listening to and acting on the concerns of the person, families, and carers. It is being implemented in both adult and children's inpatient settings in England.

The 3 core components of Martha's Rule:

- The person will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
- All staff will be able, at any time, to ask for a review from a different team if they are concerned that a person's is deteriorating, and they are not being responded to.
- This escalation route will also always be available to the person, their families and carers and advertised across the hospital.

7. ReSPECT Process

7.1 Principles

- The ReSPECT process may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, an education setting, a hospice, or a hospital.
- The process described in this policy is intended to respect the person's preferences as well as health and social care professionals' clinical judgement.
- The agreed clinical recommendations that are recorded in the ReSPECT form should include a recommendation on whether CPR should be attempted if the person's heart and breathing stop.
- For many people anticipatory decisions about emergency care and treatment, including CPR, are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.
- Every decision about emergency care and treatment options must be made based on a careful assessment of each person's situation and wishes. These decisions should never be dictated by 'blanket' policies.
- This policy applies to the multidisciplinary health and social care team involved in the person's care, including registered and non-registered staff.

7.2 ReSPECT conversations

- The ReSPECT process seeks to encourage better communication and shared decision-making through structured conversation(s).
- The person and those important to them (with the person's consent) should be given as much information as they wish about their situation, including information about CPR in the context of their own illness and sensitive communication around dying and end of life issues if this is relevant.
- Before holding a ReSPECT conversation, all parties should consider any factors that may impact people's perceptions of the ReSPECT process, such as time of day, whether person has taken their medication, communication needs, culture, and knowledge of ReSPECT.
- All reasonable adjustments should be considered, and the person and their families / carers, should be offered support and guidance to optimise their participation.

- The conversation should take place at the earliest opportunity, when a person is still able to make or express their wishes and decisions, which can support decision making. This may be particularly important where a person has a life limiting condition.
- For people with dementia, for example, this needs to be as soon as possible from the point of diagnosis, and especially for those with a learning disability and younger onset dementia.
- The conversation should be set at a pace suitable for the person, taking place face to face rather than remotely where this is possible.
- All relevant health and social care staff may contribute to a ReSPECT conversation, where this is likely to be helpful.
- In the case of a child or young person, the conversation is held with the person with parental responsibility, and / or where appropriate the young person themself.
- The ReSPECT conversation should follow a multi-disciplinary team (MDT) approach rather than one individual and should follow the sequence of sections in the ReSPECT form to guide the conversation.
- Through the ReSPECT conversation, the MDT / members of the meeting should discuss and reach a shared understanding of the person's current state of health and how it may change in the foreseeable future, including the person's preferences and goals of care.
- If a person declines a ReSPECT conversation, it may be suitable to ask them again at another time or date, as considered appropriate.

7.3 Documenting a ReSPECT conversation

- Following a ReSPECT conversation, the ReSPECT form should be completed contemporaneously (at the same time), recording the outcome of the conversation.
- Health and social care staff involved in the care of the person, who knows them well, can initiate the conversation and contribute to the ReSPECT form, ensuring that clinical recommendations are completed and signed off by a registered healthcare staff involved in the person's care.
- ReSPECT forms can be completed in hand-written format or electronically. If hand-written, black ink should be used. If electronic, an electronic signature or name is acceptable.

- It is very important that a completed ReSPECT form is legible and uses language that can be easily understood by anyone that will need to read and consider its recommendations in an emergency.

7.4 Clinical sign-off

- Registered healthcare staff will sign the ReSPECT form (section 4 and 7 of the form), making the final clinical decisions and recommendations about a person's care arrangements in an emergency.
- Following sign-off, the ReSPECT form should be shared with the wider health and social care team.
- Guidance for clinicians on how to complete the various sections of a ReSPECT form can be found at Appendix 7.
- For people being transferred into the care of United Lincolnshire Teaching Hospitals NHS Trust (ULTH) with an existing ReSPECT form, as per section 7.11, the form should be reviewed on admission and throughout the duration of the inpatient stay as appropriate by the lead clinician overseeing the patient's care.
- For people who are being cared for within United Lincolnshire Teaching Hospitals NHS Trust (ULTH), with a new requirement for a ReSPECT discussion, there is a requirement for the lead clinician to review and endorse the form within 24 hours of the decision being implemented. They must countersign the form in the space provided. There is not a similar requirement for GPs given the logistical difficulties this might present for people in the community, but where appropriate the GP may wish to countersign the form to further confirm their agreement with the decision.

7.5 Sharing the ReSPECT form

- Once complete, the person must be given a hard copy of their ReSPECT form (original or a printed copy if completed electronically), and this form must accompany them when they move from one setting to another.
- The ReSPECT form (new or updated) should be sent to the person's GP practice and attached to their healthcare record with the person's consent (see section 7.6 for details).
- When printing the electronic form, best practice is to print on a recognisable lilac card or paper. However, if this is not possible, then a normal printer paper can be used until coloured paper is sourced.

- Similarly, a black and white photocopy or printed copy of a ReSPECT form should be accepted unless there is evidence it should not be considered valid. However, best practice is to print on the clearly identifiable lilac card or paper.

7.6 Coding ReSPECT form

- The standard naming format should be followed when saving ReSPECT conversations on the electronic record:
  ReSPECT Patient Name, date (dd/mm/yy), using code:
  Has ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) | SNOMEDCT ID 1107891000000106
- A declined ReSPECT conversation should be recorded in the electronic record using code:
  Emergency health care planning declined (situation) | SNOMEDCT ID 1025371000000108

7.7 Cardiopulmonary Resuscitation (CPR) and Do Not Attempt CPR (DNACPR)

- If the person has a ReSPECT form, it will state (under section 4) whether CPR attempts are recommended (or, in a child, whether a plan for modified CPR has been agreed).
- A recommendation about CPR (including not to attempt CPR) should be discussed as part of the ReSPECT conversation, along with an honest explanation of what treatments can realistically be expected to achieve those goals.
- In the case of an acute illness, review should be sufficiently frequent to allow a change of these decisions (in either direction) in response to the person's clinical progress or lack thereof.
- It is important to note that a ReSPECT form is not the same as a DNACPR form. A person's ReSPECT form makes recommendations about emergency treatments that could be helpful and should be considered, as well as those that are not wanted by or would not work for them.
- If the person suffering the cardiopulmonary arrest is unknown to the person attending them, and / or the existence or otherwise of a ReSPECT form or other relevant documentation is unknown, then CPR should be commenced immediately.
- It would not be appropriate to delay CPR to identify the person or look for documentation regarding their wishes. Positive identification of the person and the

discovery of documentation regarding their wishes during CPR attempts may inform a decision whether to continue or cease those attempts.

7.8 Where a person lacks capacity

- If a person lacks capacity, then decisions should be made following the "Best Interests" process as per the Mental Capacity Act (2005). Those close to the person (including Lasting Power of Attorney for welfare and Independent Mental Capacity Advocate (IMCA)) should be involved in discussions to explore the person's wishes, feelings, beliefs, and values in order to reach a "Best Interests" decision, if it is practicable and appropriate to consult them. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision-makers.
- In exceptional circumstances, for example where a ReSPECT conversation would be considered detrimental to a person's mental health, it should not be carried out with the person, even if the person has capacity. However, it would be beneficial to have a conversation with the person and those important to them, to take place in that person's best interest and this conversation should be recorded in section 6D of the ReSPECT form.
- There should be clear, accurate and honest communication with the person and (with the person's permission) those close to them, including provision of information and checking of their understanding about what has been explained to them.
- For a person who lacks capacity to decide about confidentiality, there should also be a "Best Interests" decision made regarding to who to involve in the decision-making process and what information should appropriately be shared to enable this, as per the MCA.

7.9 Primacy of clinical judgement

Decisions documented in a ReSPECT form do not override clinical judgement if a person's condition changes and does not match the circumstances that were envisaged when the decisions described in the ReSPECT form were made and recorded.

7.10 Legal status of the ReSPECT form

ReSPECT forms are not legally binding. The ReSPECT form should be regarded as an advance clinical assessment and recommendations, recorded to guide immediate

clinical decision-making in the event of a person's deterioration or cardiorespiratory arrest. The ReSPECT form constitutes an 'advance statement' under the terms of the Mental Capacity Act (2005), rather than an 'advance decision to refuse treatment'. The final decision regarding whether to attempt CPR or other life-sustaining treatment rests with the senior responsible clinician responsible for the person's immediate care.

7.11 Reviewing the ReSPECT form

- The ReSPECT form should be reviewed if the person's condition changes, when the person changes their wishes and decisions, or at a transfer to a different setting.
- A review of the ReSPECT plan should be prompted by a request from the person or their representative, by a change in their condition or by their transfer from one care setting to another.
- The ReSPECT conversation should be revisited, and a new form (where required) is completed at the earliest opportunity.
- ReSPECT forms that have been reviewed and replaced should be clearly crossed through and marked as cancelled.
- It is possible that a person may have a DNACPR decision or other emergency care, and treatment plan documented on a different form. For example, they may have an old version of the ReSPECT form and / or using paperwork from out of area. Unless there is a good reason to believe the decisions are not genuine or applicable, they should be accepted as valid.
- At the point of transfer between care settings, ReSPECT decisions remain valid if they are applicable to the circumstances and should be reviewed as soon as possible by the MDT or the most appropriate health or social care staff. The ReSPECT form (Appendix 4) should be used.

7.12 Children and Young People (0-18 years)

- This policy applies to children and young people as well as adults, in all care settings across Lincolnshire.
- Children and Young People refers to individuals from birth to their 18th birthday.
- The CYP ReSPECT form should be completed as part of the *Child and Young Person's Advance Care Plan* used for children across all settings – pages 7 & 8 (version 5). Form can be accessed via the link: CYPACP.
- The ReSPECT process is particularly important to support the seamless transition of the child / young person from children's services to adult services.

- Transition between these services is often a time of great anxiety and stress for children / young people and their families.
- Healthcare professionals should be encouraged to be understanding and flexible when discussing and making clinical recommendations and decisions regarding the care of this discrete and vulnerable group of people.

Gillick competence

- In the case of a child or young person under 18 years, it is necessary to consider their age and level of maturity regarding their ability to make decisions for themselves (Gillick competence).
- Those aged 16 or 17 years are assumed to have capacity to make their own decisions unless shown otherwise through a capacity assessment, in line with the principles of the Mental Capacity Act (See section 6.1 of this policy for details on the Mental Capacity Act, the Act applies to people aged 16 years and over). Normally parents or people with parental responsibility would be included in all such conversations, providing the person agrees to this. It would be essential to include parent(s) or the people with parental responsibility in the decision-making for those who lack such competence.
- If the child or young person is over 16 or is felt to be competent to make their own decisions, and they wish their health information to be kept confidential from their parents, it should be noted that the Department of Health Code of Practice on Confidentiality (2003) provides that:
    - "The principle of confidentiality can be breached if a competent young person or child is refusing treatment for a life-threatening condition. The duty of care would require confidentiality to be breached to the extent of informing those with parental responsibility for the child who might then be able to provide the necessary consent to the treatment"
    - This should be considered as being about sharing information with the parents to enable an application to be made to court to resolve any disputes.
- For anyone under the age of 18 years, information about their diagnosis and prognosis should not be withheld if they are able to understand, unless they ask you to, or you judge that giving it might cause them serious harm.
- Assessment of Gillick competence requires an examination of how the child deals with the process of making a decision based on an analysis of the child's ability to understand and assess risks.

- Sufficient time for the assessment must be allowed by the health professional who needs to be satisfied that a child has fully understood the nature and consequences of the decision.
- The right to decide on competence must not be used to disregard the wishes of parents. Where a child is considered Gillick competent then the consent is as effective as that of an adult and cannot be overruled by a parent.
- See Section 8. Definitions - Advance Decision to Refuse Treatment (ADRT) of this policy for further details on eligibility for a legally binding ADRT.

Transition to adult services

- A point may be reached as the young person transitions into adult services where health or social care staff who have come to know the person and their condition well thinks it would be appropriate to create a new ReSPECT plan for use under adult services.
- The originally completed ReSPECT plan can be used to guide the conversation with the young person and those important to them in the creation of the new plan, including which original clinical recommendations may still be appropriate to include and any that may no longer be appropriate and require further discussion.

7.13 Situations where there is a lack of agreement

- A person with mental capacity may refuse any treatment from a doctor or nurse even if that refusal results in death and any treatment carried out against their wishes is technically an assault. In these circumstances, Individuals should be encouraged to make an Advance Decision to Refuse Treatment (ADRT).
- Should the person with capacity refuse CPR or any other form of life-sustaining treatment, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and any family members or others that they wish to be involved, has taken place.
- A previous verbal request to decline CPR or other life-sustaining treatment should be considered when making a best interest decision once a person has lost capacity, even if this was not documented formally on a ReSPECT form or as part of an ADRT. The verbal request needs to be documented in the person’s case notes by the person who it is directed to and any decision to take actions contrary to it must be robust, accounted for and documented clearly in the notes.

- Although individuals do not have a legal right to demand that doctors carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected wherever possible.
- In the case of disagreement, a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought from the organisation's legal representatives. The possibility of application to court exists as a last resort to resolve disputes and legal advice should be obtained with that in mind.

7.14 Cancellation of emergency care and treatment decisions

- If the person's clinical condition changes, the decision may be made to cancel or revoke the current ReSPECT form.
- If the form is cancelled, it must be crossed through with two diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated, and signed by the healthcare staff.
- It is the responsibility of the healthcare staff cancelling the ReSPECT form to communicate this to all relevant parties involved in the care of the person, including informing the person's GP Practice.
- Another conversation should take place with the person and those important to them, and a new ReSPECT form created where appropriate.

7.15 Temporary suspension of emergency care and treatment decisions

- **Pre-planned:** Some procedures could precipitate a deterioration or cardiopulmonary arrest, for example induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances the ReSPECT decisions should be reviewed prior to procedure and consideration made as to whether the decisions should be suspended. Discussion with key people including the person's and/or carer, if appropriate, will need to take place.
- **Acute:** Where the person suffers an acute, unforeseen, but immediately life-threatening situation such as anaphylaxis or choking, CPR or other emergency care and treatment may be appropriate.
- After the event, the ReSPECT decisions should be reviewed and discussed with the person and reinstated where appropriate.

8. Definitions

Advance Care Plan (ACP)
An Advance Care Plan is a structured documented discussion with the person and their families or carers about their wishes and thoughts for the future. It is a means of improving care for people, usually those nearing the end of life, and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. An ACP is likely to contain information about personal preferences (e.g., place of care preferences, funeral plans, understanding prognosis).

Advance Decision to Refuse Treatment (ADRT)
An Advance Decision to Refuse Treatment is a decision that can be made to refuse a specific type of treatment at some time in the future.

- It is only used if at some time in the future the person loses the ability to make your own decisions about your treatment.
- It is important to discuss the options with a doctor or nurse who knows this person's medical history.

ADRT does not have to be in writing *but if the person wants to refuse life-saving treatment*, it must be in writing, must be signed and witnessed, and clearly state that they wish it to apply, even if their life is at risk.

An Advance Decision to Refuse Treatment is a legally binding document as long as it: complies with the Mental Capacity Act (2005), is valid and applies to the situation.

An advance decision may only be considered valid if:

- you're aged 18 years old or over and had the capacity to make, understand and communicate your decision when you made it
- you specify clearly which treatments you wish to refuse
- you explain the circumstances in which you wish to refuse them
- it's signed by you (and by a witness if you want to refuse life-sustaining treatment)
- you have made the advance decision of your own accord, without any harassment by anyone else
- you have not said or done anything that would contradict the advance decision since you made it (for example, saying that you've changed your mind)

The Mental Capacity Act applies to young people from the age of 16, but a person cannot make an ADRT until they are 18.

A child or young person under the age of 18 can make an advance statement which is an expression of their wishes and preferences. Advance statements are not legally binding.

Anticipatory Care Plan
An Anticipatory Care Plan is a personalised, holistic assessment detailing proactive care and support for people living with frailty, multiple long-term conditions and/or complex needs. It helps people to stay healthy and independent and to avoid the need for a hospital stay or visit. It also focusses on what is important to supporting and caring for those who are most at risk of poorer health issues in the future and enables a wide variety of co-ordinated health and care support to be provided depending on individual needs.

Capacity
Capacity means the ability to make and express a decision in relation to a particular matter. To have capacity a person must be able to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision and to communicate that decision (whether by talking, using sign language or any other means). If their mind is impaired or disturbed in some way, making, and communicating decisions may not be possible. A person may lack capacity temporarily or permanently. However, a person should be assumed to have capacity for a decision unless or until it has been shown that they do not.

Cardiopulmonary Resuscitation (CPR)
Cardiopulmonary Resuscitation includes all the procedures, from basic first aid to advanced medical interventions, that can be used to try to restore the circulation and breathing in someone whose heart and breathing have stopped. The initial procedures usually include repeated, vigorous compression of the chest, and blowing air or oxygen into the lungs to try to achieve some circulation and breathing until an attempt can be made to restart the heart with an electric shock (defibrillation) or other intervention.

Children and Young People
In law, a child is anyone under the age of 18 years. Parental responsibility persists until a child is 18, but a child can attain competence to make decisions for themselves (Gillick competence) according to their age and maturity and, once they are 16 years old, are assumed to have capacity to make their own decisions like an adult. In this document the term “children and young people” is used to refer to anyone under the age of 18, but the law in this area is complex, particularly with regards to those who are 16 and 17.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Do Not Attempt Cardiopulmonary Resuscitation decisions have also been called DNR, DNAR or ‘Not for Resuscitation’ (NFR) decisions. They refer to decisions made and recorded to recommend that CPR is not attempted on a person should they suffer cardiac arrest or die. The purpose of a DNACPR decision is to provide immediate guidance to

health or social care professionals that CPR would not be wanted by the person or would not work or be of overall benefit to that person. This tries to ensure that a person who does not want CPR or would not benefit from it is not subjected to CPR and deprived of a dignified death or, worse still harmed by it.

Health and social care workforce
This refers to any registered or non-registered health and social care staff (often who know the person best) who are confident and competent to contribute and lead ReSPECT conversations and document the outputs of these conversations on the ReSPECT form.

Intensive Care Unit (ICU)
Intensive Care Unit is also referred to as Intensive Therapy Unit (ITU). This is the area in a hospital that provides sophisticated monitoring and equipment to assess and support the function of a critically ill person's vital organs, such as the lungs or kidneys or heart and circulation (e.g., a ventilator to help with breathing) until, whenever possible, they recover.

Lasting Power of Attorney (LPA)
LPA gives another individual the authority to make decisions regarding welfare for an individual who lacks capacity.

Lead Clinician
The health professional with overall responsibility for a patient's medical care. Ultimately, the individual in charge of a patient's care is the one who assumes responsibility for the patient's overall management and is registered with the appropriate statutory body, such as the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC).

Independent Mental Capacity Advocate (IMCA)
Is a statutory advocacy service, introduced by the Mental Capacity Act 2005 (the Act). The Act gives some people who lack capacity a right to receive support from an IMCA.

Mental Capacity Act (MCA)
MCA is a legislation designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery. See more under **Capacity**.

Personalised Care and Support Planning (PC&SP)
PCSP is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.
This process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that aren't working in the person's life and identifies outcomes and actions to resolve these. These conversations are recorded and shared with one joined-up plan that covers their health and wellbeing needs. The PC&SP is an umbrella term to describe locally named personalised plans e.g. 'What matters to me' plan.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
ReSPECT is the first nationwide approach to discussing and agreeing care and treatment recommendations to guide decision-making in the event of an emergency in which the person has lost capacity to make or express choices. This process can be used by people of all ages.

Resuscitation
Resuscitation is general term used to describe various emergency treatments to correct life-threatening physiological disorders in a critically ill person. For example, 'fluid resuscitation' is rapid delivery of fluid into the bloodstream of a person who is critically fluid-depleted. Rapid blood transfusion for someone with severe bleeding is another example. Cardiopulmonary resuscitation (CPR) is sometimes referred to as 'resuscitation' but is a specific type of emergency treatment that is used to try to restart the heart and breathing.

9. References and other documentation

- Latest guidelines please follow: 2021 Resuscitation Guidelines | Resuscitation Council UK https://www.resus.org.uk/library/2021-resuscitation-guidelines
- Advance Decision to Refuse Treatment, a guide for health and social care professionals. London: Department of Health Advance-Decisions-to-Refuse-Treatment-Guide.pdf
- British Medical Association, (2000). The impact of the Human Rights Act 1998 on medical decision-making. London, BMA Books.
- British Medical Association, (2001). Withholding or withdrawing life- prolonging medical treatment. 2nd ed. London, BMA Books.
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy NHS Scotland 2010.
- British Medical Association, (2024), Decisions relating to CPR (cardiopulmonary resuscitation) https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation
- GMC Treatment and Care Towards the end of life: good practice in decision-making (2010, updated 2024).
- Human Rights Act. (1998) London: Crown Copyright. www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1.
- NHS England, Martha's Rule
- Mental Capacity Act. (2005) London: Crown Copyright. www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1.
- ReSPECT: Recommended Summary Plan for Emergency Care and Treatment website available at https://www.respectprocess.org.uk.
- Tracey v Cambridge University Hospitals NHS Foundation Trust [2014] EWCA Civ 822 s53-54
- Recommending standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
- Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (October 2007, updated October 2014)
- Decisions about Cardiopulmonary Resuscitation (CPR) (2016). https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/
- Further information about ReSPECT is available at https://www.resus.org.uk/respect
- Local resources for health and social care professionals: ReSPECT :: Lincolnshire Palliative and End of Life
- Local resources for the public: ReSPECT :: Lincolnshire Palliative and End of Life

- Link to Lincolnshire ReSPECT webpage include case studies and videos on how to conduct ReSPECT conversation.
- RCUK guidance: A guide for Clinicians completing the plan: ReSPECT_Guide_for Clinicians_FINAL.pdf

10. Implementation, Monitoring and Compliance

10.1 Implementation of the policy.

This policy will be shared with health and care staff across the Lincolnshire Integrated Care System via Communications Teams and Networks in each organisation across the ICS the following networks, including the following:

- ReSPECT Network (which includes the ReSPECT Clinical Reference Group)
- Frailty Network
- Falls Community of Practice
- Enhanced Health in Care Homes Community of Practice
- Registered Care Homes and Home Care Managers Network

The policy will also be shared with members of the public via the Lincolnshire ReSPECT public webpage: https://eolc.co.uk/public/respect and the Lincolnshire 'Its All About People' webpage: Lincolnshire Personalised Care and Support Planning

Training is available to support implementation of this policy, see links below for details:

ReSPECT :: Lincolnshire Palliative and End of Life

https://eolc.co.uk/download_file/283/294

Please also see Appendix 3 for further details on the ReSPECT training offer.

10.2 Monitoring compliance with the policy.

Compliance with the policy will be monitored through the following routes:

Key Performance Indicators:

1. Increase in the percentage of patients who have a ReSPECT form in place. Measured via the PEOL After Death Audit (in SystmOne Practices).
2. Increase in the percentage of patients who have a scanned ReSPECT form attached to their electronic patient record. Measured via the PEOL After Death Audit (in SystmOne Practices).

3. Increase in the percentage of patients who have a conversation and a completed ReSPECT form at the point of entry onto the Gold Standards Framework register. Measured via the Lincolnshire Primary Care Activity Dashboard.

Via contract monitoring arrangements using the standard NHS contract (for NHS provider organisations). Under Schedule 2 – The Services, Section G. Other Local Agreements Policies and Procedures, there is a requirement that NHS provider organisations that are commissioned by the ICB are required to comply with the content of the policy.

Non-NHS providers are asked to demonstrate compliance through implementation of the ReSPECT process, applying a multi-disciplinary approach, as described under section 7 of this policy.

All organisations are asked to demonstrate compliance with the ReSPECT process through utilisation of the ReSPECT audit tool (See Appendix 5).

Minimum requirement to be monitored – monitoring against standards set out in policy	**Process for monitoring** **e.g. audit**	**Responsible individuals/ group/ committee**	**Frequency of monitoring/ audit/ reporting**	**Responsible individuals/ group/ committee for review of results and determining actions required**
Key Performance Indicators: 1. Increase in the percentage of patients who have a ReSPECT form in place. 2. Increase in the percentage of patients who have a scanned ReSPECT form attached to their electronic patient record. 3. Increase in the percentage of patients who have a conversation and a completed	1. Measured via the PEOL After Death Audit (in SystmOne Practices). 2. Measured via the PEOL After Death Audit (in SystmOne Practices). 3. Measured via the Lincolnshire Primary Care Activity Dashboard.	Primary Care.	Monthly.	

ReSPECT form at the point of entry onto the Gold Standards Framework register.				
NHS Contract - using the standard NHS contract requiring providers to demonstrate compliance with this policy (for NHS provider organisations). Schedule 2 – The Services, Section G. Other Local Agreements Policies and Procedures.	Existing contract management arrangements.	Provider and ICB Contracts colleagues.	To be determined by provider and ICB Contracts colleagues. At least annually.	
ReSPECT Audit Tool	Utilisation of the ReSPECT Audit Tool (See Appendix 5)	All organisations across the ICS.	Annually.	ReSPECT Clinical Reference Group. Frailty Leadership Group.

Review of document

A full review of this policy will be undertaken by 30 November 2027. Minor amendments can be made to the policy prior to this date which will not affect the full review. Any amendments made to the pilot between full reviews will be clearly stated in the Version Control section.

Appendices

Appendix 1: Equality and Health Inequality Impact Assessment Tool

Appendix 2: Quality Impact Assessment

Appendix 3: ReSPECT Training Needs Analysis

Appendix 4: ReSPECT Form v3.5 specimen

Appendix 5: ReSPECT Audit Tool

Appendix 6: ReSPECT Process Flowchart and Key Information

Appendix 7: Guide for Clinicians

Appendix 1: Equality and Health Inequality Impact Assessment Tool

A. Service or Workforce Activity Details	
1. Description of activity	This impact assessment has been undertaken to support the update of the Lincolnshire ReSPECT Policy.
2. Type of change *Describe the activity and if known at this point think about any parts of the Equality Act where there may be an impact- e.g. Direct Discrimination/ Indirect discrimination/ Provision, Criterion or Practice from the guidance*	The main changes made to the policy are described in the table below:

Change:	Section:	Page:	Reason for change:
Transferred policy to new ICS policy template.	All – whole document.	All – whole document.	New policy template implemented across the ICS in Sep 25, in line with launch of new ICS Clinical Policy Group.
Added Policy Document Statement.	-	3 - 5	Included in new ICS policy template.
Added Contents	-	7	Included in new ICS policy template.
Added Objectives	4	8	Included in new ICS policy template.
Added Scope	5	9	Included in new ICS policy template.
Updated Compliance: • Added Case Law • Added Martha's Rule	6	9 - 11	Requested by members of the ReSPECT CRG.
Added ReSPECT process: • Amalgamated section 2 Principles and section 4 Process. • Restructured section to align with ReSPECT process. • Added Clinical Sign-off section. • Added coding section. Amalgamated references to Children & Young	7	11 - 19	In line with new policy template. Reorganised wording to follow the ReSPECT process (sequential). Clarified responsibilities as requested by delegates at the ReSPECT Summer Workshop on 07.08.25. Clarified who can have a ReSPECT conversation (registered and unregistered staff),

<table>
<tr>
<td></td>
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<table>
<tr><td>People into one section.</td><td></td><td></td><td>document the conversation in a ReSPECT form (registered staff) and sign the ReSPECT form (registered staff).</td></tr>
<tr><td>Updated links to references and websites.</td><td>9</td><td>23</td><td>Ensure in line with latest national guidance and best practice.</td></tr>
</table>

No parts of the Equality Act have been explicitly impacted because of this update.
</td>
</tr>
<tr>
<td>3. Form completed by</td>
<td>Chloe Nicholson.

Ageing Well Programme Lead. Lincolnshire ICB.</td>
</tr>
<tr>
<td>4. Date decision discussed & agreed by project/programme group</td>
<td>Date: 10th September 2025 and 24th September 2025

Project Group/Programme Board: Lincolnshire ReSPECT Clinical Reference Group on 10th September 25; and ReSPECT Policy Task & Finish Group on 24th September 2025.</td>
</tr>
<tr>
<td>5. Who is this likely to affect?</td>
<td>Service users X Staff X Wider Community X

The updated ReSPECT policy is intended for anyone but will have increasing relevance for people who have complex health needs, people who are at risk of sudden deterioration or cardiac arrest, and those people who are likely to be nearing the end of their lives.

It is important to recognise that some people will want to record their care and treatment preferences for other reasons that are not described in this policy.

The policy applies to all health and social care staff (registered and non-registered) working within or represented by the organisations in the scope of this policy, as described below:

East Midlands Ambulance Service
Lincolnshire Care Association (LinCA)
Lincolnshire County Council
Lincolnshire Community Health Services
Lincolnshire Medical Committee
Lincolnshire Partnership NHS Foundation Trust
LIVES
Marie Curie
NHS Lincolnshire Integrated Care Board

</td>
</tr>
</table>

	• St Barnabas Lincolnshire Hospice • The Lincoln Hospital Circle Group • United Lincolnshire Teaching Hospitals NHS Trust • Primary Care Network Alliance

B. Equality Impact Assessment

Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc.

Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality. For example, Black men of low income are more likely to develop and die from prostate cancer. Ethnicity is a major risk factor, Black men are 2-3 times more likely to develop prostate cancer, and socio-economic status adds to the risk. While the NHS provides universal healthcare low-income black men may face barriers.

1. How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?). Please ensure you capture expected positive, negative and neutral impacts in the relevant columns and the data used to assess these impacts.	**Protected Characteristic**	**Data Used to Assess**	**Positive Impact**	**Negative Impact**	**Neutral Impact**
	Age	Resuscitation Council UK website. BMC Primary Care Journal.	Yes – The ReSPECT policy is applicable to all ages and is particularly helpful for people with complex needs.		
	Disability	Resuscitation Council UK website. UK Government Publications – Disability Unit & Office for Equality and Opportunity.	Yes - The ReSPECT policy aims to facilitate discussions about a person's preferences for treatment in emergencies, which can significantly impact individuals with disabilities. **Barriers to Inclusion:** Disabled individuals often		

Think about any parts of the Equality Act where there may be an impact e.g. Direct Discrimination/ Indirect discrimination/ Provision, Criterion or Practice from the guidance **Where a negative impact is identified a Heath Equity Assessment Tool (HEAT) should be completed** [**Health Equity Assessment Tool (HEAT) - GOV.UK**] ***Please refer to the APPENDIX1*** *and consider which nationally and locally identified Inclusion Health Groups/'PLUS groups' need to be considered as*			face barriers to social inclusion, affecting their everyday lives and access to community engagement and support services. **Quality of Life:** Respectful treatment and recognition of disability rights enhance the quality of life for people with disabilities, as highlighted in studies showing that respect leads to better outcomes in various domains, including personal goals and treatment fairness. **Advocacy and Support:** The ReSPECT process encourages individuals to express their preferences, which can empower them and their families in discussions about care and treatment, ultimately improving their quality of life. Overall, the ReSPECT process is essential for ensuring that the needs and preferences of		

[Assessment](#) [GOV.UK](#)			individuals with disabilities are considered in emergency care planning.		
	Gender Reassignment				No direct impacts identified.
	Marriage/Civil Partnership	Resuscitation Council UK website. Acas – Marriage and discrimination law	Yes - The ReSPECT policy will have a positive impact on marriage and civil partnerships by promoting respectful and supportive relationships, and by targeted engagement in families and informal carers in ReSPECT conversations.		
	Pregnancy/Maternity	Resuscitation Council UK website.	Yes - The ReSPECT policy encourages healthcare providers to understand and appreciate the varied backgrounds of individuals, including pregnant women, promoting inclusive approaches to maternal care. The ReSPECT process emphasizes the right of women to make decisions about their bodies, feel safe, and have care teams who respect their values,		

			preferences, and goals.		
	Race	Resuscitation Council UK website.	Yes - The ReSPECT policy has a positive impact on race-related issues, particularly in the context of anti-racism and inclusion practices by ensuring that decisions about people's care are person-centred and open.		
	Religion/Belief	Resuscitation Council UK website.	Yes – The ReSPECT policy does not directly impact on religion, but the principles of respectful and person -centred communication and understanding apply to ReSPECT.		
	Sex	Resuscitation Council UK website.	Yes – The ReSPECT policy does not directly impact on person's sex, but the principles of consent, mutual boundaries and open communication have a positive impact on the person.		
	Sexual Orientation	Resuscitation Council UK website.	Yes – The ReSPECT policy does not directly impact on person's sexual orientation, but the principles of consent, mutual boundaries and open communication		

			have a positive impact on the person.		
	Other Vulnerable Groups	**Data Used to Assess**	**Positive Impact**	**Negative Impact**	**Neutral Impact**
	No other groups identified	As described in column above.	Age Disability Marriage/Civil Partnership Pregnancy/Maternity Race Religion/Belie Sex Sexual Orientation	No negative impacts	Gender reassignments.

2. Overall what data has been / do you need to consider as part of this assessment? What is this showing / telling you? Are there any gaps in the data? If so what are they and how has this affected your assessment of impact?	Data has been used from the Lincolnshire Health Intelligence Hub (Website: [Lincolnshire's Population - Lincolnshire Health Intelligence Hub]) and the Office for National Statistics. This data reflects that Lincolnshire has a higher-than-average population aged 65 years and over. **Age Demographics:** Lincolnshire's coast has an older age profile and a population that is ageing relatively rapidly with slow population growth. In the First Coastal PCN, which includes the coastal towns and communities around Skegness and Mablethorpe, nearly 32% of registered patients are aged 65 or over, compared with 18% in England. Whilst population growth is very low in the coastal areas, it is driven by increases in the over 65s. The 65 and over population is projected to increase by another 43.9% by 2041 (nearly 8,000 people) and the over 85s by 116.6% (more than 2,000 people). [Source: Chief Medical Officer's Annual Report 2021 Health in Coastal Communities]. Key points to note: • There is a higher proportion of adults over the age of 75 and the number in this age range is expected to double over the next 20 years. • It is estimated that around 1-2% of the population should be recognised as palliative. In Lincolnshire recognition is 0.67%. • A combination of an ageing population, rural geography and areas of high socioeconomic deprivation creates a challenge to delivering high quality and effective treatment and preventative services. • Hospice UK estimated that as many as one in four people are not able to access palliative and end of life care services and support needed [source]. • Currently around 50% of overall number patients of palliative patients are also on cancer register, suggesting low recognition of other diagnoses. Nationally, around 1 in 4 deaths are cancer related.

	• Around 43% of people have been placed on the palliative register in the last 4 weeks of their life –this late recognition is higher in areas of higher deprivation. • Only 42% of people who have died with an Identified Health Need –had been recognised and on palliative register. • Across all ages, locally around 54.9% of females are being identified as palliative, compared to 45.1% males, whilst the population distribution is 50.5% and 49.5% respectively. This suggests inequality in the services received by men. • 'White other' - disproportionately low recognition compared to White British – 2% only whilst constituting 6% of the population. This picture is similar in other ethnicities. The absence of national datasets and resulting analysis on access to end-of-life care for different population groups means we are unable to accurately assess how widely people are being reached. A common dataset on access and outcomes across specialist and generalist palliative and end of life care services, reported regularly and accessible to all, would be an important step to understand how well needs are being recognised and responded to. The information above is taken from 2021/22 data (latest published data available at time of completing this impact assessment) therefore it should be noted that this position may have changed since that time.
3. What is the potential impact of your work on health inequalities? How can you make sure that your work has the best chance of reducing health inequalities? *Please refer to the APPENDIX 1 and consider which nationally and locally identified Inclusion Health Groups/'PLUS*	The project work on ReSPECT has highlighted the need to expand reach and engagement of ReSPECT process to all people who are at risk of deterioration, earlier in the person's pathway, and expand communication and awareness of ReSPECT across the system. This work will have a positive impact on the whole target population including those with protected characteristics via the following initiatives: • Early recognition of frailty via Neighbourhood Frailty approach, leading to improved care planning, co-ordination and continuity of care. • Early recognition of the palliative status, improved care planning, co-ordination and continuity of care (ACP, ReSPECT) with decreased number of acute admissions as a result. • Higher identification of palliative patients that are non-cancer and/or known to other specialisms and on registers. • Systemwide collaborative approach to ReSPECT will enable increased opportunity, consistency, parity and access for all hard-to-reach groups. No negative impacts have been identified.

groups' need to be considered as part of this assessment **Where a negative impact is identified a Heath Equity Assessment Tool (HEAT) should be completed** **Health Equity Assessment Tool (HEAT) - GOV.UK**	
4. What engagement have you undertaken to gain the views of any potential affected groups? What feedback have you received? *Where there is a new service or change to service is being planned NHS organisations have a Duty to Involve –* ***See APPENDIX 2 for***	Engagement was undertaken with the following: • Lincolnshire health and care system via a ReSPECT Workshop on 7th August 2025* • Palliative and End of Life Patients by Experience Group* • ReSPECT Clinical Reference Group* The following organisations were consulted during the development and review of this document: • East Midlands Ambulance Service • Lincolnshire Care Association (LinCA) • Lincolnshire County Council • Lincolnshire Community Health Services • Lincolnshire Partnership NHS Foundation Trust • NHS Lincolnshire Integrated Care Board • St Barnabas Lincolnshire Hospice • United Lincolnshire Teaching Hospitals NHS Trust Feedback reflected that not all people are aware of ReSPECT process, and for those who are aware, the ReSPECT conversation is not always initiated early enough in the person's journey. It has also been identified that ReSPECT conversations need to be more holistic and centred on the individual's culture age, and background to ensure that ReSPECT plans are targeted to the person's needs. This is reflected in the upaded ReSPECT policy. *Outputs have been used to inform the updated ReSPECT policy and inform this impact assessment.

***information on what this means** and please contact your Engagement Team for further advice.*	
C. Risks and Mitigations	
1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	No negative impacts have been identified. Improvement opportunities that have been identified via engagement work have been incorporated in the updated ReSPECT policy.
2. What data / information do you have to monitor the impact of the decision?	Data on 'ReSPECT plan in place' and 'ReSPECT declined' is incorporated in the PEOLC data dashboard which is shared with PCNs each month. Compliance with ReSPECT training.
D. QEIA Review and Decision Making	
1. Recommendation from System QEIA Review Group to proceed	Yes / No *Delete as appropriate and add detail or rationale*
2. Any further actions required?	*eg. risk to be added to the risk register or capturing in local action log et*
3. Date of consideration by System QEIA Review Group	
4. Recommendation from System Clinical Cell to proceed?	Yes / No *Delete as appropriate and add detail or rationale*
5. Date of consideration by System Clinical Cell	
Date for review	*Please note: the equality impact assessment is a 'live' document and must be reviewed regularly / when any significant change occurs. In particular the EIA should be reviewed following engagement work and/or measuring impact of change.*

Appendix 2: Quality Impact Assessment

Download QIA: https://eolc.co.uk/download_file/force/368/294

Download EIA: https://eolc.co.uk/download_file/force/367/294

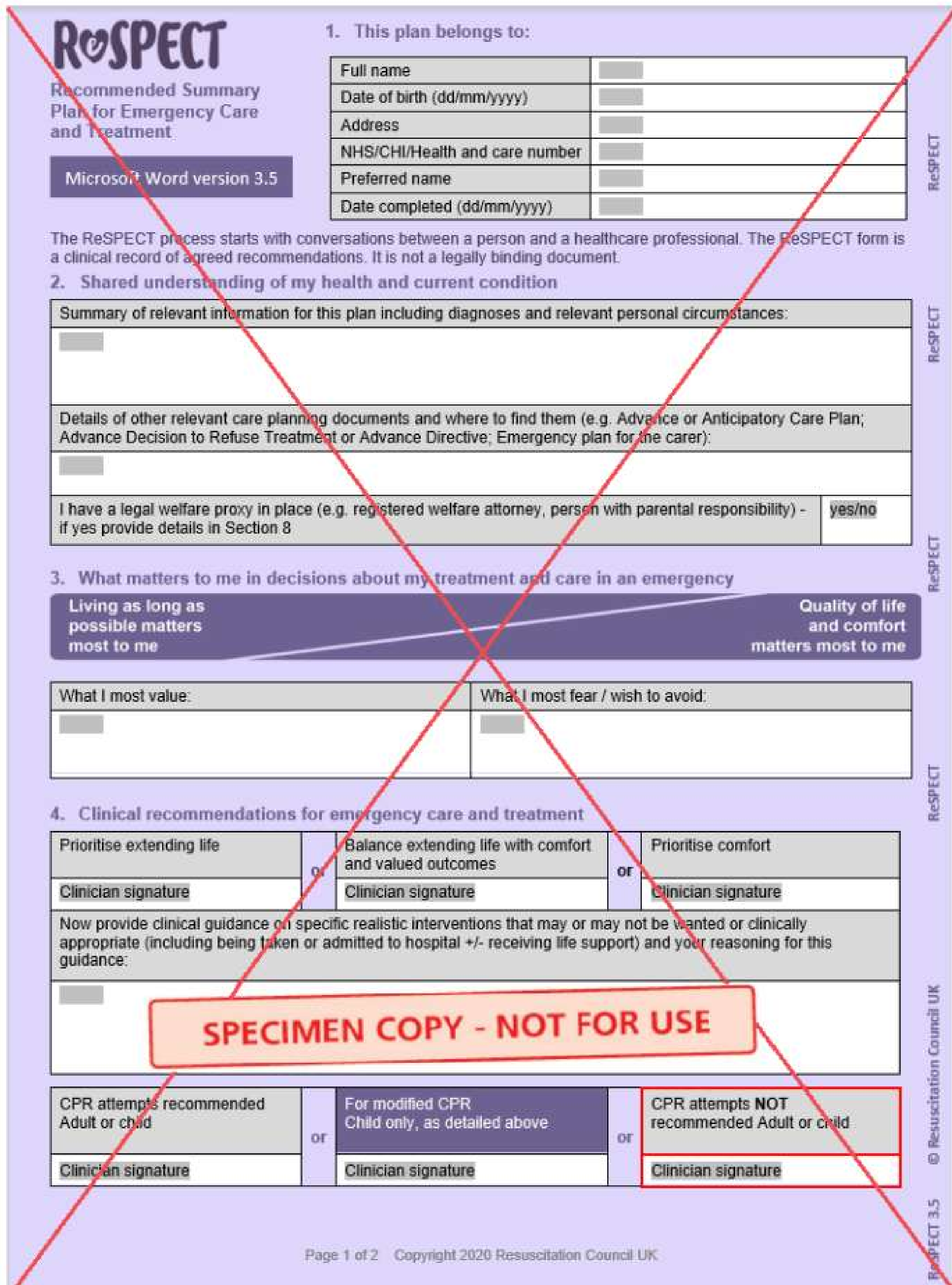
Appendix 3: ReSPECT Training Needs Analysis

* It is recommended that awareness of the ReSPECT process is undertaken by all administrative staff involved in clinical administration including ward clerks, Emergency Department receptionists, medical secretaries, medical records staff involved in registration and clinic preparation, and relevant managers and service managers. ** Business as Usual training will need to be developed with the support of Learning and Development/ Training and Education strategy/ Medical Education as part of the Junior Doctors programme.	Consultants, Registrars and GPs	Core medical trainees (CMTs), Foundation Year	Senior and specialist nurses and AHPs who would like/ need to be able to implement the process	Paramedics, clinical hub and Out of Hours practitioners	Nurses, AHPs and other registered healthcare professionals	Care Home Managers/ Non-registered care assistants and support workers	Non-clinical and administrative staff *
ReSPECT Tier 1 — Awareness (What is ReSPECT?) For all staff working with patients (clinical and non-clinical) undertaken through • face-to-face/ Microsoft team updates including drop-in sessions (re-launch) • face-to-face induction (new starters) • e-learning (relaunch and updates)	✓	✓	✓	✓	✓	✓	✓
ReSPECT Tier 2 — Action (How to care for a person with ReSPECT) For clinical staff (including non-registered staff) working in care homes, ambulance services, acute Trusts, out-of-hours and community providers who will need to recognise the form and act on the recommendations undertaken through: • face-to-face/ Microsoft team updates including drop-in sessions (re-launch) • face-to-face induction (new starters) • e-learning (re-launch and updates) • incorporating into business-as-usual training (e.g., updates, simulations, and ongoing role essential training)**	✓	✓	✓	✓	✓	✓	
ReSPECT Tier 3 — Conversations and authorship (Having and recording ReSPECT conversations) For clinical staff (Registered Practitioners including nurses, AHP, and Doctors) who will undertake the process with patients, and for staff interested in supporting: • face-to-face/ Microsoft team updates including drop-in sessions (re-launch) • e-learning (launch and updates) • Support/ buddying/ confidence and competence/proficiency in practice • incorporating into business-as-usual training (e.g., updates, simulations, and ongoing role essential training)**	✓	✓	✓	✓	✓		
Advanced communication skills training – optional training For clinical staff who wish to further develop their skills – please liaise with your local organisations in sourcing this training package.	✓	✓	✓	✓	✓		

ReSPECT Training and Education resources can be accessed via the links below:

- ReSPECT Modules on **E-learning for health (E-lfh):** Home - elearning for healthcare
- https://eolc.co.uk/download_file/283/294
- ReSPECT :: Lincolnshire Palliative and End of Life

Appendix 4: ReSPECT Form v3.5 specimen



ReSPECT

Recommended Summary Plan for Emergency Care and Treatment

Microsoft Word version 3.5

1. This plan belongs to:

Full name	
Date of birth (dd/mm/yyyy)	
Address	
NHS/CHI/Health and care number	
Preferred name	
Date completed (dd/mm/yyyy)	

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8	yes/no

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me — Quality of life and comfort matters most to me

What I most value:	What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
Clinician signature		Clinician signature		Clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

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CPR attempts recommended Adult or child	or	For modified CPR Child only, as detailed above	or	CPR attempts **NOT** recommended Adult or child
Clinician signature		Clinician signature		Clinician signature

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5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Document the full capacity assessment in the clinical record.	yes/no
If no, in what way does this person lack capacity?	
If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.	

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A, B or C, OR complete section D below):		
☐	A	This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
☐	B	This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
☐	C	This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
☐	1	They have sufficient maturity and understanding to participate in making this plan.
☐	2	They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
☐	3	Those holding parental responsibility have been fully involved in discussing and making this plan.
☐	D	If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade / speciality	Clinician name	GMC/NMC/HCPC no	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature (optional)
*			

* First line is for primary emergency contact

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9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade / speciality	Clinician name	GMC/NMC/HCPC no	Signature

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Appendix 5: ReSPECT Audit Tool

Download tool template excel spreadsheet from:

https://eolc.co.uk/download_file/force/339/294

Updated May 2023

ReSPECT Audit Tool - Name of Placement

						Please look at the sections and respond Yes/No or comment regarding whether the boxes have been clearly completed or not																	
						Section 1	Section 2		Section 3		Section 4			Section 5		Section 6	Section 7		Section 8	Section 9			
Name (initials)	Ward/ setting name	Care Homes only: Type of bed	Is the ReSPECT in the front of the person's record?	In which setting was the ReSPECT form completed?	Date of completion	This plan belongs to (V2: Personal Details)	Shared understanding of my health and current condition (V2: Summary of relevant information)	Details of other planning documents	What matters to me scale (V2: Personal preferences)	What I value most (V2: What is important to you)	Clinical recommendations box choices (1of 3) (V2: Treatment/ symptom control scale)	Clinical guidance box?	Resus status?	Capacity	In which way does the person lack capacity	Involvement in making this plan	Clinicians' Signatures	Clinician who completed the form	Emergency contacts & those involved in completing this plan	Form reviewed and remains relevant (V2: Confirmation of validity)	Does the ReSPECT form pass the '3AM test'?	Do you feel a ReSPECT should already have been in place?	Comments

Appendix 6: ReSPECT Process Flowchart and Key Information

Download from: https://eolc.co.uk/download_file/force/366/294

For more information see links:

Lincolnshire End of Life website

Resus Council website

Has a ReSPECT conversation taken place?

YES

NO

A ReSPECT conversation should be initiated for those with deteriorating health or a further conversation if a person has a change in their condition or change of setting in which they stay/live
LINK to ReSPECT Patient Guide

Does this person have capacity for a ReSPECT conversation?

YES

NO

Does this person have LPOA/ Best interest decision making in place?

YES

NO

Complete Best Interest Decision making

Engage with the LPOA/ family/ carers/ loved ones/ advocates

Where it may be available:
- Hard copy at person's home/ care home notes/ hospital notes
- Shared Care Record
- SystmOne/ EMIS/ RIO

Does the person have a ReSPECT form recording their conversation in place?

YES

NO

Start a new conversation

Refer to the ReSPECT Policy

Discuss each section with the person / significant ones and document the their wishes and clinical recommendations – using MDT approach where necessary

When does it need to be reviewed:

Has there been a change of condition?
Has there been a change of setting?
Has there been a change with a person's wishes and decisions?

NO

YES

No change required

Date & Sign Form reviewed (Section 9)

Update required

A Guide to completion and recording the ReSPECT conversation
CLICK here

- Minor amendments can be made (as long as the form remains legible) by the registered practitioner dating & signing each of the updated sections
- Major amendments require completion of a new form for clarity

Date & Sign

Document the ReSPECT conversation in person's records

Bring to attention of the Senior Responsible Clinician

Scan on to the shared care record e.g. SystmOne/ EMIS/ RIO/ EDD

Provide person/ family/ carers/ loved ones with information

A person should be advised to keep their form in a safe, easily accessible place in case of an emergency e.g. in front of notes, message in a bottle, and make sure it travels with them

Communicate updates with other professionals involved in care

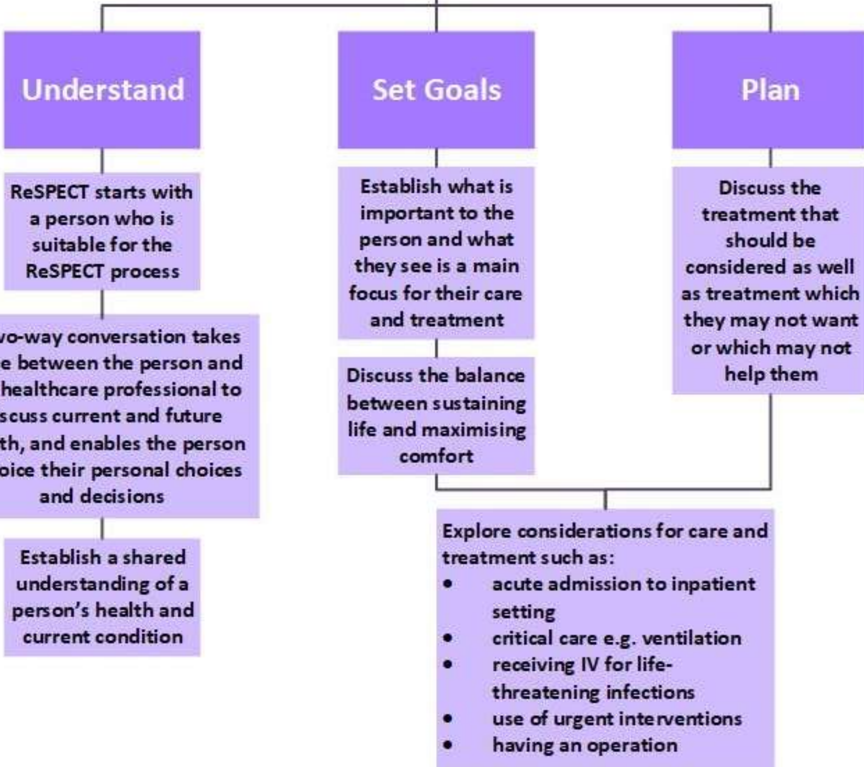
ReSPECT

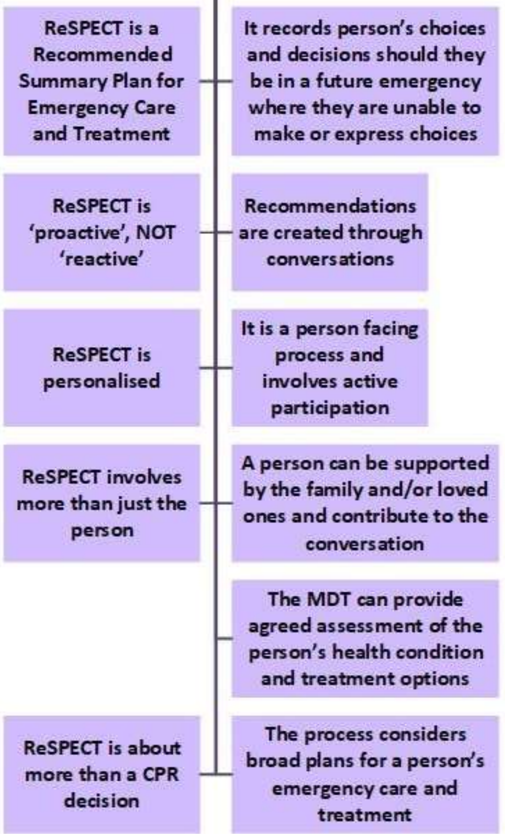
Key Information

For more information see links:
Lincolnshire End of Life website
Resus Council website

Main Points

- ReSPECT is NOT a legally binding document however the recommendations made must be considered when making decisions about person's care and treatment
- Following the ReSPECT conversation, a person's wishes and clinical recommendations for appropriate treatment are recorded on the ReSPECT form which they keep with them
- ReSPECT should be reviewed and updated following a change of condition, circumstances or if a person wishes to reconsider their recommendations
- The ReSPECT form is recommended to be printed on purple card/ paper wherever possible to make it easily identifiable and located in the event of an emergency
- The colour of the form, however, does not invalidate the content





Appendix 7: Guide for clinicians

The ReSPECT process - A guide for clinicians completing the plan

Before you start:

- Remember that completing the plan is only part of the ReSPECT process.
- You can use the sequence of sections on the plan to guide you through the conversation that is an essential part of that process.
- Do **not** complete the plan without maximum possible involvement of the person in the process (or of those best able to speak for them if they do not have capacity for involvement).
- Use the plan to summarise what was discussed and agreed. Document more detailed information in the person's health record.

Section 1: "This plan belongs to"

Complete all details fully and clearly. Those responding to a future emergency must be able to identify the person immediately and confidently.

Section 2: "Shared understanding of my health and current condition"

Discuss, explain and achieve a shared understanding of the person's relevant health conditions and how these may progress or change. Summarise in this section's three boxes:

- relevant conditions and circumstances. Do not record unnecessary detail (e.g. of past medical history, medication). Include communication problems and how to overcome them. Make sure that the person (or anyone speaking for them) knows and agrees with what you record.
- specific detail of any other planning documents and where to find them.
- whether or not they have a legal proxy. If so, put name and contact details in section 8.

Section 3: "What matters to me in decisions about my treatment and care in an emergency"

- Summarise what the person says would matter most to them (values and fears), both in daily life and as an outcome of future emergency treatment. If possible, use their own words. If the person does not have capacity to participate, whenever possible family or other representatives must be involved in establishing what is important to the person.
- Help the person understand how some people want all possible interventions to try to live as long as possible, others want care to focus only on maintaining their comfort and many want a balance between these.
- Explain that this plan is for use only when they cannot express what is important to them about their emergency care and treatment.

Section 4: "Clinical recommendations for emergency care and treatment"

- Record recommendations for a future emergency on interventions that:
- could result in desired outcomes and would be wanted
- are likely to result in a feared outcome and would not be wanted

have little or no realistic chance of success, so would not work.

Following from clinical understanding and the values and fears agreed in sections 2 and 3, establish an agreed overall goal of care, and sign one of the three boxes:

- **Prioritise extending life:**
  they would receive treatment to control symptoms, and would want potentially life-sustaining treatments, even if they involve some discomfort and/or risk.
- **Balance extending life with comfort and valued outcomes:**
  they would want some potentially life-sustaining treatments in some circumstances.
- **Prioritise comfort:**
  they want care and treatment to control symptoms and maintain their comfort. This does not mean that they should not receive (for example) an antibiotic for an infection. They would not want invasive intervention with a primary purpose of extending life.

Next, record freehand clinical recommendations on **specific interventions** that would or would not be wanted or clinically appropriate, and summarise the reason for these. This may include whether the person would want to be taken to hospital and in what circumstances. Include other relevant recommendations (e.g. whether they should be considered for intensive care, or for 'invasive' ventilation).

Complete this box clearly. Avoid jargon; use wording that will be easily understood by all who may respond to an emergency in any health or care setting.

Now, after discussion and agreement, sign in **ONE** of the boxes to indicate whether CPR attempts are recommended (or, in a child, whether a plan for modified CPR has been agreed). A recommendation about CPR should be discussed within the discussion of overall goals of care, along with an honest explanation of what treatments can realistically be expected to achieve those goals. Remember that clinicians **must** discuss a recommendation not to attempt CPR with the person concerned, unless it is thought that it will cause physiological or psychological harm; if you believe this is so, you must document your reasons in section 6 and in the person's health record.

Section 5: "Capacity for involvement in making this plan"

- Assume the person has capacity.
- If you suspect the person has an impairment or disturbance of mind or brain, you must test their capacity for each specific decision. If the person lacks capacity for a specific decision, or they cannot have capacity (e.g. they are unconscious), the decision must be made by following the requirements of capacity legislation.

Section 6: "Involvement in making this plan"

Select **A, B** or **C** as appropriate, or complete section **D**.
Select **D** – if there has been:

- no involvement of the person (adult with capacity or child with sufficient maturity and understanding) because you believe it would cause physiological or psychological harm.
- no involvement of family or other representatives of a person who lacks capacity, because you believe this impracticable or inappropriate (e.g. no contact details or you believe that contacting a frail family member in the middle of the night would place them at risk).
- no involvement of those with parental responsibility for a child.

Summarise your reasons here; document them fully in the clinical record, together with a clearly defined plan to involve the person and/or their representatives as soon as possible/appropriate.

Section 7: "Clinicians' signatures"

As the professional who completed the ReSPECT plan, you must sign this section and record the date and time. If you are not the senior responsible clinician, inform them of the plan and – at the earliest practicable time – they should review and endorse it by signing the shaded line (or – if appropriate – undertake further discussion and revision of the plan before signing it).

Section 8: "Emergency contacts and those involved in discussing this plan"

If they want to, let the person and/or those close to them confirm their involvement by signing here. Their signatures are optional. They do not make the plan legally binding. Record details of people to be contacted in an emergency. Remember that the plan is for use across all health and care settings.

Section 9: Plan reviewed (e.g. for change of care setting) and remains relevant

- Leave this blank at initial plan completion.
- Review may be prompted by a request from the person or their representative, by a change in their condition or by their transfer from one care setting to another. The responsible clinician should review the ReSPECT plan entries, and discuss the plan with the person themselves, unless to do so is justifiably unnecessary or would be harmful to them. If the recommendations are still appropriate, they should sign and date Section 9 to confirm this.
- If the recommendations are (or may be) no longer correct, they should be discussed and reviewed with the person (or representative(s) of a person who lacks capacity) and – where appropriate – a new ReSPECT plan should be completed.

Signature Sheet

Policies and Standard Operating Procedures will not be accepted for review and ratification by the Lincolnshire ICS Clinical Policies Group without this signature sheet being completed and included as part of submitted documentation.

Names of people consulted about this policy:

Name	Job title	Organisation	Department
Dr Sadie Aubrey	Frailty Clinical Lead	Lincolnshire ICB	NA
Professor Colin Farquharson	Group Chief Medical Officer	Lincolnshire Community and Hospitals NHS Group	NA
Dr Adam Brown	Consultant in Palliative Care	St Barnabas Hospice	NA
Dr Reid Baker	GP; Lincolnshire LMC Medical Director	Lincolnshire LMC	NA
Dr Kaval Patel	Chief Executive Officer	Lincolnshire PCN Alliance	NA
Plus, members of the ReSPECT Clinical Reference Group which includes ReSPECT representatives from the following organisations: • East Midlands Ambulance Service • Lincolnshire Care Association (LinCA) • Lincolnshire County Council • Lincolnshire Community Health Services • Lincolnshire Medical Committee • Primary Care Network Alliance • Lincolnshire Partnership NHS Foundation Trust • NHS Lincolnshire Integrated Care Board • St Barnabas Lincolnshire Hospice • United Lincolnshire Teaching Hospitals NHS Trust			

Person's and public engagement activity	When took place

ReSPECT Workshop (with representation from colleagues across the ICS (approx. 80 attendees))	7 August 2025
PEOL Co-Production Group	22 August 2025

Names of meetings / committees which have approved the policy	**Approved on**
ReSPECT Policy Task & Finish Group	24 September 2025
ReSPECT Clinical Reference Group (virtually, initial draft changes supported at CRG meeting on 10 September)	30 September 2025