

## The *Preferred Priorities for Care* (PPC) Document: Guidelines for Health and/or Social Care Staff

### Introduction

***Preferred Priorities for Care (PPC)***, formerly known as *Preferred Place of Care*, is a document that originated in Lancashire and South Cumbria Cancer Network as part of a District Nurse education programme. The original document was intended as a patient-held form for people living in the community with a cancer diagnosis, and focused on where people wanted to be cared for at the end of their lives. PPC has since been used in other care settings and with groups of people with any life-limiting condition. This process is voluntary and is appropriate for people who may want to make specific statements about their wishes as they approach the end of their lives. Experience of using the PPC has shown that it has a broader focus than simply place of care, and this, together with the Mental Capacity Act (2005) (further information available at [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)), led to a review of the original documentation by a national review team. After wide consultation and an evaluation process, a revised version of PPC has been produced. One of the fundamental changes has been the change of title to ***Preferred Priorities for Care***. The new title reflects the importance of discussing with individuals their priorities, preferences and wishes, understanding that place is only one of the possible priorities for people facing the end of life. The PPC has been identified within the NHS End of Life Care programme as an example of an advance care plan.

### Advance Care Planning

Advance care planning (ACP) is a process of discussion between an individual and their care providers. If the individual wishes, their family and friends may be included. This discussion should be documented, regularly reviewed and communicated, with the individual's agreement, to key persons involved in their care. An advance care planning discussion might include the individual's concerns, their important values or personal goals for care, their understanding about their illness and prognosis, as well as particular preferences for types of care or treatment that may become necessary in the future and the availability of these.

ACP should be an integral part of the care and communication process, and of the patient's regular care plan review, but sometimes the process will take place in the context of an anticipated deterioration in the future when the patient may lose the capacity to make decisions and/or to communicate their wishes to others. In this context, the outcome of ACP *may* be the completion of an advance statement or decision, but this is not mandatory or automatic and will depend on the person's wishes.

A statement of wishes and preferences documented in a PPC is not legally binding, but under the Mental Capacity Act (2005) anybody making a decision about the care or treatment of an individual who has been assessed as lacking the capacity to make that decision for him/herself will be required to take any statement of wishes and preferences into account when assessing a person's best interests.

### Who is PPC suitable for?

Any person, with or without a life limiting illness, may complete a PPC. The process may be initiated and completed by an individual without involvement of a health or social care professional, but people are encouraged to complete PPC through discussion with family, friends, and health and/or social care staff. People who want to make specific statements about their wishes as they approach the end of their lives may wish to complete a PPC.

### When should PPC be introduced?

There is no right time to introduce PPC as it is a very individual and person centred process. In some instances the person may initiate the conversation, or their carers may want to discuss what will happen as the person nears the end of life. In other instances PPC may be initiated by a health or social care professional who will need to consider a person's wishes and preferences in order to plan end of life care.

**It is important to promote the use of PPC at the earliest opportunity in order to allow for planning to occur.** Planning care with people who have end of life care needs requires constant review as the person's wishes, preferences and priorities may change, as may the needs of carers. The PPC promotes regular review and recording of the process.

### Sharing of Information

The PPC belongs to the person whose plan it is and can be taken with him/her if he/she is transferred into a different care setting. Although the information within the PPC belongs to the person, people need to be encouraged to share the information with those people who may be involved in their care. Whilst it is the person's wishes which are recorded there may be an impact on carers, service demands, etc that requires an element of support to facilitate achieving the wishes. Before any sharing of information takes place consent needs to be obtained from the person whose plan it is.

### What happens to the PPC when a person dies?

The PPC belongs to the person and does not need to be recalled. However for audit purposes, systems may be in place to undertake audits using locally developed tools in order to look at whether patients have had their wishes met.

### Completing the actual document

It is preferable if the individual completes his/her own PPC as it is then written in his/her own words. However, some individuals may not want or be physically able to write in the document. In this instance it is up to the individual to identify someone to help complete this document; that person may be a relative, friend, or health or social care professional.

- Page 1: Title page. It is useful to print this page in colour in order to make it easily identifiable.
- Page 2: The name and address box needs to be completed in case the person is transferred to a different care setting, so that the document remains identifiable. The remainder of this page is explanatory guidance.
- Page 3: This page also contains further explanatory guidance. There is then a section to complete which identifies who else may be involved in the discussions. The first section is about if the person has formally registered a Lasting Power of Attorney through the Office of Public Guardianship (OPG) (further information can be accessed on: <http://www.publicguardian.gov.uk/index.htm>). The second box is to provide contact details for anyone else the person would like involved in care discussions in the event of a loss of mental capacity. This person does not need to be legally registered with the OPG.
- Pages 4 and 5: These two pages are for the person to complete with professional facilitation if required. This section gives the person the opportunity to discuss and record any possible changes to their health or social care needs. This then leads into the section where they can record their preferences and priorities in relation to their future care and where they would like that care to take place if possible. If a health or social care professional is facilitating this discussion, it is important for him/her to provide information to the person about available resources. For instance an individual may express a wish to die in the local hospice; however, the health professional needs to explain about the implications of the lack of hospice beds, to explore with the individual why he/she wishes to die at the hospice, and to discuss other alternatives which may address the person's underlying priorities.
- Page 5 also includes a section for recording any changes to the person's preferences and priorities. There is no specific time frame for the review process as this is individual to the person. However, regular review should be undertaken in order that the PPC remains up to date. It is important that the person signs and dates any changes to the PPC.
- Page 6 is a further information page and people may wish to use this page to record any other issues or to list questions they have for health or social care professionals.
- Page 7 is a contact information sheet which can be used to record contact details for health and social care professionals or family or friends.
- Page 8: This page contains a box to record details of the member of staff introducing the PPC, so that individuals will have a local contact for further information if required.

For further information about PPC please email: [information@eolc.nhs.uk](mailto:information@eolc.nhs.uk) or Les Storey (PPC National Lead): [lstorey@uclan.ac.uk](mailto:lstorey@uclan.ac.uk).