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INDIVIDUAL PROGRAMME PLANS: EVALUATION AND DEVELOPMENT IN A HOSPITAL SETTING

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Introduction

Individual Programme Plans (IPPs) have become one of the central mechanisms for better service delivery to clients with a learning disability over recent years. Part of the reason for the increased use of IPPs is that they focus on the individual persons needs, that goals are specified clearly and that there is accountability built into the system (by making a named person responsible for goal achievement, which is usually the keyworker). This makes IPPs, in theory at least, easy to evaluate (Fleming, 1988).

Humphreys and Blunden (1987) carried out an extensive evaluation of 19 IPPs in a community based service for people with a learning disability. They stressed the importance of commitment of professionals, and the need to link the goals more closely with quality of life. In addition they argued that there often seemed to be a mixture of feelings regarding clients' needs and the role of the client within the IPP system. Humphreys and Blunden described 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

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puts emphasis upon efficiency, planning, economic use of time, organisation, co-ordination and other administrative issues. Client-related issues, on the other hand, are orientated towards choice, expression and client-involvement".

In a recently published study Wright and Moffat (1992) recommend a number of procedural changes to ensure higher quality IPP service. Among these are the following recommendations: that the maximum number of goals to be set per client at each IPP meeting is 3; that alterations be made to the assessment procedure; and that all agencies who are unable to attend a meeting are to send a written report.

Laws *et al.*,(1988), Flemming (1988) and Dunne and O'Regan (1990) all reported on the use of IPPs and attempted evaluation studies. However, none of these studies describe the implementation of the results, although Dunne and O'Regan describe a two stage process of evaluation which attempted to incorporate the findings of the first stage of the evaluation with a degree of success.

This paper describes an evaluation procedure which was carried out over a period of two years (1992-1994) at a long stay hospital for people with learning disabilities in the UK, and will describe how the results of the evaluation procedure were used to develop IPP practice within the hospital.

Background

The hospital concerned was a fairly typical Victorian style building which had been a hospital for people with learning disabilities since the 1930s. In the 1970s there were 350 people living in the hospital although this figure declined gradually throughout the 1980s when a policy of community care, as opposed to admission, reduced the number to 207 by 1988. With the deadline of March 31st, 1994 reprovision in the community gained momentum and by mid 1992 when the study began the number of people resident on site reduced to 85. During the course of the study, the number of people living on site continued to decline up to the deadline for closure of the hospital.

Rationale of the Study

The IPP system had been introduced in 1990 to the hospital staff and some training had been provided to staff to develop the keyworker role particularly. IPP meetings were set up along traditional lines of discussing client needs, determining goals and recording them etc. The IPP meetings took place on a regular basis, but there appeared to be much confusion about the role of the IPP among staff. The IPP meetings were attended by a large number of people (anything up to 14 members of staff), the discussions often took the form of a case conference, focusing on crisis in the client's life or some form of challenging behaviour and hardly any planning appeared to take place at the IPP meetings.

These subjective impressions of the IPP system led to the decision to try and establish objectively how the IPPs were

really working and to what extent the IPPs were effective in meeting client needs.

Design of the Study: Phase 1

Three houses/wards on the hospital site were chosen at random together with one house in the community as a basis for evaluating the IPP system. The house in the community was chosen to see if there were any indications that the IPP system operated in a different/more effective manner in the community. The analysis of the IPPs in the four houses was carried out in the summer of 1992 to establish a baseline of functioning for the IPP system as a whole in the service.

As will be noted from TABLE I, houses A and B were rather large containing ten residents each, whilst houses C and D were small containing five residents each (house D was the community house). As will also be noted, there were a large number of goals set across all four houses (total 149), although overall the average number of goals per IPP

TABLE I
Baseline Findings of IPP Evaluation

	House A	House B	House C	House D (Community Home)	TOTAL
Number of IPPs	10	10	5	5	30
Total No. of Goals	37	52	24	36	149
Number of General (Ambiguous) Goals	20 (54%)	20 (38%)	6 (25%)	8 (22%)	54 (36%)
Number of Specific (Unambiguous Goals)	17 (46%)	32 (62%)	18 (75%)	28 (78%)	95 (64%)
Average No. of Goals per IPP meeting	3.7	5.2	4.8	7.2	4.97
Range of Goals	2-8	3-7	4-6	4-10	2-10
Number of Clients who attended	9 (90%)	6 (60%)	4 (80%)	5 (100%)	24 (80%)
Number of Relatives/ Guardians who attended	4 (40%)	0	1 (20%)	1.20 (20%)	6 (20%)
Total number of participants	60	51	27	29	167
Average number of participants	6	5	5	5	5

was just under 5. It is interesting to note that it was the community home which had the highest average number of goals at 7.2 with a range of goals from 4-10, which is wider than that of the houses on the hospital site.

A simple dichotomy of general/specific goals was used to examine how well the goals were expressed and written down. This dichotomy was chosen as it has been convincingly demonstrated by Locke *et al.* (1981) that specificity of goals leads to greater commitment and achievement of goals, whilst vague ambiguously written goals are more difficult to achieve and increase the likelihood that the goals will not be acted upon by staff. A goal was categorized as **general** if it was stated in vague, ambiguous terms, such as "Needs social skills training" or equivalent. A goal was categorised as **specific** if it was written in clear, unambiguous terms, such as "John will be taught to brush his teeth every morning and evening by Mary S. (keyworker)".

As can be seen from TABLE I, the number of vague, ambiguous goals in the three hospital houses ranged from 25% to 54% whilst the community house had a slightly lower score of 22% ambiguous goals. The hospital houses C had 25% ambiguous goals, which is close to that of the community home D. C is also the smallest house on site, similar to the community house. The other two houses, A and B, had significantly higher percentages of ambiguous goals. It is possible that staff in these two houses might not have been aware of the consequences of writing down vague, generalised statements as goals.

The next figure of interest in this study is the total number of participants involved in IPP meetings. As can be seen from TABLE I this figure is higher for houses A and B on the hospital site, even though the average number of participants at each IPP meeting is similar to that of houses C and D. Thus, it would appear that the bigger the house in terms of number of clients residing there, the greater the number of people who became involved in the IPP meeting. This, combined with the results discussed in the preceding paragraph, suggests that the more people involved in the running of the IPP meeting, the greater the likelihood of reaching vague, ambiguous goals and thus increasing the likelihood that the goals may not be followed through.

However, as this first phase was to establish a baseline for the effectiveness of the IPP system in the hospital, few firm conclusions could be drawn from the findings, apart from noting some general trends as stated in the preceding paragraphs. Accordingly, a follow-up of the same four houses was undertaken six months after the baseline study, in early 1993.

Phase 2

As will be apparent from TABLE II, for houses A and B on the hospital site the IPP meeting had not been held within the six month period, as is recommended practice for IPP systems. The houses C and D had held a second IPP meeting, but some of the results could not be ascertained because some

information was not recorded on the IPP forms. These omissions were in relation to the number of clients who attended the meeting (house D), the number of relatives/guardians who attended (houses C and D) and the total number of participants (house C). Consequently, these headings will not be discussed further.

As can be seen from TABLE II Phase 2 produced very little difference in the average number of goals being set or in the range of goals being set in houses C and D, nor is there any great change in the ratio of general/specific type goals in either house from baseline to Phase 2.

Because of the lack of data, few conclusions can be made from TABLE II. Perhaps the most significant aspect is the fact that two houses did not hold IPP meetings for their clients within six months. As this represents 50% of the sample, it is rather an alarming figure, particularly if it could be generalised to the whole hospital, and there is no reason to assume that this would not be the case. This conclusion is further reinforced by the reactions encountered among staff during the Phase 2 survey. A strong impression was gained that the whole IPP system was merely regarded as a paper exercise by staff, best forgotten about as soon as the IPP meeting

TABLE II
Follow-up of IPP Evaluation Six Months Later

	House A	House B	House C	House D (Community Home)
No. of IPPs	IPP meeting not held	IPP meeting not held	4	4
Total No. of Goals			19	29
No. of General Goals			5 (26%)	8 (27%)
No. of Specific Goals			14 (74%)	21 (73%)
Average No. of Goals			4.7	7.25
Range of Goals			4-5	4-10
No. of clients who attended			4 (100%)	-
No. of relatives who attended			-	-
Total No. of participants who attended			-	14
Average No. of participants			-	4

had ended, with no reference to the goals as the basis for daily activities for the clients. This impression was based on comments made by staff in the various houses when IPP forms were requested for the study. In the houses where the second IPP meeting had been held, no reference was made to the goals set at the previous IPP meeting. It was as if a first IPP meeting was held every time, with no checking on whether previously specified goals had been achieved or not.

Thus, after a period of one year of evaluating the IPP system in the hospital, the initial subjective impressions that the IPP system was not working according to recommended practice, was largely confirmed by the two phase evaluation. The IPP meetings were not happening regularly, when they were happening, there was a large number of people involved, vague generalised goals tended to be set, few follow-up IPP meetings were held within six months and no reference to the specified goals was made in the day to day planning activities for client. Where there was another meeting after six months, no reference was made to the last IPP meeting as a basis for the agenda of the following IPP meeting and no assessment took place to check whether the goals set last time had been reached.

The Way Forward

One of the problems which emerged regarding the IPP system was staff difficulties with literacy. It can easily be appreciated that this is a factor which will determine whether or not the IPP system can function effectively, since the IPP process will be impeded if a staff member has difficulties with reading and/or writing. A literacy programme was devised and implemented with help from the staff union. Allied to this was the need to re-design the IPP system in an attempt to make it more user friendly, focused and effective. A streamlined IPP meeting format was devised in the hope of achieving those goals.

A set of proposals was put to the management of the hospital and agreement was reached to implement a pilot project in one house on the hospital site. The house chosen was a house which had recently taken on a whole new staff complement together with new clients from other reprovided services. The staff had not used the IPP system before which was an advantage because they had no "unlearning" to do and could be inducted fairly easily into the new IPP system. An induction programme was carried out with each staff member on an individual basis prior to any IPP meetings. This included brief training in the rationale behind the new IPP system, the role of the keyworkers, as well as training in how to translate needs into clearer goals.

The Pilot IPP System

Based on the analysis of the findings, certain key elements were identified as requiring attention if the IPP system was to work effectively:

1. **The meeting needed to focus on the client's life where the person lived.**
   In the old system, the IPP meeting tended to be rather unfocussed with generalised goals relating mainly to clinical needs, e.g. "Johnny needs bereavement counselling". By focusing the meeting on the clients' needs where they live, staff could gain more responsibility for the clients' daily activities and the IPP goal setting exercise would, hopefully, be translated into reality.

2. **The IPP meeting needed a chairperson.**
   Under the old system, no one was identified as a chairperson. This left the IPP meetings open to drifting off the topic, lasting longer than the time specified (which often happened), and focusing on crises rather than planning.
   One of the authors agreed to chair the pilot IPP meetings. The chairperson's role was defined as chairing the discussion, helping all participants to focus on needs leading to goal formulation, summing up and keeping time etc.

3. **The IPP meeting should last one hour.**
   Under the old system the IPP meeting often lasted one and a half to two hours because of the difficulties identified above. By keeping to a time limit of one hour with the help of a good chairperson, there was no reason to believe that all the business could not be completed in this time.

4. **A smaller number of key people to attend.**
   As is evident from the analysis, a large number of people involved in the IPP meetings tended to produce a large number of general, ambiguous goals. In an effort to counter this, it was suggested that the IPP meeting be kept small, with only the chairperson, keyworker, client, relative and one other staff member who would act as recorder of the proceedings, present at the IPP meeting.

5. **Keyworker's role changed slightly.**
   The keyworker's role was not changed substantially. Information gathering before the meeting, by discussing the client with other staff and clinicians who know the client, was still a central part of the pre-IPP activity for the keyworker. However, the lengthy form used hitherto was dispensed with and a simpler form with a strengths/needs list was substituted, partly in an effort to cope with the literacy problems mentioned earlier.

6. **Clear, unambiguous goals to be set at the IPP meeting.**
   As is evident from the evaluation of earlier IPP meetings, many of the goals which had been set were vague and ambiguous. In an effort to increase the likelihood that goals would be used to direct daily activities, the chairperson's role was to ensure that clear, unambiguous goals were set at the meetings.

Implementation

On the basis of the above points, series of pilot IPP meetings were held in September, 1993, in the designated house. The meetings lasted one hour and were attended by no more than six people. An average of five goals was set per IPP meeting and dates were set for follow-up meetings six months later. These new meetings, in general, received a favourable response from relatives, keyworkers and clients. At the time of writing, the follow-up meetings were being held using the earlier IPP meetings as a basis for an agenda and evaluating previously set goals.

Conclusions

This paper has described a two years evaluation study of an IPP system at a hospital for people with learning disabilities. The main results of this evaluation revealed that the IPP system was not functioning as well as it might have done and that certain key parts of the IPP system (six monthly meetings, focusing on needs, clear, specific goals etc.) were not complied with. The findings also revealed that the IPP system was not operating significantly differently in the community house. A revised IPP system was described and a pilot project of implementation discussed.

The purpose of this paper has been to highlight the need for an ongoing evaluation of systems such as the IPP system with a view to introducing changes based on the evaluation. With the closure of the hospital in March 1994, the current need is to ensure the implementation of the revised IPP system into the community houses.

Summary

Individual Programme Plans (IPPs) have emerged in recent years as a key feature of service delivery for people with a learning disability. Yet, there appear to be few evaluation studies published in the literature. This paper describes an approach to evaluation of IPPs, and the outcome of an evaluation study carried out on an IPP system in a long stay hospital for people with learning disabilities in the UK. The paper concludes by showing how the findings contributed to the development of a more effective and task focused IPP system as a result.

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