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## CONFERENCE ABSTRACT

### The Indicator of Relative Need (ioRN) - information for integrated working

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In the health and care field there is a widespread convention to label all people aged over 65, or perhaps over 75, as 'older people' - as if somehow they comprise a single homogenous group, with similar needs. Of course we acknowledge that many older people live at home in good health perhaps requiring informal support from family or friends and with occasional contact with health services. Many however also live with multiple long-term conditions - and, for some, increasing frailty. But these generalisations alone are insufficient to measure and understand the impact of health conditions on the functional status or degree of independent living of an individual. And to enable the planning and delivery of well-targeted integrated care and support for those who need it we require more systematic information.

For over a decade in Scotland we have been developing, using and improving a method to measure people's needs in such a systematic way. The ioRN tool is used by many health and care providers to help summarise issues and stratify the older people clients/patients according to how well they are functioning.

The ioRN uses a set of (16) questions, each straightforward and standardised - and a choice of discrete answers that are readily chosen by someone (irrespective of their discipline) who knows the person well. People are assigned to defined groups through application of a sophisticated algorithm that works by inspection of the information recorded. The original design of the tool involved a unique fusion of talents and experience on both analytical and in front-line care practice, the latter drawing on the experience of teams of health and social care practitioners from every part of Scotland.

A separate version of the ioRN was designed for use in care home settings - to support a staffing model and to provide care homes with better understanding of the needs of their residents overall and individually. A further development of this has resulted in a version, still at prototype stage in NHS Lothian, for use in acute or downstream hospitals.

Very recently the community ioRN has been carefully reviewed and has, after real-time testing in six areas of Scotland, been re-designed - keeping similar questions but enhancing the algorithm that drives the classification stage. The review has produced a more sensitive instrument, especially at the 'more independent' end of the range of needs. Early results show that this ioRN2 now offers an easy to collect outcome measure showing the change in a person over time such as would be anticipated through access to Intermediate Care services or in social care re-ablement.

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The ioRN offers much more however. In an integrated context it offers the ability to summarise the functional characteristics of people to support transitioning from one stage of care to another. It provides a language that allows practitioners to communicate succinctly details using a common language across disparate agencies and service types. For example it would be possible for ioRN data to be shared by social work with a hospital to allow the hospital staff to know how the person was functioning at home prior to a change requiring admission to hospital.

Lastly, a critical characteristic of ioRN data is that it can readily be aggregated. This means that the information can inform the management of services at an operational timescale, or can be used strategically for planning, population health and well-being and other broad purposes. Thus, this is information for integrated working that is useful at a person level, for clinical and social support purposes and to measure individual outcomes; and in aggregate, to review system outcomes, and to design and plan future health, social care and housing services in an integrated way. The ioRN is available for use now in integrated settings.

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