

AN EVALUATION OF AN INDIVIDUAL PROGRAMME PLANNING SYSTEM

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Introduction

There has been very little published research evaluating the Individual Programme Planning (IPP) systems, despite their widespread use in Britain for approximately ten years. Fleming (1985) examined attendance at IPP meetings and goal setting in a 70-place hospital for people with a mental handicap. He found problems with multi-disciplinary involvement and commitment, difficulties for staff in setting clear, realistic goals, and problems evaluating outcomes of previously set goals. Later he examined (Fleming, 1988) the effectiveness of IPPs in a hostel for 29 adults with a mental handicap and an adjoining 70-place Adult Training Centre (ATC). He replicated the finding that there were problems for staff setting realistic goals, and problems of service deficiencies in meeting some goals. He also highlighted the need for increased commitment by service managers to the IPP system. Humphreys and Blunden (1987) carried out an extensive evaluation of 19 IPPs in a community based service for people with a mental handicap. They too

stressed the importance of commitment from professionals, and the need to link the goals more closely with quality of life: "at present neither research nor service has a systematic way of reviewing each individual's progress towards the general objectives of integration and independence . . ."

The current project took place in the Locally Based Hospital Units (LBHUs) in the East Dorset Health Authority whose residents had transferred from a large mental handicap hospital. The first LBHU opened in 1972 and the development plan was completed in July 1991; there are now 14 LBHUs, providing 245 beds. At the time of the survey there were 12 LBHUs and 208 residents. The first IPPs were implemented in 1986 and the current project is the first attempt at an evaluation. It aims to investigate the effectiveness of the IPP system through the attitudes and opinions of the staff involved.

This Study

1. To study the attitudes of staff towards the use of the existing IPP system in the Locally Based Hospital Units.

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2. To examine practical issues in the implementation of the IPP system.
3. To evaluate the IPP system and implement improvements/modifications where necessary.

Subjects

Members of staff from the LBHUs (at least one member of staff from each unit) and 10 members of the multi-disciplinary team completed the questionnaire.

The members of staff from the LBHUs were senior clinical nurses, charge nurses, team leaders, keyworkers and houseparents. Consultant medical staff, speech therapists, physiotherapists and occupational therapists, together with social services staff from the adult training centres represented the multi-disciplinary team. Psychology was not included as this was the department carrying out the research.

Method

A 27 item questionnaire was designed to address the three main areas of involvement in the IPP system: clients, staff and management/system issues. These issues were covered by questions on the following areas: client/family involvement, the IPP meeting, the involvement of the multi-disciplinary team, paperwork, goal setting and evaluation.

Respondents were asked to answer yes/no/not sure (sometimes) to a series of questions. Some questions required the answer to be one of three choices and other questions were open for descriptions and ideas.

Results

Client issues/family involvement:

There were mixed opinions as to whether the IPP system meets with the needs of clients, and whether it conflicts with the principles of normalisation. Most respondents said that only "sometimes" clients should attend their own meetings. Approximately two thirds felt that relatives should attend IPP meetings and contribute to decision making, and most of the other third felt that only "sometimes" should relatives attend and contribute.

The IPP meeting: 30 respondents attended the IPP meetings of between 1-10 clients and a variable number attended the meetings of 10-50 or more. Five respondents said they were expected to, and two said they did attend over 50 clients' meetings. Most felt the frequency of meetings should vary for clients and that the venue should not vary. Twenty said the meetings should take place at 6 monthly intervals, and 6 preferred 12 monthly intervals. Two suggested a 9 monthly interval. Most respondents thought it would be useful to distribute IPP notes prior to meetings, but 8 thought it would not be useful or were not sure. Suggestions for improvements to meetings included more input from the multi-disciplinary team, better communication, a yearly rota and time limits on meetings.

Multi-disciplinary involvement: The main theme which emerged was a need for better communication with, and more support from the multi-disciplinary team to the LBHUs, and vice versa. Only 5 out

of the 30 respondents felt adequately supported working on IPPs. All respondents said it is important that professionals should send a written report when unable to attend an IPP meeting.

Paperwork: There were mixed feelings regarding the amount of paperwork involved in the IPP system and the need to change the record system. The paperwork covered checking, planning and organisation. The problems identified were repetition, layout, and access to resources (eg. photocopiers). The paperwork was also described as a "chore" and in general it was felt it needed simplifying, condensing and making more specific. Suggested improvements included the use of computers, improved assessment and recording procedures, and organisational input from psychology

Goal setting: Most people said 3 goals were set at a meeting, the remainder said 3-6 goals were set. Some were unsure whether or not new goals could be set between meetings. Twenty-three respondents said there were no problems defining goals. Factors which did impede goal setting, however, included inadequate assessment sheets, inconsistency amongst staff and staff changes, and difficulty setting goals for severely handicapped clients. Other issues included whether goals were being set to meet clients' or staff needs, and problems with the difference of aims and goal setting between social services and health services. It was also suggested that goals should be more specific and always be appropriate to everyday routines and life planning.

Evaluation: At that time there was no system for evaluating the IPP system, and almost all respondents said such a system would be useful. However, they were divided on the benefit of establishing an overall method of evaluation which could compare, for example, the number of goals achieved in each of the LBHUs. Suggestions for a system of evaluation included to assess the number of successful and unsuccessful goals, to hold regular staff meetings, to devise a column/section on IPP forms indicating 'date achieved', client advocate meetings, a study of a cross-section of clients' goal achievements, and the implementation of a quality assurance scheme.

Discussion

There appears to be a mixture of feelings regarding clients' needs and the role of the client within the IPP system. Humphreys and Blunden (1987) describe this problem in terms of there being a conflict between two sets of aims which co-exist in the IPP system: 'client-related' and 'service-related' aims. The latter puts emphasis upon efficiency, planning, economic use of time, organisation, co-ordination and other administrative issues. Client-related issues are orientated towards choice, expression and client-involvement.

This conflict could be the underlying reason behind the mixed opinions regarding clients attending their own meetings, i.e., the involvement of the more profoundly handicapped clients would be time-consuming if they were to participate fully. Humphreys *et al.* (1985) comment: "client and family attendance

alone does not guarantee participation and involvement in the meetings." Blunden *et al.*, (1987) set out five 'Principles of Planning with Individuals' the second of which is that "people with mental handicap should be involved in planning their own futures". Client involvement in the IPP system is fundamental to its aims, as Fleming (1988) points out, but how this is achieved still needs much more detailed thought and planning.

Prior to this survey taking place, IPP meetings were held every 6 months for all clients in the LBHUs. The timetables for meetings were organised in the individual units by the senior staff. Therefore it was possible for meetings to clash and hence it was difficult for members of the multi-disciplinary team to attend all meetings. The length of meetings was also variable. This survey has shown a need for more structure, organisation and boundaries, which is understandable in such a large service. Fleming (1985) described the importance of timetabling IPP meetings, and Humphreys and Blunden (1987) describe the importance of adequate preparation before a meeting. The frequency of IPP meetings has not officially been variable for different clients, but maybe it would be more appropriate to hold meetings at different frequencies. Humphreys and Blunden (1987) feel that following the first referral to a service, an IPP meeting for that person should be held every 6 months, but subsequent meetings can be varied according to the individual's needs. Blunden *et al.* (1987) suggest two alternative ways of holding meetings and involving the client: 1) Meetings

comprising of all professionals and family involved, including the client, 2) A coordinator to meet with the client prior to the meeting and to separately meet with the professionals involved, but taking the role of 'plan co-ordinator', or 'broker'. This second approach is quite different from the traditional approach of one single multi-disciplinary meeting per client, but as it is often difficult to co-ordinate and gain total commitment and co-operation for such a meeting (eg. Fleming 1985, 1988) then this alternative may be worth considering.

Both the multi-disciplinary team and staff from the LBHUs expressed a need for more support, co-operation and communication from each other. This could be due, in part, to the practical difficulties caused by a relatively small multi-disciplinary team, and the fact that the residents in the units are geographically spread over an area of approximately 400 square miles.

Fleming (1985) noted that "the attendance of a small number of professionals was relatively poor", and "it seems as if some of the professions have not allocated it priority". Humphreys *et al.* (1985) also found that "questions of inter-agency co-operation and communication were a recurring theme, and implicit in this was the need for a greater commitment to full involvement from all agencies concerned". A further problem impeding attendance at meetings could be caused by the number of meetings in general the professionals are required to attend, creating clashes of time and overlapping of meetings. The aforementioned need for a timetable of meetings could go

some way towards solving this problem, but overlapping is almost inevitable due to the number of other meetings which are held within the service.

The need for modifications to the record system and paperwork has been highlighted. The assessments which preceded meetings were a major paperwork problem as many of them are very long and time consuming. There also appears to be a need for more organisation and consistency.

The literature discusses the problems incurred by unclear, unmeasurable and unrealistic goals (eg. Fleming 1985, 1988) as well as the need for goals to be relevant to the clients' long-term and short-term needs. The current project has discovered the same kind of problems within its own IPP system. Blunden *et al.* (1987) in their guide for IPP systems, differentiate between 'goals' and 'tasks', the latter being for the staff or the service to carry out for an individual. This is an important distinction and one which could be incorporated into the present system.

Blunden *et al.* (1987) suggest an IPP system should be reviewed 2 or 3 years after its implementation and then any necessary modifications should take place. Again the two aims of the system, i.e. client-related and service-related, influence evaluation. An IPP system needs to be measured in terms of its effectiveness as an administrative framework, and also the outcome for clients. The current project has focussed on service-related issues and the feelings, attitudes and ideas of staff. From this a need has been identified for assessing the

system in terms of outcome for clients. Outcome for clients also operates on two levels itself - goal achievement eg. learning a new skill, and quality of life. Some long-term goals such as where someone will live, are directly linked with quality of life, but for clients who are long-term residents and clients with more severe handicaps, goals are much more limited and of quite a different nature.

One method of evaluating an IPP system fully would be to examine goal outcome, quality of life, and staff attitudes. A checklist or guidelines would be useful for evaluating the latter, such as the 5 'Principles of Planning with Individuals', a matrix for analysing quality of life drawn up by Blunden *et al.* (1987). Ideally the IPP system itself should have an inbuilt system of evaluation, but this can realistically only cover the issue of goal outcome. A package which incorporated all 3 areas: goals, service-needs and quality of life, could be a future goal for services themselves.

The Development of an Action Plan

Based on the findings of this survey an action plan was evolved. It contained:

1. Structured timetable for IPP meetings. This was designed by the psychologists to aid organisation and promote attendance by all disciplines. The main features of the timetable are: a) all meetings to take place on the same day each week throughout the year with advanced notice given to those involved. Each LBHU would therefore have fixed dates

for meetings, with a follow-up date 6 months later for each client. The timetable, i.e. the list of dates for each LBHU to be distributed to all LBHUs and other agencies in the IPP system, b) half an hour would be allocated to each clients IPP meeting, and would follow an agenda.

2. Change format of paperwork. Three forms were designed to aid organisation and reduce paperwork, i.e. all disciplines would complete the same forms and this could be done during a meeting rather than having to be transposed afterwards. The forms were for: a) goal setting and information, b) programme design, c) a checklist of goals set, and whether or not they were achieved.

3. Maximum number of goals to be set per client to be 3.

4. Unit goals or 'tasks' to be specified as well as client goals.

5. Alterations to be made to assessment procedures.

6. All agencies to send a written report when unable to attend an IPP meeting.

The Action Plan was operationalised in April 1990. The timetable has helped the meetings to run more smoothly, and the submission of reports by agencies unable to attend meetings has eased communication. The recommendations were tailored to the responses from the survey, and as the attendance of clients at meetings was met

with diverse opinion, action was not taken on this issue. The new paperwork has been readily accepted, although as with all new ideas, it is taking time to fully integrate. The time limits and limit on number of goals set have generally been accepted. The inclusion of 'unit goals' or 'tasks' has somewhat clarified certain areas of responsibility and accountability although, again, as a new concept it is taking time to be fully understood. The unification of assessment procedures and goal planning is still contentious, largely due to the increasing number of clients and the mixed range of abilities. We are still aiming for some consensus agreement on assessment procedures and the issue continues to be discussed.

The findings and recommendations which have evolved from this survey reflect other similar projects in the literature. The IPP system is a dynamic process which will need to change and adapt as services for people with learning difficulties expand. As IPP systems are now establishing themselves, methods of evaluation will increasingly be called upon to measure their effectiveness in terms of client-outcome and as an administrative framework.

Summary

The evaluation of the IPP system described in this paper has identified some of the inherent problems within the IPP system, discussed them where possible with references to other evaluations, and outlined an Action Plan which was put forward in an attempt to remediate the problems.

The main area of concern centred around the involvement of the multi-disciplinary team, which it was recognised could be accounted for by timetabling difficulties, and therefore a yearly timetable was designed and implemented. To help staff with some of the issues surrounding goal setting, more specific guidelines were devised; alterations to the paperwork were also made in order to ease the work load and the communication between the professionals involved.

More general requirements for further evaluation, client involvement and more emphasis on 'quality of life' were also highlighted and recognised as areas highly suitable, and in need of, further investigation and research.

References

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