Future Care Planning including ReSPECT and DNACPR Policy

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DOCUMENT CONTROL		POLICY NO.	168
Policy Group:	Clinical Governance		
Lead Author:	Consultant Palliative Medicine		
Lead Executive:	Medical Director		
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Policy on a page

Summary & Aim	Key Requirements

Local policy to support future care planning discussions and recording, including emergency plans such as ReSPECT, DNACPR, and others. It sets out the roles and responsibilities for health and social care staff developing and using these documents.	• This policy compliments the national Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) policy and should be read in conjunction with that. This policy fully supports national guidance and recommendations published in a joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). This policy should be read in conjunction with that guidance.
	
	• This policy ensures staff across health and social care settings understand their roles and responsibilities regarding Future Care Planning in line with Healthcare Improvement Scotland (HIS) guidance for a 4 step approach:
	  • preparation and planning,
	  • meaningful conversations,
	  • documentation, and
	  • sharing and regular review.
	
	• This policy acknowledges that people are central in decisions about the treatment that they receive and supports shared decision making between people and those providing treatment and care to them.

Target Audience	**Previous Names**
Staff involved in Future Care Planning and staff using the plans in practice.	Not applicable

Equality and Diversity Statement
NHS Dumfries and Galloway recognise that some communities within society are more likely than others to experience discrimination, prejudice and inequalities. The Equality Act 2010 specifically recognises the protected characteristics of **age, disability, sex, race, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership**. The Fairer Scotland Duty, also requires NHS Dumfries and Galloway to actively consider how socio-economic disadvantage can be reduced when making strategic decisions.

The New Armed Forces Covenant Statutory Duty places an expectation on NHS Dumfries and Galloway to consciously consider the Armed forces Covenant when developing, delivering and reviewing policies and decisions which may impact the Armed Forces community and help improve their access to public services.

Consideration on all of the protected characteristics, the Fairer Scotland Duty and the Armed Forces Covenant are included within the Equality Impact Assessment process and documentation, which must be completed as part of the Policy Development Process.

NHS Dumfries and Galloway is committed to promoting and advancing equality, removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those who do not. This applies both in the provision of services and as our role as a major employer. NHS Dumfries and Galloway believe that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discrimination practice.

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1. PURPOSE AND RATIONALE

Ongoing developments and continuous improvements in healthcare mean that many people are able to live well, for longer than ever before. For the vast majority of people, the over-riding aim of care and treatment in an emergency situation is to return them to their pre-illness level of health, or as near to that as possible. However, recent advances cannot extend life or stave off ill health indefinitely.

Some people with complex or rare conditions want an easy way to communicate their wishes in an emergency, should they be unable to communicate, including the correct lifesaving treatment.

Many people want to be able to influence the treatment that they receive, and take part in decision- making about treatment, whether currently in a state of ill health, or in anticipation of ill health. For others, decisions about the treatment that they receive may need to be taken by others, if they lack the mental capacity to make those decisions themselves.

This policy compliments the national Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) policy and should be read in conjunction with that.

This policy fully supports national guidance and recommendations published in a joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). This policy should be read in conjunction with that guidance.

This policy's purpose is:

- To acknowledge that people are central in decisions about the treatment that they receive, and to support shared decision making between people, family/Carers and those providing treatment and care to them.
- To support future (anticipatory) care planning for those who choose to undergo this process, whether or not they have an advanced, progressive illness.
- To support the right of people over 18 years of age to refuse, in advance, any treatment, even if that treatment is potentially life-sustaining. This right applies to adults with the mental capacity to refuse treatments in advance, in line with existing legislation.
- To support the legal requirement to treat those who lack mental capacity in relation to a particular decision in line with the Adults with Incapacity Act. This extends to making decisions about potentially life-sustaining treatments on behalf of a person, including decisions about cardiopulmonary resuscitation (CPR).
- To clarify the legal status of a completed Future Care Plan, including a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) document.

- To support the use of and transferring future care plans including a ReSPECT document across boundaries of healthcare, accompanying the person and applying in all settings.
- To support the use of the ReSPECT document as a summary document for use in an emergency, and not a replacement for comprehensive documentation that includes details of discussions that have taken place. Such discussions must still be documented in relevant professional notes if ReSPECT does not have enough details. Other future care plan forms are likely to be summaries and follow the same principle.

2. POLICY AIMS

Local policy to support future care planning discussions and recording, including emergency plans such as ReSPECT, DNACPR, and others. It sets out the roles and responsibilities for health and social care staff developing and using these care plans.

3. POLICY SCOPE

This policy applies to all of the multidisciplinary healthcare team involved in a person's care in all settings. It applies to adults over the age of 18. Paediatric services will create an aligned policy reflecting the decision making framework for this group of people.

4. DEFINITIONS

Cardiorespiratory arrest: The cessation of cardiac output and spontaneous breathing. Unless this can be reversed by CPR, it will inevitably lead to death.

Consent: The process by which a person with mental capacity can accept or refuse a treatment that is offered to them. To be valid, consent must be given freely, based on adequate information. Please refer to local policy for further information.

CPR (cardiopulmonary resuscitation): A broad term which refers to attempts made to restart the heart and provide effective breathing in a person who is in cardiorespiratory arrest. The chances of success vary, depending on several factors including any underlying illness that the person may have. In Scottish law, CPR is classed as a medical treatment.

Current healthcare record: Often referred to as 'medical notes' or 'patient notes', a person's usual healthcare record may change between places of care. For example, it might refer to the GP notes for a person at home, or the hospital's 'medical notes' when the person is in hospital.

Emergency Treatment Decisions: The term often given to decisions about providing or limiting potentially life-sustaining treatments for a given person. Decisions about CPR are an example of emergency treatment planning.

Emergency Treatment Plans: The term given to a written record of a shared decision making process about care and treatment in an emergency situation. The ReSPECT document is an example of an emergency treatment plan. In acute settings, the “Summary Plan for Deteriorating Health” or Treatment escalation Plan is used for that admission but should be transferred to a ReSPECT form on discharge.

Future Care Plan: A future care plan summarises what people say about themselves alongside clinical advice to guide treatment and care if they become unwell.

Future Care Planning: The process of developing a Future Care Plan. It is a voluntary process through which people can plan about the care that they may be offered at a time when they lack capacity to give or withhold consent. It may take the form of stating wishes, preferences and values. It is broader than, but includes, ‘emergency treatment planning’ (see above).

Healthcare Professional with overall clinical responsibility: The healthcare professional involved in a person’s care who is ultimately professionally responsible for a person’s healthcare in a given setting. This person will also be professionally responsible for engaging in the Future Care Planning process and documentation for that person.

Healthcare setting: A place where a person receives healthcare from a distinct healthcare team, or a distinct healthcare professional with overall clinical responsibility. For example, a hospital, and a person’s home, will count as different healthcare settings.

Potentially life sustaining treatment: Any medical treatment that, in the judgment of the healthcare professional with overall clinical responsibility for a person, has a significant chance of extending a person’s life. This may include CPR, clinically assisted hydration and nutrition, assisted ventilation and intravenous antibiotics (this list is not exhaustive).

Mental capacity: the ability to understand information relevant to a decision or action and to appreciate the reasonably foreseeable consequences of taking or not taking that action or decision (decision specific). There is presumption in favour of capacity. A person is judged to be incapable if they cannot:

- act on that decision; or
- make a decision; or
- cannot communicate a decision (ensuring all possible means to support this are explored); or
- understand a decision; or

- retain the memory of a decision

Reference should be made to the Adults with Incapacity (Scotland) Act 2000.

Nominated deputy: A healthcare professional with delegated responsibility from the healthcare professional with overall clinical responsibility, who has the necessary knowledge and skills required. This may be, for example, a resident doctor or advanced practitioner.

Provider / healthcare provider: This is a broad term that refers to the organisations and institutions responsible for the provision of healthcare to a person in any setting. It includes, for example, hospitals, ambulance services, and General Practices (but not individual practitioners and clinicians).

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document: An emergency care plan (see above) that summarises information about plans for emergency treatment and potentially life-sustaining treatment for a person in the event of their clinical deterioration and includes decisions about CPR. A copy of the form is included in Appendix 1.

Treatment Escalation Plan: Treatment escalation plans (TEP) are emergency care plans for single episodes of care in acute settings. They allow specific guidance on complex treatments in acute care relevant to that admission. There is ongoing work to have a nationally agreed TEP for Scotland.

5. DUTIES / RESPONSIBILITIES

Clinical decision making: Health and social care workers have individual responsibility for those in their care and should know how to escalate to more senior staff when required. When an emergency care plan such as ReSPECT or DNACPR is completed by a member of staff, that individual takes responsibility for what is on the form. The person with overall clinical responsibility (usually a Consultant or GP) should be informed as soon as possible. For e-ReSPECT forms the GP will receive a copy as soon as the document is live. However, if the patient is not in a community setting then responsibility remains with the responsible clinician (usually Consultant).

When acting on guidance within an emergency care plan the person in attendance is responsible for following it where appropriate, and in line with their overall duties and responsibilities. Where that involves seeking help, for example a care home support worker, the person in attendance should alert the senior decision maker to the presence of a future care plan, particularly an emergency care plan.

Decisions must always be made in accordance with existing legal and professional guidance including the National DNACPR policy. In all circumstances where it is practicable to do so, a DNACPR should be accompanied by either a ReSPECT form or a TEP form to ensure compliance with this guidance and reduce patient harm.

Validity and Applicability of a person's ReSPECT and TEP document. Where a patient no longer has capacity for the relevant decisions, the ReSPECT document should be used as a guide to decision-making by healthcare professionals in an emergency including potentially life-sustaining treatments in line with the principles of the Adults with Incapacity Act.

A person's ReSPECT will remain valid as an up-to-date plan for emergency care and potentially life-sustaining treatment until it is cancelled, or unless the decision-maker at the time has reasonable doubt that the document is not valid, or not applicable to the current situation.

A TEP plan is only applicable to the single admission in which it was created and remains valid throughout unless it is cancelled, or unless the decisionmaker at the time has reasonable doubt that the document is not valid, or not applicable to the current situation. A TEP should be reviewed following inter hospital transfer, for example to a tertiary centre or between DGRI and GCH. On discharge from DGRI or GCH to a community setting, if an ongoing Future Care Plan is appropriate then the ReSPECT process should be initiated.

The decision-maker should bear in mind that they should have good reason for, and be prepared to justify, a decision to go against the shared plan in an existing ReSPECT or TEP document that is valid and applicable (reflecting the wishes or the patient or proxy) but also understand that these documents are not legally binding in Scotland. The following is taken from Scottish Government's Adult's With Incapacity: Code of Practice for Medical Practitioners (2010):

> "2.29 Medical records may record the past wishes of the adult from earlier contacts with the medical profession. It will be essential to try to ascertain the adult's past wishes and feelings from those who know him or her. While these reports should be taken into account, the practitioner should guard against taking at face value everything that relatives or carers say about the adult's past wishes and feelings, in case these have been misunderstood or are being misrepresented. If time allows and it is feasible to do so, it may be appropriate to contact the patient's solicitor, member of the clergy or other adviser to ascertain whether the patient at any time in the past expressed wishes or feelings on the subject of his or her medical treatment.

> 2.30 A competently made advance statement made orally or in writing to a practitioner, solicitor or other professional person would be a strong indication of a patient's past wishes about medical treatment but should not be viewed in isolation from the surrounding circumstances. The status of an advance statement should be judged in the light of the age of the statement, its relevance to the patient's current healthcare needs, medical progress since the time it was made which might affect the patient's attitude, and the patient's current wishes and feelings. An advance statement cannot bind a practitioner to do anything illegal or unethical. An advance statement which specifically refuses particular treatments or categories of treatment is called an 'advance directive'. Such documents are potentially binding. When the practitioner contemplates overriding such a directive, appropriate legal and ethical guidance should be sought."

Note that the ReSPECT and TEP processes and documents are not solely aimed at decisions about limiting treatment; the process is intended to support people to articulate and share their views about treatments and approaches to care that they do want, as well as about those that they don't. A patient's wishes to have a particular treatment cannot compel it to be offered. A healthcare professional has no legal duty to give a person a treatment that they judge to be futile, or to be clinically inappropriate, including CPR, in line with the National DNACPR policy, the joint statement and GMC guidance.

Information Sharing: The professional completing a Future Care Plan is responsible for sharing with other appropriate colleagues in line with data protection and information governance policy. Future Care Plans uploaded to Clinical Portal will be scanned under "00 Patient Directives". ReSPECT plans are electronic and will automatically be shared with the GP surgery via Docman and uploaded to Clinical Portal and will be accessible to Scottish Ambulance Service and Adastra (GP Out of Hours) for use in an emergency as intended.

6. PROCESS / PROCEDURES

Future Care Planning should be carried out using the four step process described by HIS. The following diagram from HIS illustrates this:



Step 1: Preparation and planning. Ensure staff member feels confident and competent to have conversation. Check person is ready for conversation and has those relevant to them present. Consider any additional communication or support needs.

Step 2: Meaningful Conversations. Person centred conversation at a pace and level appropriate to that person. May be more than one conversation and may need to involve specialists where relevant.

Step 3: Documentation and sharing. Document clearly in the care record (healthcare record if an emergency care plan) and summarise on relevant form. Share, as appropriate with relevant professionals. ReSPECT sharing is described in appendix 2.

Step 4: Regular review. Review dates will vary depending on clinical condition and context. Admission or discharge from acute settings or community based alternatives to acute should trigger a review. Other review “triggers” are described in appendix 3.

A local standard operating procedure for Future Care Planning has also been drafted and is attached in appendix 4.

7. CONSULTATION

This policy has been shared in line with local governance and as appropriate with the Deteriorating Patient Group, Values Based Health & Care Steering Group, Area Partnership Forum, Board Management Team, Health and Social Care Leadership Group and Staff Side Representatives.

8. TRAINING AND SUPPORT

Each healthcare setting within Dumfries and Galloway Health and Social Care Partnership will be responsible for delivery of education and training to staff relevant to their role. The Future Care Planning Collaborative will agree educational materials for different roles (i.e.) those creating future care plans, those acting on care plans but not creating them, in community and in acute settings and those acting as responsible clinician in different settings. All groups will have access to online learning materials and there will be face to face available as recommended, but not mandated, for those who are having future care planning discussions. For non-medical practitioners line managers will use the competency framework prior to allowing access to e-ReSPECT for authors (appendix 5). The online learning materials specific to ReSPECT and TEP emergency care plans will have links to other relevant reading and learning materials such as communication skills.

Leaflets and other materials (e.g. audio-visual), informing patients about the Future Care Planning or ReSPECT must be available to patients in a format and in a way they can interpret and understand well. Any written patient information should follow NHS D&G local and other national guidance standards (minimum of 12 Arial typeface). It would be good practice to record the date/issue number of written information as there can be significant differences between different versions. Where possible and dependant on individual circumstances/needs, information may need to be provided in alternative languages or via interpreters. Additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues. Further information can be found in the Interpretation and Translation guidance available here: http://hippo.citrix.dghealth.scot.nhs.uk/ Information about resources can be found here: http://hippo.citrix.dghealth.scot.nhs.uk/

9. MONITORING

The Future Care Planning Collaborative will oversee and support governance issues around this policy, for example adherence to this policy, audits of the policy and review incidents reported using a Team Based Quality Review Approach. They will also ensure relevant national developments are identified and acted upon, such as Digital Front Door and electronic Treatment Escalation Plan developments. This group will report to the Deteriorating Patient group and Values based practice group, who in turn will inform Leadership and then Board management group.

10. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EQIA) was completed on 22/05/25 (see appendix 6).

11. DATA PROTECTION AND CONFIDENTIALITY IMPACT ASSESSMENT

A Data Protection Impact Assessment (DPIA) screening questionnaire was completed on 07/05/25 (see appendix 7). It is not a legal requirement for a full DPIA to be completed for the development of this policy. The completion of a DPIA will be considered during each subsequent review of this policy.

12. REFERENCES

National DNA CPR Policy
Cardiopulmonary resuscitation decisions - integrated adult policy: guidance - gov.scot

Joint guidance from the BMA, Resuscitation Council (UK) and Royal College of Nursing (RCN) on decisions about CPR – including decisions not to attempt CPR. Decisions relating to CPR (cardiopulmonary resuscitation)

Adults with Incapacity (Scotland) Act (2000)
Adults with Incapacity (Scotland) Act 2000

Scottish government: Adults with incapacity act: code of practice for medical practitioners
Adults with incapacity: code of practice for medical practitioners - gov.scot

HIS Future Care Planning Toolkit
Future Care Planning Toolkit | Health and social care improvement in Scotland - Future Care Planning toolkit

13. DOCUMENT CONTROL SHEET

Document Amendment History

Version	Section(s)	Reason for update
1.0	All	New Policy

Distribution

Name	Responsibility	Version number
Corporate Governance Manager	Place on policy register	1.0
Corporate Governance Manager	Add approved policy to the Policy Page on the external website	1.0
Corporate Governance Manager	Notify Directors through Monthly Policy list	1.0
Directors	Disseminate through Directorates as appropriate	10.

Associated documents

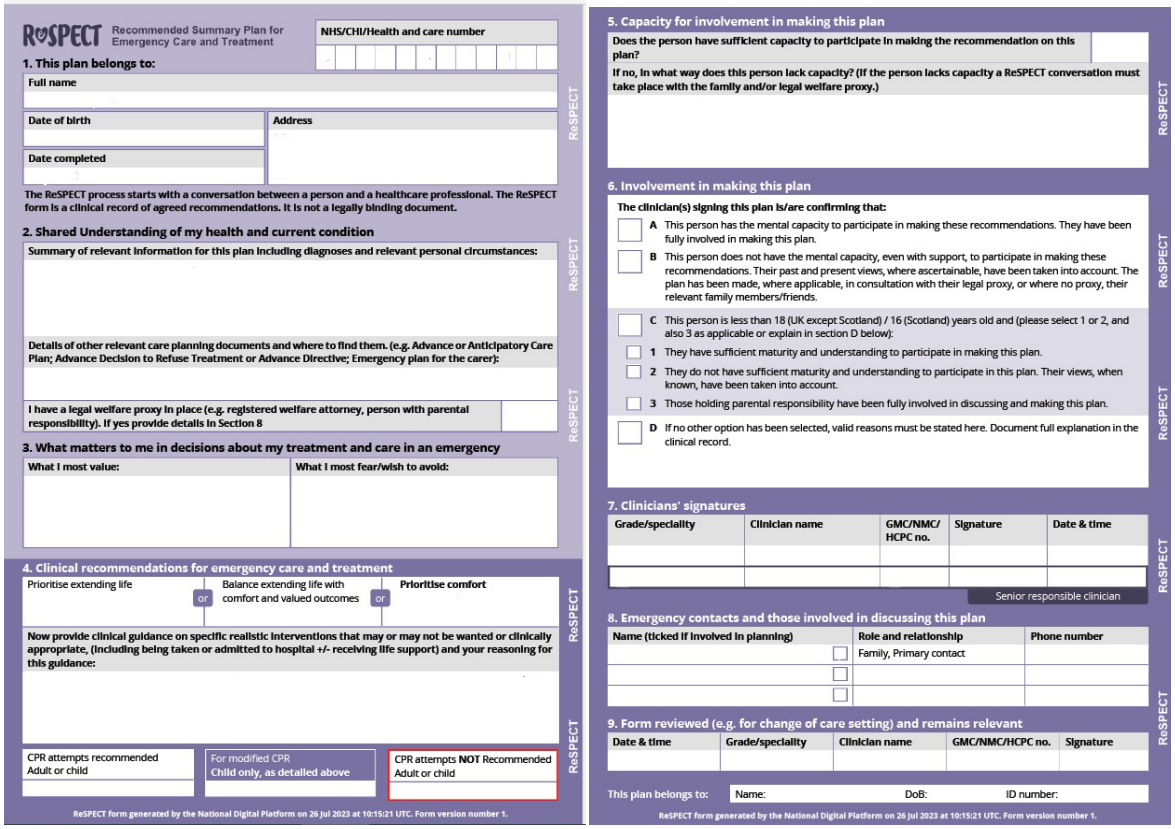
- Equality and Diversity Impact Assessment Policy.

Action Plan for Implementation

Action	Lead Officer	Timeframe
Dissemination to senior staff through line management	Management Team	October 2026
Raise awareness and inform staff	All line managers	October 2026
Use policy	All staff	Ongoing

Appendix 1

Appendix 1 – ReSPECT Document. Please note, as we use electronic (e) forms, there is no completely blank form. This example has not for resuscitation highlighted in red, and priority comfort in bold. However, when creating a live form there is no default.



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

NHS/CHI/Health and care number

1. This plan belongs to:

Full name

Date of birth

Address

Date completed

The ReSPECT process starts with a conversation 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

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

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**

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:

CPR attempts recommended Adult or child

For modified CPR Child only, as detailed above

CPR attempts **NOT** Recommended Adult or child

ReSPECT form generated by the National Digital Platform on 26 Jul 2023 at 10:15:21 UTC. Form version number 1.

5. Capacity for involvement in making this plan

Does the person have sufficient capacity to participate in making the recommendation on this plan?

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:

- A This person has the mental capacity to participate in making these recommendations. They have been fully involved in making 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, their relevant family members/friends.
- C This person is less than 18 (UK except Scotland) / 16 (Scotland) years old 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 (ticked if involved in planning)	Role and relationship	Phone number
	Family, Primary contact	

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

Date & time	Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature

This plan belongs to: Name: DoB: ID number:

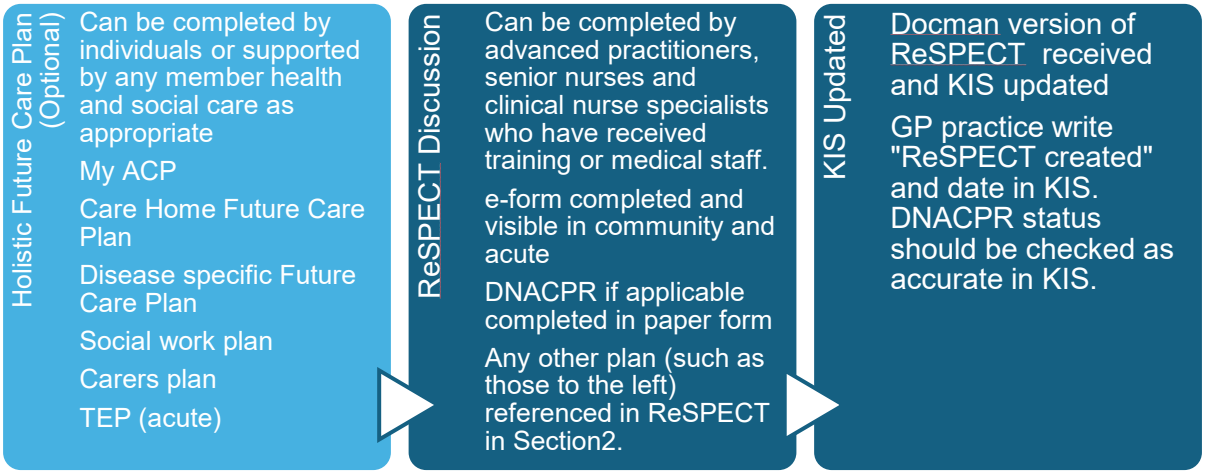
ReSPECT form generated by the National Digital Platform on 26 Jul 2023 at 10:15:21 UTC. Form version number 1.

Appendix 2

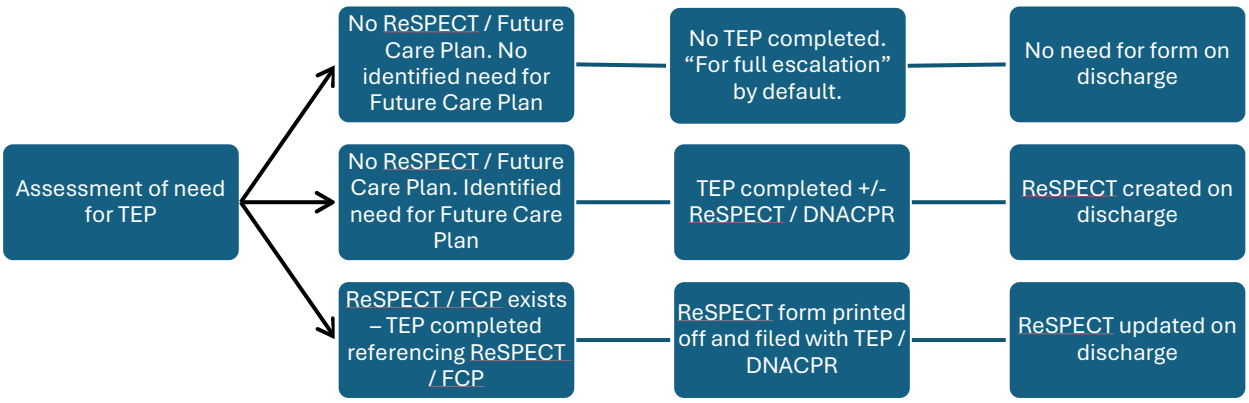
Sharing of Future Care Plans

Community

Holistic plans will prompt completion of a ReSPECT, which should reference any other plans in place. Thus acute, community and SAS can be aware of them. The list of plans on the left is not exhaustive. If there is no pre-existing future care plan, a ReSPECT can be completed independently.



Acute settings



Appendix 3

Taken from HIS: Triggers for Future Care Planning Conversations

Situation	Condition	Assessment
Frequent unscheduled contacts	Long term condition or conditions where an emergency plan is relevant	Identified as vulnerable using risk predictive tools
Carer and family stress	Frailty	Identified as Frailty score 5 or more.
Unplanned hospital admissions	Requiring specialist nurse or multidisciplinary team input	Polypharmacy review
Complex physical or mental health needs	On certain disease registers, including palliative care, dementia, mental health, learning disability	Falls assessment
Living in a care home	DNACPR in place	Identified as vulnerable or unstable by professional or team
Receiving respite care		SPICT or GSF assessment suggesting would benefit from Future Care Planning and a palliative care approach
Recognised as vulnerable due to social or environmental circumstances		

Appendix 4

Future Care Planning Standard Operating Procedure

Printed copies must not be considered the definitive version

DOCUMENT CONTROL		SOP NO.	
Lead Author:	Consultant Palliative Medicine		
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1. PURPOSE

To describe the procedure for completing and sharing future care plans within Dumfries and Galloway Health and Social Care Partnership. Particular reference is made to Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and Treatment Escalation Plan (TEP) forms.

2. SCOPE

This SOP relates to all staff in health and social care who may create a Future Care Plan. It describes the four step approach to Future Care Planning including where to record future care planning discussions and how to share them. Although it references social services care plans, the policies and procedures and legal implications are covered elsewhere.

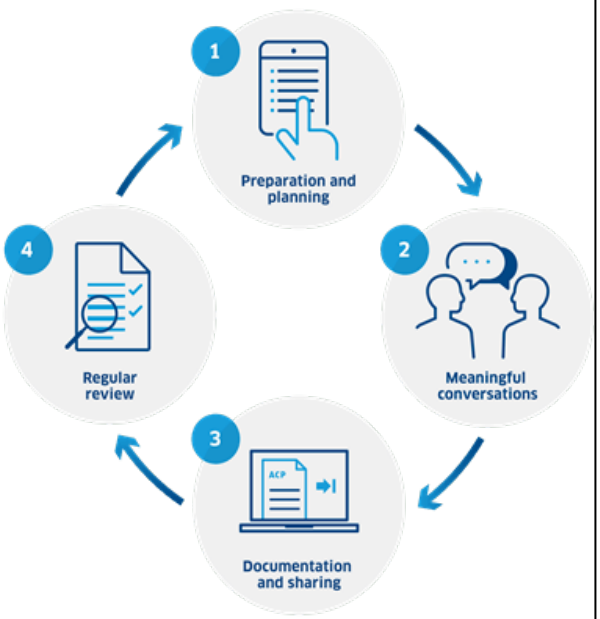
3. RESPONSIBILITIES

Responsibility for accurate completion of the forms, reflecting a person centred future care planning discussion, is the responsibility of the person completing the form. The senior responsible clinician should be consulted as soon as is practical in line with local and national policy listed below.

Detailed roles and responsibilities for Future Care Planning are defined in Appendix 1 Responsibility Matrix (RACI) – Future Care Planning (ReSPECT).

4. PROCESS

4.1 Future Care Planning should be carried out using the four step process described by HIS. The following diagram from HIS illustrates this:



Step 1: Preparation and planning. Ensure staff member feels confident and competent to have conversation. Check person is ready for conversation and has those relevant to them present. Consider any additional communication or support needs of the person involved.

Step 2: Meaningful Conversations. Person centred conversation at a pace and level appropriate to that person. May be more than one conversation and may need to involve specialists where relevant.

Step 3: Documentation and sharing.
Document clearly in the care record (healthcare record if an emergency care plan) and summarise on relevant form. Share as appropriate with relevant professionals.

Step 4: Regular review. Review dates will vary depending on clinical condition and context. Process described below.

4.2 Preparation and Planning

Part of preparation is identifying those who would potentially benefit from having a Future Care Plan. The following is not exhaustive but is taken from HIS.

Situation	Condition	Assessment
Frequent unscheduled contacts	Long term condition or conditions where an emergency plan is relevant	Identified as vulnerable using risk predictive tools
Carer and family stress	Frailty	Identified as Frailty score 5 or more.
Unplanned hospital admissions	Requiring specialist nurse or multidisciplinary team input	Polypharmacy review
Complex physical or mental health needs	On certain disease registers, including palliative care, dementia, mental health, learning disability	Falls assessment
Living in a care home	DNACPR in place	Identified as vulnerable or unstable by professional or team
Receiving respite care		SPICT or GSF assessment suggesting would benefit from Future Care Planning and a palliative care approach.
Recognised as vulnerable due to social or environmental circumstances		For acute inpatients, TEP discussions should be arranged and forms should be completed if patient deteriorating (e.g.) NEWS 5 or above

Individual areas will have to work out how they identify groups or people who will benefit, or whether they may discuss Future Care Planning ad hoc when possible and relevant. When an individual has been identified as potentially benefitting from having an emergency care plan, this should be offered and they should have an appointment made with the relevant clinician, or the plan may be created at the time of review if the person is able to do this. Written information can be provided. Special attention should be made to any additional support needs including communication. If a person refuses to participate this should be respected and this should be reflected in the notes. Where this involves DNACPR decisions the Integrated Adult national policy should be followed.

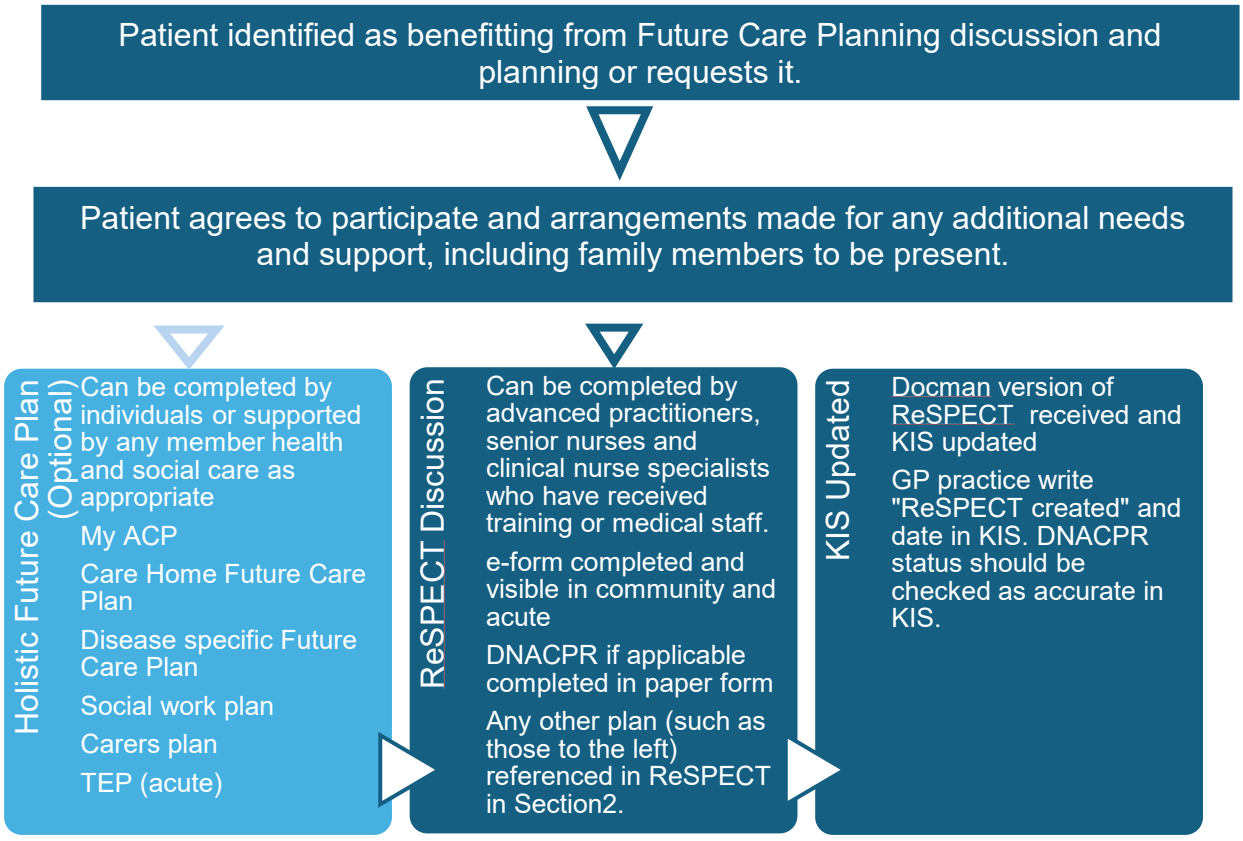
4.3 Meaningful Conversations

Staff should have the skills to undertake a person centred conversation eliciting the values and priorities of the person and combining this with the clinical knowledge of the staff member to come to a shared decision about what care and treatment is right for that person in the future. When having a conversation, the forms are often helpful to guide staff members through conversations (e.g.) ReSPECT for emergency planning.

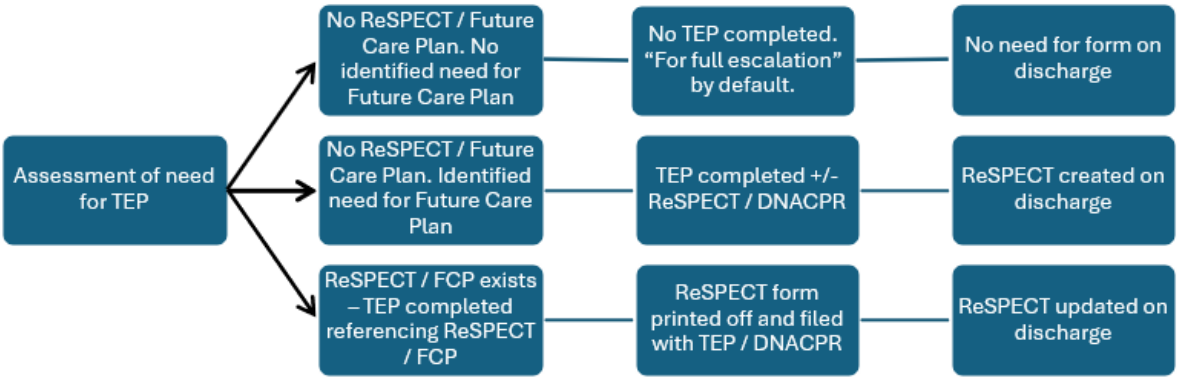
4.4 Documentation and Sharing

Choosing the right document Community

Within community settings, there are a number of future care plans. These include, but are not limited to, social work care plans, myACP (HIS), disease specific plans (e.g.) MND association template and care home future care plans. If one of these exist, the person should be asked if they wish to create a ReSPECT plan for guidance to professionals regarding treatment and care in an emergency.



Acute



*TEP does not need completed on day of admission unless there is an urgent need to do so. As per national DNACPR policy, Future Care Planning Policy and TEP Guidance notes, there is no need to have these discussions in a less than ideal environment without family unless there is a real risk of inappropriately over or under treating.

TEP form can be completed by resident doctors and non – medical professionals who have been assessed as competent as per Future Care Planning policy. It should be countersigned by the responsible consultant as soon as practicable. This will usually be within 24 hours of admission, or on a ward round in a general hospital. In Community hospitals the same process applies but will be signed by the advanced practitioner and the GP with overall responsibility will sign as senior responsible clinician at an appropriate time, acknowledging that there may be a delay of several days. Where an AP wishes senior support, this need should be escalated in the usual way. In Galloway Community Hospital, rural practitioners will undertake TEP and ReSPECT discussions. They can request support from the CD for GCH or Consultants in DGRI where there is complexity or specialist advice would be helpful.

TEP, ReSPECT and DNACPR (if relevant) forms will be placed together at the front of the notes.

TEP should be updated following any further future care planning discussions including any significant change in the condition of the patient and critical care admission and discharge.

When the ReSPECT form is completed for discharge (including transfer) the ReSPECT process must occur and therefore the patient or their relevant proxy must be involved. Where the TEP has been completed without involvement of the patient / family, in line with the national TEP guidance, the discussion may have to happen from the beginning or be postponed until a later date. A DNACPR should not be in place on discharge without a ReSPECT form.

4.4 Review

The Future Care Planning document must be reviewed:

- With appropriate frequency for each individual as part of good clinical care
- If a person's clinical condition changes substantially (deterioration or improvement)
- If the person or their representative requests it.

Emergency care plans (ReSPECT and TEP) must be reviewed:

- If a person moves from one healthcare setting to another (including, for example, a change of healthcare team in community, admission to care home, or ward within a hospital)
- Before discharge from Hospital.
- These reviews are not passive reviews to just confirm the existence of a decision but should be active confirmation of the validity of the decision and ensure it meets the standards set out by this policy and the law. This may include a further senior review.

5. MONITORING

5.1 The Future Care Planning Collaborative will oversee and support governance for future care planning across Dumfries and Galloway. This will include audit and review of practice, monitoring compliance with this SOP, and supporting continuous improvement. The SOP will be reviewed periodically by the Collaborative to ensure it remains aligned with national guidance and local practice.

6. Associated documents

- Future Care Planning Policy, Dumfries and Galloway.
- National guidance and recommendations published in the joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016).
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) integrated adult policy, Scottish Government 2010, with updated guidance 2016.
- Adults with Incapacity (Scotland) Act 2000
- GMC Treatment and care towards the end of life (GMC 2010, revised 2016, 2022) • Treatment Escalation Plan Guidance Notes, National TEP group.
- ReSPECT Guide for Clinicians Completing the Plan, RCUK.
- Future Care Planning, HIS.
- Care Home Plan guidance notes, Dumfries and Galloway

Appendix 1

Responsibility Matrix (RACI) – Future Care Planning (ReSPECT)

To ensure clarity in roles and responsibilities across all stages of the future care planning (ReSPECT) process, we are implementing a **RACI matrix**. This tool helps define **who is Responsible, Accountable, Consulted, and Informed** for each key activity within the care planning process.

Task	Responsible	Accountable	Consulted	Informed
Identify patients for FCP	Clinical Team	Senior Clinician	MDT, GP	Patient, Family
Conduct FCP conversation	Clinician	Responsible Clinician once countersigned	Patient, Family	MDT
Complete ReSPECT form	Clinician	Responsible Clinician once countersigned	Patient, Family	Admin, GP
Update electronic records (e.g., KIS)	Admin / Clinician	GP	IT Support	MDT
Review and update care plans	Clinical Team	Responsible Clinician	Patient, Family	MDT
Provide training and competency support	Line Manager (for signposting to resources and ensuring competent)	Future Care Planning Collaborative	Department Heads	All staff
Monitor compliance and audit	Future care Planning Collaborative	Deteriorating Patient Group, individual areas of practice may wish to explore	Clinical Leads	All staff

Appendix 5

Competency framework for non medical practitioners undertaking ReSPECT and DNACPR discussions. Please note this framework is currently in draft format and is likely to change. The final version will be included once finalised.

Competency Framework to Accompany NHS D&G Future Care Planning Policy
This framework is for Future Care Planning incorporating the ReSPECT process and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making by **non-medical registered healthcare practitioners** [1]. The frameworks supporting this procedure are provided by the NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy (2016) and Decisions relating to Cardiopulmonary Resuscitation decision-making- guidance from the BMA, RC(UK) and the RCN 3rd edition first revision (2016), and GMC Treatment and care towards the end of life (GMC 2010, revised 2016, 2022, 2024). Part of the competency framework is to ensure staff are familiar with the NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation Integrated Adult Policy (2016) and local NHS Dumfries and Galloway Future Care Planning policy, 2025, which incorporates the RCUK model policy for ReSPECT.

The national DNACPR policy only applies to adults. For children and young people, up to the age of 18 years please use NHS Scotland Children and Young People Acute Deterioration Management (CYPADM) (Scottish Government 2012). These young people may already have a CYPADM form in their possession which details their wishes when there is an acute deterioration in their health. **This framework does not cover CYPADM decision making.** ReSPECT can be used for all ages but there will be separate competencies for young people under 18.

Guidance on completion
The competencies and associated learning and education is intended to support nurses*, advanced practitioners and Allied Health Practitioners in NHS D&G to develop the required knowledge, skills, competence and confidence to appropriately discuss and record Future Care Planning discussions including ReSPECT and DNACPR decisions.

For certain competencies, your Practice Assessor (often line manager) may stipulate the evidence required to demonstrate the competency, appropriate to your area of practice.

Alternatively, with your Practice Assessor you may jointly agree a specific assessment method for a particular competency. This may involve a different assessor (details can be provided on the assessor sheets). Written feedback should be sought from other assessors and stored in the NES Turas Professional Portfolio to allow reflection with your Practice assessor when going through the competency framework.

Specific assessment methods can be stipulated in the 'Evidence' column. Practitioners are encouraged to use the NES Turas Professional Portfolio to store their evidence.

Once all 4 competencies have been achieved and your Practice Assessor has reviewed and agreed that all evidence provided supports "sign-off", this competency form should be uploaded and saved to your TURAS professional portfolio alongside the supporting evidence. One reflective practice may cover multiple competency domains. It is expected that all competencies will be met within a timeframe of 12 months unless personal circumstances complicate this. If more than 12 months elapse, "sign off" will include checking working knowledge of all areas of competence.

The Practice Assessor will inform your line manager (if not the same person) that competencies have been met and line manager will request access permission to write electronic ReSPECT forms using the SYSMAN system.

Ongoing evidence of competency should be checked at appraisal. This may include anonymised completed forms for discussion or reflections on discussions with people undergoing future care planning.

These are some resources which are not required reading, but may be helpful depending on level of experience:
REDMAP - YouTube

Future-care-planning-prompt-cards-for-staff-July-2024-1.pdf
Support Around Death Scotland | Support Around Death

*Nurses working in an advanced practice, clinical nurse specialist, relevant band 5 or above clinical decision-making role.

Practitioner undergoing Competency Assessment for Future Care Planning

Details	
Name:	
Job title:	
Qualifications:	
NMC/HCPC Number:	
Email address:	

Practice Assessor / Line Manager for Appraisal (referred to as PA below)

Details	
Name:	
Job title:	
Qualifications:	
NMC/HCPC Number:	
Email address:	

Other Assessors

Details	
Name:	
Job title:	
Qualifications:	
NMC/HCPC/ GMC Number:	
Email address:	

Details	
Name:	
Job title:	
Qualifications:	
NMC/HCPC / GMC Number:	
Email address:	

Details	
Name:	
Job title:	
Qualifications:	
NMC/HCPC /GMC Number:	
Email address:	

Details	
Name:	
Job title:	
Qualifications:	
NMC/HCPC/ GMC Number:	
Email address:	

Competency 1: Communication – Understands theory and has experience of communication skills relating to shared decision making and deteriorating health		
Knowledge, Skills and Behaviours	**Recommended Learning and Education**	**Evidence** Examples given in *italics* Highlight evidence uploaded to Portfolio.
Applies enhanced communication skills to undertake Future Care Planning and DNACPR conversations with patients & relevant others, promoting a values-based approach to health and care and providing emotional support to patients and their families, addressing their concerns and questions with empathy and compassion.	Attend TrEDS course locally and / or watch pre-recorded Treatment escalation planning discussion parts 1 and 2 below: NHSGGC - Realistic Conversations Discussing Treatment Escalation Plans Part 1 NHSGGC - Realistic Conversations Discussing Treatment Escalation Plans Part 2 Attend EC4H – if not possible due to waiting list then discuss cases and ensure on waiting list.	*Supervised practice with x1 Turas feedback from PA or other practitioner.* *Turas learning form outlining learning outcomes from training days (TrEDS or EC4H)* Patient feedback: CollaboRATE tool following Future Care Planning / ReSPECT discussions collaborate_for_patients_5_anchor_point_scale.pdf
Demonstrates the ability to effectively reflect and respond to communication challenges including uncertainty, strong emotions, denial, tension and conflict.	Observe and describe helpful and unhelpful communication behaviours in others. Reflect on cases involved directly with and how you dealt with communication challenges.	*Turas feedback from PA* *Reflective account*

Knowledge, Skills and Behaviours	Recommended Learning and Education	Evidence Examples given in *italics* Highlight evidence uploaded to Portfolio.
Ensures that patients and families are aware of available support services and resources	Familiarise yourself with online resources**:** National: Cardiopulmonary resuscitation decisions: information for patients, relatives and carers - gov.scot Decisions about CPR | NHS inform Local: What should I expect at the end of someone's life – Palliative Care Dumfries & Galloway	*Discussion with PA around content of available resources* *Turas feedback from PA and other practitioners*
Engages collaboratively and communicates effectively with the MDT to lead planning and co-ordinating complex future care plans to address individual needs, ethical choices and patient priorities including robust record keeping.	Reflect on care planning discussion(s) and collaboration / discussion undertaken with the wider MDT	*Reflective practice uploaded to TURAS.*

Competency 2: Knowledge and skilled practice - Applies a comprehensive knowledge of current legislation in relation to Future Care Planning including DNACPR and ReSPECT.		
Knowledge, Skills and Behaviours	**Recommended Learning and Education**	**Evidence**
Possesses a thorough understanding of the ethical and legal principles surrounding DNACPR decisions, including patient autonomy, informed consent, and the right to refuse treatment.	Read: DNACPR Integrated Adult Policy Read: NHS D&G Future Care Planning Policy Read: https://www.resus.org.uk/library/publications/publication-decisions-relating-cardiopulmonary	*Discuss with PA key points learned from reading.*
Demonstrates awareness of NMC: The Code	Read: https://www.nmc.org.uk/standards/code/	
Demonstrates awareness of Adults with Incapacity (Scotland) Act 2000 and how these principles apply to Future care planning and DNACPR decisions	**Read:** Adults with incapacity: code of practice for medical practitioners - gov.scot	***Complete:*** *Introduction to the Adults with Incapacity (Scotland) Act 2000 | Turas | Learn* *Advanced practitioners may already have capacity assessment in their portfolio. Provided this is valid there is no need to undergo further capacity training.*

Competency 3: Realistic Medicine – Good knowledge of the principles of realistic medicine and how to apply these to people living with deteriorating health and long term conditions.		
Knowledge, Skills and Behaviours	**Learning and Education**	**Evidence**
Demonstrates the ability to assess the appropriateness of CPR for individual patients, considering their medical condition, prognosis, and expressed wishes and when to seek advice.	Read: Treatment and care towards the end of life - professional standards - GMC	*Case based Discussion + Turas feedback from PA or other assessor (eg) medical specialist.*
Incorporates knowledge of clinical condition into care planning and decision making that reflects realistic treatment options and ethical care decisions, applying a comprehensive knowledge of the management of potentially reversible causes of deterioration.	Complete: TURAS shared decision making *or* attend TrEDS	*Reflective practice on cases appropriate to role with PA or other members of the MDT (eg) medical staff*
Works collaboratively with healthcare professionals across disciplines to ensure a holistic approach to DNACPR decision-making, and participates in team discussions and case reviews to ensure that DNACPR decisions are consistent and well-coordinated	Observe/Describe: Case Based discussion detailing shared decision making and care planning	*Reflective practice on team discussions / cases*

Competency 4: Documentation and governance - Applies a comprehensive knowledge of current policies, legislation and local processes.		
Knowledge, Skills and Behaviours	**Learning and Education**	**Evidence**
Understands local processes and accurately documents Future Care Plans including ReSPECT and DNACPR decisions, using paper copies and electronic systems available in their area of practice, sharing appropriately and in a timely manner with relevant members of the MDT.	ReSPECT local learning available in Clinical Handbook for summary of local ReSPECT process in acute and community.	*Discuss with PA.*

Appendix 6

Equality Impact Assessment (EQIA) Impact Assessment Screening Tool

This Tool has been developed to ensure that equalities, human rights, economic, social factors and the Armed Forces Covenant Duty are being considered ahead of the implementation of any new or revised policies, provisions, criteria, functions, practices and activities, including the delivery of services. Please note for the purpose of this document these will be grouped together and simply referred to as '**activity**'.

General Information			
Name of activity	Development of the Future Care Planning including ReSPECT and DNACPR Policy Dumfries and Galloway		
Lead person and job title	Consultant in Palliative Medicine, Lead Clinician Specialist Palliative Care		
Contact Information (telephone and/or email)	dg.feedback2@nhs.scot	Date of this assessment	Started 30/04/2025, 27/05/25, 02/09/26
Names and roles of those involved in the impact assessment process	Project Support Manager, Programme Management Office Consultant in Palliative Medicine, Lead Clinician Specialist Palliative Care Strategy Support Manager		
Describe the activity in no more than 200 words	This assessment will focus on the development of Development of the Future Care Planning including ReSPECT and DNACPR Policy. This assessment aims to identify and record any potential negative and positive impact(s) on protected characteristic groups from the policy. Where possible negative impacts are identified, action will be taken to minimise or mitigate these.		
How will **people** be affected by this activity?	Healthcare Staff specifically clinical practitioners who are responsible for shared decision making with people who are at risk of acute deterioration, and the documentation of such discussions and decisions. Patients and Carers will be affected as they will be encouraged to take part in decision- making about treatment, whether currently in a state of ill health, or in anticipation of ill health. For others, decisions about the treatment that they receive may need to be taken by their guardian, continuing attorney, welfare attorney or other proxy, if they lack the mental capacity to make those decisions themselves.		

Who has been **involved** in the development of this activity and in what capacity?	Project Support Manager Consultant in Palliative Medicine, Lead Clinician Specialist Palliative Care
Please include any evidence or relevant information that has influenced the overall decision being considered within this impact assessment	This policy compliments the national Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) policy Fully supports national guidance and recommendations published in a joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). It is in line with Healthcare Improvement Scotland (HIS) guidance Consideration of all protected characteristics included in the Equality Act 2010, the Fairer Scotland Duty and the Armed Forces Covenant are included within the Equality Impact Assessment process and documentation. Takes into account the Adults with Incapacity (Scotland) Act 2000 The ReSPECT process was developed by the Resuscitation Council (UK) in partnership with the Helix Centre. Its development was highly collaborative with a human-centred design approach taken. While the output of the work was a new form, the overall project redesigned the process for capturing people's wishes for future emergency care, with a shared decision-making conversation at the heart of it. This facilitates patient and family involvement in CPR decision making in alignment with the existing medico-legal framework. ReSPECT was subject to equalities impact activity during its formation. Rather than this resulting in the publication of an EQIA (or similar), the approach taken focussed on legislative compliance given the context of legal challenge around this area of healthcare practice. Where possible we have tried to mirror the language and terminology used within our local policy. Where possible we have linked information around Carers with the Carers Strategy for Dumfries and Galloway 2025-2028.

Impact Assessment Questions
Please complete the table below and outline within the comments sections: 1. any evidence, relevant information or involvement that has influenced the decision on impact (this may also include demographic profiles, audits, research, health needs assessment, work based on national guidance, findings from engagement and consultation). Prompts are available on **page 6** to support discussion around potential impacts. 2. Mitigating measures that will be taken to ensure that no impact is negative When assessing the impact on each protected characteristic, you should consider the following aims of the Public Sector Equality Duty: • Does the proposed activity impact on the **elimination of discrimination**? • Does the proposed activity contribute towards **advancing equality of opportunity** by removing or minimising disadvantages, meeting the needs of particular groups and encouraging participation in a particular activity? • Does the proposed activity **foster good relations** between different groups?

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Age • Early years, children and young people, including care experienced young people • Working aged people • Older People	Yes	No	Scottish law (as described in the Age of Legal Capacity (Scotland) Act 1991) allows that "a person under the age of 16 years shall have legal capacity to consent on his own behalf….where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment." There is no minimum age stipulated to this direction. The policy states any person over the age of 18 years can give or withhold consent to any treatment offered to them, if they have the mental capacity to do so, so long as their decision is voluntary and adequately informed. This applies even if a decision concerns whether or not to undergo treatment that is potentially life-sustaining. It may be that this changes over time particularly if we extend the roll out of ReSPECT to paediatrics, but this is the current stand point.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Disability *(This includes physical disability, learning disability, sensory impairment, long term medical conditions and mental health conditions)*	Yes	No	The policy makes it clear that any patient not capable of giving or refusing consent to treatment offered will be covered by the Adults with Incapacity (Scotland) Act 2000. The policy sets out that leaflets and other materials (e.g. audio-visual), informing patients about their condition and the treatment being offered must be available to patients in a format and in a way they can interpret and understand well before proposed treatment. The policy states any written patient information should follow NHS D&G local and other national guidance standards (minimum of 12pt Arial typeface). The policy states that additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Sex/Gender	No	No	The ReSPECT Policy is unlikely to have a positive or negative impact on people specifically because of their gender/sex. The policy has been developed to be inclusive regardless of gender/sex or other protected characteristics. The language and terminology used is gender neutral throughout.	
Gender reassignment and Transgender	No	No	The ReSPECT Policy is unlikely to have a positive or negative impact on people specifically because of their gender reassignment or transgender status. The policy has been developed to be inclusive regardless of gender reassignment or transgender status or other protected characteristics. The language and terminology used is gender neutral throughout.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Marriage and Civil Partnership	Yes	No	The ReSPECT Policy is unlikely to have a negative impact on people specifically because of their relationship status. Throughout the policy the importance of the role of family in respect of shared decision making is recognised. This could be seen as having a positive impact in that people's relationships are recognised. The policy promotes inclusive, person-centred approaches, discouraging assumptions about all protected characteristics including relationship status and encouraging inclusion. The Partnership promotes respect for individual people and relationships and ensure that care and support is delivered with no favour or discrimination based on marital status.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Pregnancy and Maternity	No	No	The ReSPECT Policy is unlikely to have a positive or negative impact on pregnancy and maternity. The policy has been developed to be inclusive regardless of pregnancy and maternity or other protected characteristics.	
Race *(includes Gypsy/Travellers and those whose first language is not English)*	Yes	No	The policy encourages discussions around 'What Matters to You; and records any spiritual or cultural preferences.	
Religion or belief	Yes	No	The policy encourages discussions around 'What Matters to You; and records any spiritual or cultural preferences.	
Sexual orientation	No	No	The ReSPECT Policy is unlikely to have a positive or negative impact on people specifically because of their sexual orientation. The policy has been developed to be inclusive regardless of sexual orientation or other protected characteristics.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Human Rights	Yes	No	The policy states Any person over the age of 18 years can give or withhold consent to any treatment offered to them, if they have the mental capacity to do so, so long as their decision is voluntary and adequately informed. This applies even if a decision concerns whether or not to undergo treatment that is potentially life-sustaining. The policy states that leaflets and other materials (e.g. audio-visual), informing patients about the Future Care Planning or ReSPECT must be available to patients in a format and in a way they can interpret and understand well. It also states that Where possible and dependant on individual circumstances/needs, information may need to be provided in alternative languages or via interpreters. Additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Carers	Yes	No	Carers are included throughout the policy. The policy acknowledges unpaid Carers of all genders and ages, and makes it clear that they are included in the decision making process.	
Staff: • Full time • Part time • Shift workers • Staff with protected characteristics • Staff vulnerable to falling into poverty	Yes	No	The policy sets out what is and is not expected as part of the ReSPECT process and what is and is not the responsibility of staff. Local policy to support future care planning discussions and recording, including emergency plans such as ReSPECT, DNACPR, and others. It sets out the roles and responsibilities for health and social care staff developing and using these care plans. The policy includes a clear process in section 6 describing the steps staff should take when undertaking future care planning. Section 8.1 describes the training and education put in place to support staff to take these extra decisions.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Poverty 'at risk' groups • Unemployed people • People on benefits • Pensioners • Care Experienced people • Those living in the most deprived communities • Remote rurality	No	No	No positive or negative impacts specific to poverty 'at risk' groups have been identified	
People with low literacy/numeracy, poorer skills and/or attainment	Yes	No	Leaflets and other materials (e.g. audio-visual), informing patients about future care planning/ReSPECT must be available to patients in a format and in a way they can interpret and understand well. Additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues.	

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Those involved in the criminal justice system and their families	No	No	No positive or negative impacts specific to those involved in the criminal justice system or their families have been identified	
Homelessness	No	No	No positive or negative impacts specific to homelessness have been identified	
People who are displaced incl. refugees & asylum seekers	Yes	No	Where possible and dependant on individual circumstances/needs, information can be provided in alternative languages or via interpreters.	
Economic & Social Sustainability	No	No	No positive or negative impacts specific to Economic & Social Sustainability have been identified	
Environmental			This policy does not have any negative or positive impact on the environment. The policy is in an electronic form which helps to minimize printing.	
Armed Forces Personnel and Veterans	No	No	No positive or negative impacts specific to armed forces personnel have been identified.	

Does this activity require consideration of the Fairer Scotland Duty? If yes, please outline the steps taken to meet the needs of the duty.	*This places a legal duty on public bodies to actively consider how they can reduce inequalities of outcomes because of socio-economic disadvantage, such as low income, area deprivation and material deprivation, and to produce a written assessment of the results. This duty only applies to strategic decisions or activity. More information can be found here..*	
Please indicate how are you ensuring the information about the activity and around the proposed changes is accessible in terms of communication in the following formats, where relevant:	Easy Read	Easy Read information available through Resus UK
	British Sign Language	Interpretation available on request. The workstream group will consider including information in BSL format within the local website and will liaise with the Patient Experience Team and Communications Team around this.
	Alternative Languages	Interpretation available on request
	Large Print	Available through the Resus UK Easy Read documentation - produced in Arial 14pt
	Other (please specify)	

Summary Sheet	
Name of Activity	Development of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy Dumfries and Galloway
Date of Impact Assessment	22/05/25 & 27/05/25
Key Lead Contact	Sarah Pickstock , Consultant in Palliative Medicine, Lead Clinician Specialist Palliative Care

Please summarise any identified negative impacts and associated mitigations/actions:		
Negative Impact	**Mitigation/Action**	**Responsibility/ Timescale**

Monitoring	
How will you monitor the ongoing impact of the activity on all population groups?	This will be part of the ongoing review process around this policy.

Next Steps in the Impact Assessment Process

When complete, the lead person should send a copy of the full Impact Assessment Tool to the Equality and Diversity Lead by emailing it to dg.cbsteam@nhs.scot.

The impact assessment will then be published on the NHS Dumfries and Galloway public website at www.nhsdg.co.uk.

Please take 5 minutes to share your experience of completing this Impact Assessment by completing this short survey

Please note that this is a legal document stating that you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission.

Appendix 7

Data Protection Impact Assessment (DPIA) Questionnaire for

Development of Future Care Planning (including ReSPECT and DNACPR) Policy for NHS Dumfries & Galloway

V1.0

07/05/2025

DOCUMENT CONTROL SHEET

Key Information

Title	Development of Future Care Planning (including ReSPECT) Policy for NHS Dumfries & Galloway
Date Completed	07/05/2025
Document Type	DPIA Screening Questionnaire
Document Status	FINAL
Respondent	Amy Sellors, Project Support Manager, HSCP
Owner	Dr Sarah Pickstock, Palliative Medicine Consultant, Acute & Diagnostics
Approvers	Gillian Jamieson (DPO), Scott Bowman (eHealth Cyber Security Manager)
Contact	Amy.Sellors@nhs.scot

Approvals

Version	Date	Name	Designation
1.0	07/05/2025	GJamieson	DPO

About the Data Protection Impact Assessment (DPIA)
The DPIA (also known as privacy impact assessment or PIA) is an assessment tool which is used to identify, assess and mitigate any actual or potential risks to privacy created by a proposed or existing process or project that involves the use of personal data. It helps us to identify the most effective way to comply with our data protection obligations and meet individuals' expectations of privacy. An effective DPIA will allow us to identify and fix problems at an early stage, reducing the associated costs and damage to reputation which might otherwise occur. Failing to manage privacy risks appropriately can lead to enforcement action from the Information Commissioner's Office (ICO), which can include substantial fines. The DPIA is just one specific aspect of risk management, and therefore feeds into the overall risk management processes and controls in our organisation.

A DPIA is not a 'tick-box' exercise. Consultation may take a number of weeks to complete, so make sure that key stakeholders are engaged early, and that you have enough time prior to delivery to iron out any issues.

Carrying out a DPIA is an iterative process. Once complete, a review date within the next 3 years must be set. Should a specific change in purpose, substantial change in service or change in the law occur before the review date, the DPIA must be re-done.

The ICO code of practice on conducting privacy impact assessments is a useful source of advice.

Is a DPIA required?
If the process or project that you are planning has one or more the aspects listed below then you must complete a DPIA at an early stage.

What are you trying to do and why?
Please provide a high level summary description of the process, including its nature, scope, context, purpose, assets e.g. hardware, software used, dataflows. Explain the necessity and proportionality of the processing in relation to the purpose(s) you are trying to achieve.

Local policy to support future care planning discussions and recording, including emergency plans such as ReSPECT, DNACPR, and others. It sets out the roles and responsibilities for health and social care staff developing and using these documents.

To ensure staff across health and social care settings understand their roles and responsibilities regarding Future Care Planning in line with Healthcare Improvement Scotland (HIS) guidance for a 4 step approach: preparation and planning, meaningful conversations, documentation, and sharing and regular review.

This policy compliments the national Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) policy and should be read in conjunction with that.

This policy fully supports national guidance and recommendations published in a joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). This policy should be read in conjunction with that guidance.

To acknowledge that people are central in decisions about the treatment that they receive, and to support shared decision making between people and those providing treatment and care to them.

	DPIA SCREENING QUESTIONS	**YES/NO**
1.	The work involves carrying out a ***systematic and extensive evaluation*** of people's personal details, using ***automated processing (including profiling).*** Decisions that have a ***significant effect*** on people will be made as a result of the processing. Includes: Profiling and predicting, especially when using aspects about people's work performance, economic situation, health, personal preferences or interests, reliability or behaviour, location or movements Processing with effects on people such as exclusion or discrimination Excludes: Processing with little or no effect on people	NO
2.	The work involves carrying out ***large scale*** processing of any of the ***special categories*** of personal data, or of ***personal data relating to criminal convictions and offences.*** Includes: • Racial or ethnic origin data • Political opinions data • Religious or philosophical beliefs data • Trade Union membership data • Genetic data • Biometric data for the purpose of uniquely identifying a person • Health data • Sex life or sexual orientation data • Data which may generally be regarded as increasing risks to people's rights and freedoms e.g. location data, financial data • Data processed for purely personal or household matters whose use for any other purposes could be regarded as very intrusive	NO

	DPIA SCREENING QUESTIONS	**YES/NO**
	To decide whether processing is ***large scale*** you must consider: • The number of people affected by the processing, either as a specific number or as a proportion of the relevant population • The volume of data and/or the range of different data items being processed • The duration or permanence of the processing • The geographical extent of the processing activity	
3.	The work involves carrying out ***large scale*** and ***systematic monitoring*** of a ***publicly accessible area.*** Includes processing used to observe, monitor or control people.	NO
4.	The work involves ***matching or combining datasets*** e.g. joining together data from two or more data processing activities performed for different purposes and/or by different organisations in a way that people would not generally expect; joining together data to create a very large, new dataset.	NO
5.	The work involves processing personal data about ***vulnerable groups.*** This includes whenever there is a power imbalance between the people whose data are to be used e.g. children, the mentally ill, the elderly, asylum seekers, and the organisation using their personal data.	NO
6.	The work involves ***significant innovation*** or use of a ***new technology.*** Examples could include combining use of finger print and face recognition for improved physical access control; new “Internet of Things” applications.	NO
7.	The work involves transferring personal data across borders ***outside the United Kingdom.***	NO
8.	The work involves processing that will ***prevent people from exercising a right*** or using a service or a contract e.g. processing in a public area that people passing by cannot avoid.	NO
9.	The work involves the processing of Children’s data and must meet the 15 standards of The Children’s code (or the Age appropriate design code) which online services need to follow. This ensures they are complying with their obligations under data protection law to protect children’s data online.	NO

Review and Recommendation
Based on responses provided to the screening questions, NHSDG Data Protection Officer and eHealth Cyber Security Manager (where appropriate) will review and determine whether a DPIA or an SSP (System Security Policy) is needed. Please be aware that a DPIA is a legal requirement under Article 35 of the GDPR for all high risk processing activities.

Role	Advice/ Action/ Sign-Off	Date
IG/ Data Protection (DPO) Review with advice/comments	The development of this policy does not involve any high risk processing activity. Of note, a DPIA was completed for ReSPECT by NHSDG and was approved 19/09/2023. DPIA is not required based on screening question responses. 	07/05/2025
eHealth Cyber Security Manager Review with advice/comments	Not required	
Others, if necessary e.g. Caldicott Guardian, Senior Information Risk Owner (SIRO)	Not required	
DPO opinion on whether residual risks need prior notification to the ICO	N/A	
Information Asset Owner(s) or Project Lead Sign Off		

Step One – Consultation Phase

Consult with all stakeholders about what you wish to do as early as possible in the process. Stakeholders will normally include:

- Key service staff e.g. those who will be managing the process.
- Technical support, especially if a new system is involved. This may involve the relevant IT supplier.
- Information governance advisors e.g. Caldicott Guardian, Information Security Officer, Data Protection Officer.

Sometimes it will be necessary to consult with service users. This will be particularly relevant if the change in process will change how they interact with our NHS Board, or what information is collected and shared about them.

Early consultation will ensure that appropriate governance and security controls are built into the process as it is being designed and delivered, rather than being 'bolted on' shortly before the change is launched.

Step Two- DPIA drafting
The responsibility for drafting a DPIA will normally sit with the service area that 'owns' the change, however, all stakeholders will have an input. Depending on the nature and complexity of your proposal, more than one service area and/ or Information Asset Owner (IAO) may be the owner(s).

Step Three- Sign-off
When a DPIA has been fully completed, it must be submitted for formal review by an appropriate IG professional/ the Data Protection Officer. They will review the DPIA to ensure that all information risks are fully recognised and advise whether appropriate controls are in place. The Data Protection Officer will decide, where the DPIA shows a high degree of residual risk associated with the proposal, whether it is necessary to notify the ICO. It may be necessary to inform and/or involve the Board's Senior Information Risk Owner (SIRO) as part of this risk assessment and decision-making.

Once reviewed, the DPIA will need to be signed off by the Information Asset Owner(s) (IAOs), normally a head of service.

Completed DPIA documents should be returned to NHSD&GDPO@nhs.net. The NHS Data Protection team will record the DPIA, update the Information Asset Register, schedule reviews of the DPIA, etc.