**Name of Initiative or Service:**
Fife SPARRA

**Overview of the Service:**
CHP SPARRA groups exploring SPARRA data and identifying patients from a case management approach to support older people in their own homes

**Geographical Area Covered by Service:**
Dunfermline & West Fife CHP; Glenrothes & North East Fife CHP; Kirkcaldy & Levenmouth CHP

**Key Objectives of Service:**
Targeting COPD and Heart Failure patients: we aim to improve the quality of life of these patients by supporting practices and other clinical staff to reduce preventable hospital admissions

**Start / End date of project:**
Jun-12 Ongoing

**Stage of Development:**
Building on existing SPARRA use

**Target Patient Group:**
COPD and Heart Failure at present. In future Fife hopes to utilise SPARRA in conjunction with Hospital @ Home (H@H aims to reduce hospital admissions for people aged 75+ - SPARRA would indicate whether this was successful or not)

**Approximate Number of Patients Targeted:**
Plan is to build up the number of patients slowly as capabilities within the service increase and working practices become established. Heart Failure Specialist Nurses will target highest 10 SPARRA score patients in Fife with a HF LTC; Nurse Case Managers will focus on 3 patients per practice with highest SPARRA score (predominantly COPD but including other types of morbidity) whom services believe ACP can have biggest effect.

**GP Local Enhanced Service:**
No

**Local Data Sharing/Linkage:**
There is data sharing between Social Services and NHS Fife, but this is only a one-way process; Social Services provides data for each SPARRA patient such as number of assessments, type of care co-ordinator, whether they have an ACP in place. Social services does not receive the SPARRA list due to NHS Fife confidentiality policy as interpreted by the NHS Fife Medical Director.

**Professions/Agencies Involved:**
Nurse Case Managers and Specialist HF nurses will coordinate with full range of health & social care and the third sector (e.g. CHSS) as required.

**New Roles created by service:**
No new roles

**Processes Involved:**
Data to be reviewed by teams as it becomes available.

**Examples of Specific Use of SPARRA (V3) data?**
In progress. We are looking at patients with a history of COPD and Heart Failure and particularly those with high use of polypharmacy. Also patients with A&E attendance >= 10 in previous year are being looked at and CHP contact will investigate further with patient's practice.

**Evaluation:**
N/A - Measures will be put in place once key areas of work have been identified

**Key Challenges which were Overcome and/or Lessons Learned from the Project:**
N/A - Until specific work streams and projects have been identified

**Perceived Successes to Date:**
N/A

**Key Contact(s):**
Dunfermline & West Fife CHP: Olga Fielding - District Nurse (olgafielding@nhs.net, 01383 565493) and Lorna Stewart - District Nurse (lornastewart@nhs.net, 01383 518632); Kirkcaldy & Levenmouth CHP, Karen Gibb - Clinical Nurse Specialist- Vascular Services (karengibb@nhs.net, 01592 226867); Glenrothes & North East Fife CHP; Genna Dall SPAM - Single Point of Access Manager (genna.dall@nhs.net, 01592 643 355)

**Link to Further Information:**
See Key Contacts for further information

**Keywords:**
Heart Failure; COPD; Hospital at Home (Virtual Ward)

**Report Review Date:**
Jun-12