NHS SCOTLAND

The Scottish Government
Health Delivery Directorate
Improvement and Support Team

SPARRA Made Easy

Guidance developed by Long Term Conditions programme teams from Lanarkshire, Ayrshire and Arran and Greater Glasgow and Clyde in collaboration with ISD Scotland

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SCOTTISH GOVERNMENT

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Understanding SPARRA

The purpose of this guidance is to provide health and social care practitioners with an understanding of SPARRA data and its role in the delivery of Proactive, Planned and Co-ordinated care for people with complex or frequently changing care needs.

We have listed some Frequently Asked Questions, suggestions and solutions.

What does SPARRA mean?

SPARRA stands for…

- **S**cottish
- **P**atients
- **A**t
- **R**isk of
- **R**eadmission and
- **A**dmission

What is SPARRA data?

SPARRA data is a way of identifying those people at greatest risk of emergency admission to hospital over the next year. The SPARRA tool was developed by Information Services Division (ISD). It identifies people who have entered a cycle of repeat admissions to hospital in the previous 3 years and predicts their risk of future hospitalisation. From January 2009, SPARRA data has been enhanced to provide risk scores for people of all ages.

Why would I want this information?

The information on the SPARRA lists supports your local team to provide the proactive, planned and co-ordinated care required for people with complex or frequently changing needs. Instead of reactive or crisis care, people and their carers will receive an improved service through a more robust assessment and care planning approach. Delivering continuous, supportive care with a single point of co-ordination improves the experience for the person and their carer, supports care at home and may prevent avoidable hospital admissions.

Any member of your team (e.g. GP, District Nurse, Practice Nurse, Community Psychiatric Nurse, Allied Health Professional, Social Worker or Care Manager) may already be providing care to people on the SPARRA list. Using SPARRA data regularly and systematically will prompt opportunities for discussions at multi-disciplinary, multiagency team meetings within Practices or other settings. Practitioners can reassess the person centred care plan, address any gaps in a collaborative way and make more effective use of the local team and services.

How often will I get a SPARRA list?

SPARRA lists are currently distributed to General Practice teams four times a year. Make sure you know who will distribute your list and when to expect it. SPARRA data is confidential and should be handled in line with local data sharing and information governance protocols. Each list will include names of people already identified from previous SPARRA data plus a new cohort.

Who is the SPARRA list sent to in your local area?

Do you know who will send the list to you?

Has it been 'cleaned up' to exclude people who have died, moved away or moved into a care home?

What format will the list be available in?

SPARRA data from ISD is received in GP Practice specific format. If your SPARRA list is provided in an Excel spreadsheet it may be arranged by GP Practice code number. The list may need to be 'cleaned up' by cross matching with the Practice's clinical system to exclude people who may have died or moved away. SPARRA data logs up to 16 conditions if recorded on the hospital record. You can filter the output to select people with a particular condition or combination of conditions. These can be colour coded for easy reading and to quickly identify groups of particular interest, e.g. colour all patients with COPD in yellow, show new names in green and people with increased risk scores in red.

One suggestion for 'cleaning the data' is to use the GP Practice database as this information is generally up to date.

It will enhance your understanding of the data if you print this list out. Simple tips are to alter the page setup to landscape, insert the gridline and alter the page set up so that it is displayed across 1 or 2 pages maximum.

More detailed tips are attached in Appendix 1

How can I use the SPARRA list to identify people with a high risk of being admitted to hospital?

The SPARRA list will alert you and the multi-disciplinary, multi-agency team to a group of people who are at risk of being admitted to hospital in the next year. The threshold for 'high' risk can be set at any point – this threshold will vary for local NHS Board areas. Most teams consider 'high' risk as those people with a risk score of 50% or more.

You and other members of your local team will already know many people on the SPARRA lists. Through discussions at your team meetings, at Practice or locality level, you can reach decisions about the most appropriate lead practitioner to follow up the assessment and care planning for each person. Appendix 3 provides examples of PDSAs showing how SPARRA data was used by a district nursing team to identify patients at risk of hospital admission.

Will all patients identified from SPARRA require Care Management?

Not all of the people on the SPARRA list will require to be care managed. Some people, for example those who need less intensive interventions and those in low to medium SPARRA risk groups, will benefit more from other targeted approaches from a range of practitioners with the skills to support self managed care. These targeted approaches include provision of information, education, advice and support from the practice nurse, community rehabilitation team and from local community and voluntary sector partners.

A decision about the most appropriate intervention and arrangements for review will be made following multi-disciplinary discussion and assessment. The decision regarding care management and the appropriate level of support required should be made in partnership with the patient and carer, shared at integrated team meetings at Practice and locality level, and communicated to all other partners involved in the person's care.

The 65+ SPARRA list identified 14 patients in my practice with over 50% risk of hospital admission. After 'cleaning' the data I found that four had died, three were in long term care and two were appropriately linked to the practice nurse. This meant that my team had only to review and assess three patients for care management before the next SPARRA download in 12 weeks time.

A District Nurse from Lanarkshire.

How else can I identify people needing to be care managed?

SPARRA is only one way of identifying people at high risk of admissions. You can identify people who will benefit from care management by sharing local intelligence at Practice and locality team meetings and by using other community risk prediction tools. Weekly hospital Emergency Admission data gives real time information. Social Work Services hold useful data on dependency in Indicator of Relative Need (IoRN) Scores and in Single Shared Assessments (SSA). Practice registers hold disease specific and prescribing information.

What other tools are used in your area?

SPARRA data can be enhanced by linking it with other data sources - e.g. using GP QOF disease registers, falls databases, prescribing data, Out of Hours and NHS 24 contacts and A&E attendees

Can you share any local successes?

Notes

How should I share SPARRA information?

It is important that each locality has a robust integrated system that includes opportunities for you and your team to discuss people on the SPARRA lists with other partners providing care and services. Where care management is considered appropriate for an individual, the team should agree the 'best placed' lead practitioner or care manager for that person from Community Nurses, Social Work, Allied Health Professional or Mental Health Team. The lead practitioner will plan, co-ordinate, monitor and review care for the person and their carer. This approach reduces duplication of work and confusion for both the person and their carer. All providers, including Out of Hours services, should be alerted to the risk of hospital admission and know how to contact the appropriate care manager. A sample notification form is attached at Appendix 2.

Do you have this type of integrated working established? Or another joint forum that could be adapted to address SPARRA issues?

Do you have processes in place so that everyone in your system knows who is being care managed? e.g. GPs, OOH, Care Managers, Community Nurses, Scottish Ambulance Service, Acute Hospital.

Reporting SPARRA data outcomes

SPARRA DATA OUTCOMES		
Locality		
Team		
Date range		
Section 1	**Number**	**Comments**
No of new patients identified from SPARRA		
Deceased		
Live outwith the area		
Live in Care Home		
Currently care managed		
Total number of patients remaining		
Section 2		
Number eligible for a care management assessment		
Number of care management assessments carried out		
Variance		
Care management not required following assessment		
Care Managed following assessment		
Total number of new patients being care managed		
Section 3		
No of patients identified as eligible but had no assessment carried out		
Not housebound attends surgery		
Refused/moved away		
Being assessed for long term care		
Variance		

A template similar to the one displayed above could be used to report the outcomes from the quarterly SPARRA list. The precise reporting process will vary in NHS Board areas. Reporting on outcomes is important to help continuously improve the system so you can provide even better care for people with complex needs.

What's the timescale for reporting outcomes?

Who do I send the outcome report to?

What will it be used for?

Some Useful Contacts for advice

Janette.Barrie@lanarkshire.scot.nhs.uk
Caroline.Mitchell@lanarkshire.scot.nhs.uk
Marjorie.mcGinty@lanarkshire.scot.nhs.uk
Hazel.Towers@Lanarkshire.scot.nhs.uk
Elaine.Learmonth@Lanarkshire.scot.nhs.uk

Margaret.anne.dale@glasgow.gsx.gov.uk
Kathleen.mcguire@aapct.scot.nhs.uk
Lyall.Cameron@aapct.scot.nhs.uk
Allison.blackman@aapct.scot.nhs.uk
Sheila.buchanan@aapct.scot.nhs.uk
Laura.Kelso@aapct.scot.nhs.uk

Peter.Martin@isd.csa.scot.nhs.uk
Mandy.Andrew@scotland.gsi.gov.uk
Marie.curran@scotland.gsi.gov.uk

YOUR LOCAL CONTACTS

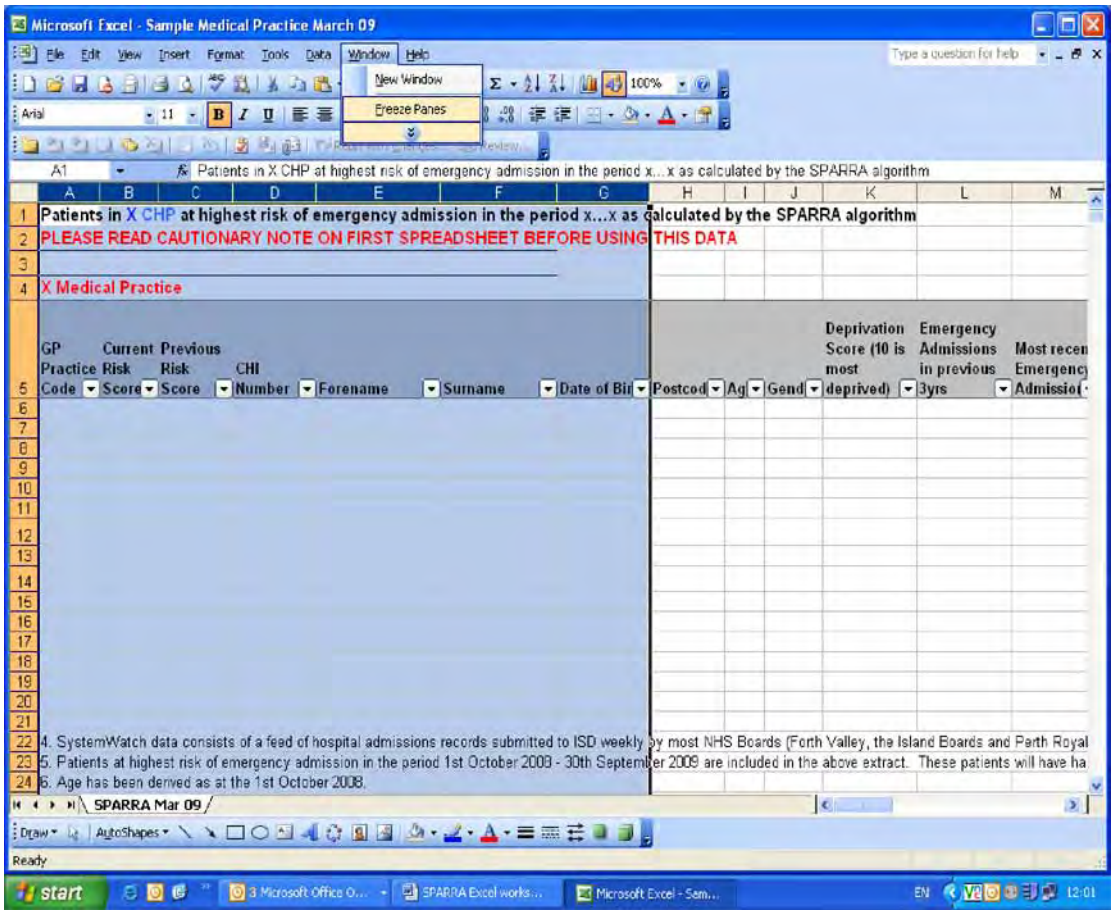
Appendix 1

Navigation within SPARRA Excel spreadsheet: Help Sheet

Viewing SPARRA spreadsheet 'Freezing' columns As the Excel sheet is too long to be viewed in its entirety on the screen, the columns can be 'frozen'. This can be done really easily to 'freeze' the patient details columns and still be able to see these whilst scrolling along the other columns.

Open the template. Click on Column A and drag across to column G (this will highlight the sections GP Code, Current Risk Score, Previous Risk score, CHI, Forename, Surname and DOB).

Click on 'Window' in the top tool bar: Select '**Freeze panes**'. The columns can now be scrolled across whilst still keeping the patient details visible on the screen.



To 'unfreeze' panes, go back to 'Window' tab and uncheck the box.

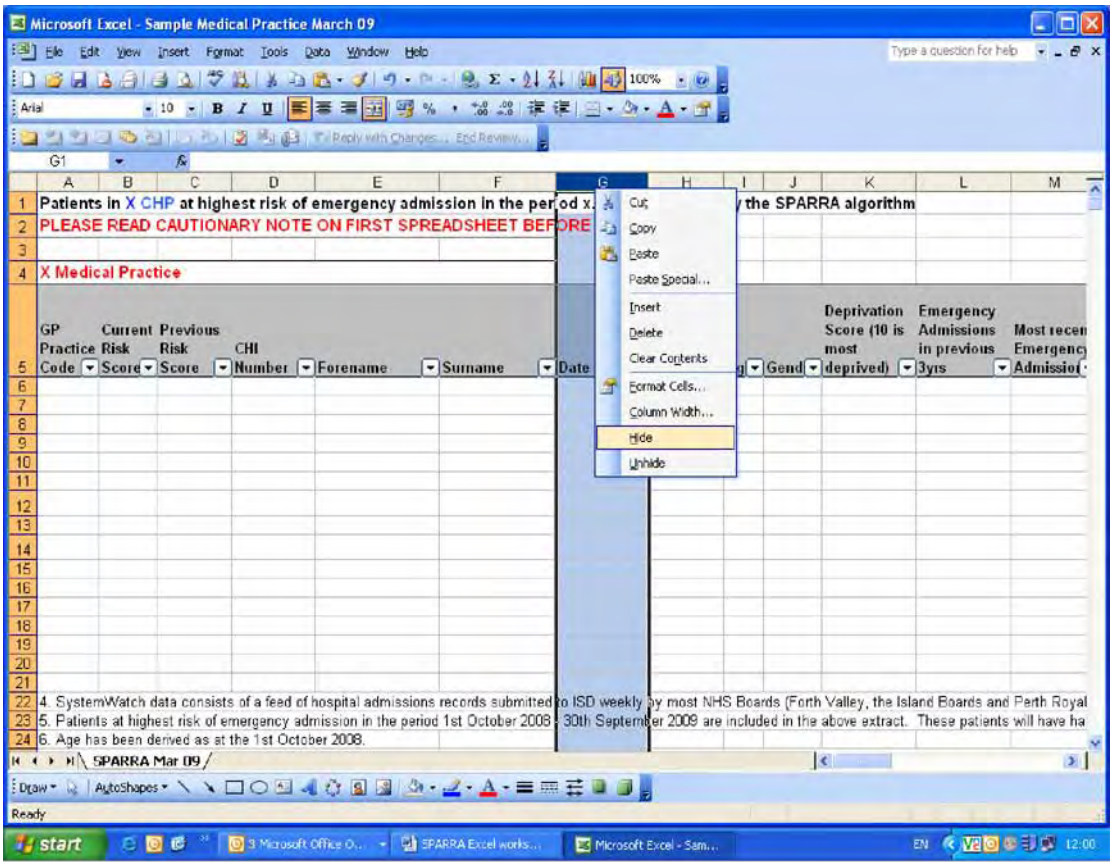
'Hiding' columns

You can also 'Hide' columns in the spreadsheet if you don't need them – this makes it easier to print on one or two pages –

Click on the shaded box at the top of the column, e.g. Column G (Date of Birth) then right click to get a drop down menu.

Click on '**Hide**'.

To hide multiple columns, click on the shaded box at the top of the column, hold down left mouse button and drag over the columns, then release mouse button and then right click to get the 'Hide' command.



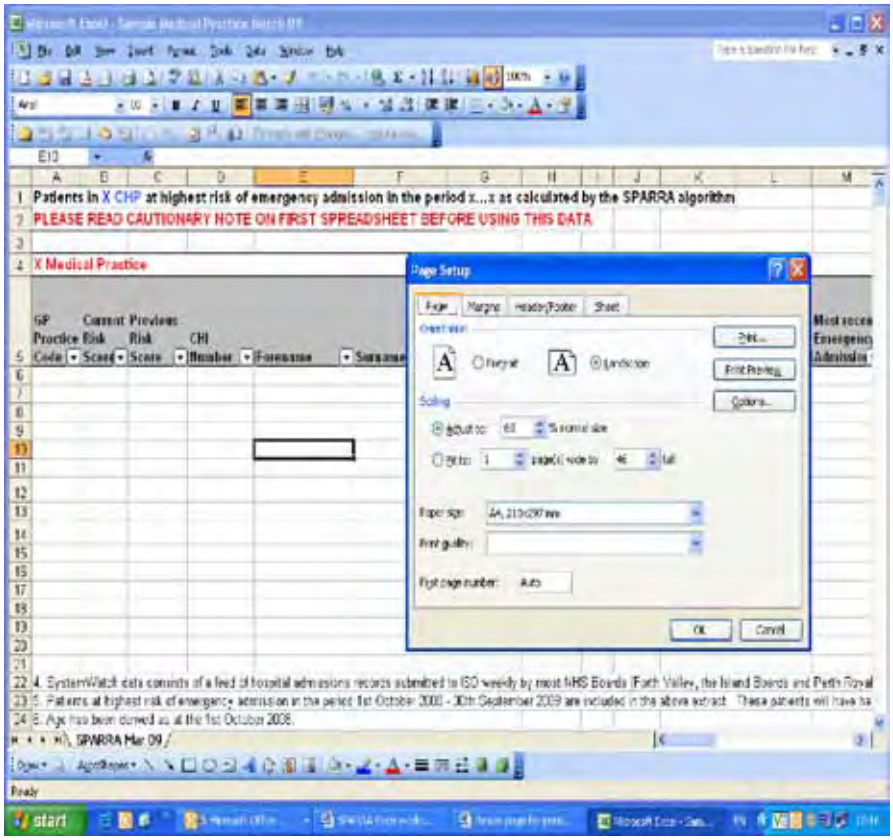
Columns can be 'unhidden' – Highlight the whole document. This can be done by left-clicking on the box in the top left corner, above '1' and to the left of 'A'–

Then right click within document, and then 'Unhide'

Printing the document

To change print size and adjust document layout:

Before printing, access '**Page Set-up**' via '**File**' button on top toolbar



Adjust to: (Percentage size required)

Use arrows to select percentage of normal size text. Use Print Preview button to see how it will look when printed.

When happy with print preview, hit OK button

Then select Print

Patient Details

Practice Address or stamp

Appendix 2

LTC Management/SPARRA notification

This patient has been identified as having a **high risk of admission to hospital**

Delete as appropriate

- *He/she has *COPD/other long term condition.
- *There is a COPD self management plan in the home.
- *He/she lives *[alone]/[with carer]/[don't know].
- There is *[no] community service input.

Please refer to the Emergency Care Summary and laminated local management of COPD exacerbation protocol as indicated.

Review Summary – To include e.g.: Equipment/adaptations at home; support services (both informal and formal); oxygen saturation levels

The above patient is care managed in the community by:

***Please add name and telephone number**

*The Care/Case Manager is: .....

*The Named Health contact is: .....

*The Named Social Service contact is: .....

Community Nursing Team contact details

- There is an answer machine within each nursing base and all calls will be returned timeously. This Nursing team Tel no.
- The District Nursing Team's regular hours of duty are 0830 – 1700 hrs Monday through to Friday.
- During Out of Hours period from 1700 – 0800 and at weekends there is a District Nursing Service which can be contacted via ADOC. The professional contact number is 01563 545575 (this number should not be given to patients)

Additional information/comments

The patient has agreed to a copy of this notification being sent to hospital and to ADOC

Information compiled by ..... Signature .....

Date completed .....Agreed review date .....

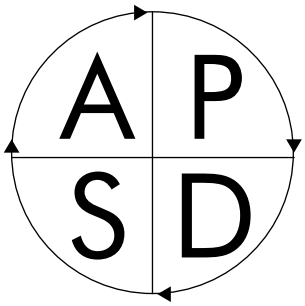
Appendix 3

MODEL FOR IMPROVEMENT

CYCLE: 1 DATE: February 2010

OBJECTIVE FOR THIS PDSA CYCLE:

Community Nurses and the use of SPARRA



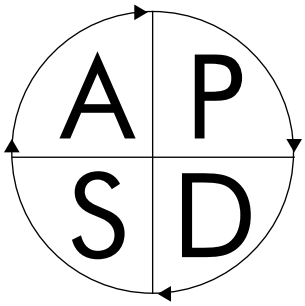
PLAN:
Arrange to meet with LTC team _____ on _____ and discuss approach to be taken regarding use of SPARRA data to identify people at high risk of hospital admissions.
DO:
An initial meeting was held on _____ with the team _____ which the project manager and the District Nurse attended. The information contained within the SPARRA information data sets was worked through: • The list was screened with the help of the Practice Manager to exclude those who had died and entered long term care (30 mins). • Secondly the practice nurse checked to identify the patients that attended her disease management clinics (10 mins). • The nurse then identified the patients current on community nurses caseloads (10 mins). • Remaining patients were contacted and offered a visit from DN.
STUDY:
• The DN's SPARRA list identified **14** patients over 65 with a 50% or more risk of hospital admission. Five had died; three were now in long term care and three known to DN. Leaving **three** patients to be assessed.
ACT:
• The patients identified above were to be contacted and offered a visit from the DN. • A work plan was developed in which the DN planned over the following eight weeks to investigate the patients on her list in a manageable way.
Completed By: _____ **Date:** _____

MODEL FOR IMPROVEMENT

CYCLE: 2 DATE: February 2010

OBJECTIVE FOR THIS PDSA CYCLE:

Community Nurses and the use of SPARRA



PLAN:

Contact Mrs A and arrange date/time to visit for assessment to be carried out.

DO:

Assessment carried out by _____ on _____where

STUDY:

Lady age 70 had been in hospital 12 times and had 72% risk of readmission. On checking medical notes:

- Multiple long term conditions
- Suffered from memory problems
- Poly pharmacy issues
- Lived alone but had informal support from her family that lived nearby

At the assessment the house was unkempt and very cold. The lady was wearing food stained clothing. Medication was in a Dosette box dispensed by the local pharmacist. The dosette box was kept on top of a living room unit to reduce the risk of the lady taking her medication without supervision. However a large bag of medication was found at the side of her couch. She was mobile and attended the local lunch club.

On discussion she recalled going into hospital and on most occasions had been admitted through Out of Hours as she was in pain.

Services involved in her care:

- Social Work Home Care Team
- Alert service
- CPN
- Voluntary agencies

ACT:

Following this visit the DN carried out a full assessment and contacted social work home care service, CPN, local community pharmacist and also the family member whom the lady offered as Next of Kin. This prompted arrangement of an all services review of care provision. It was agreed the District Nurse would be the Care Manager at this stage.

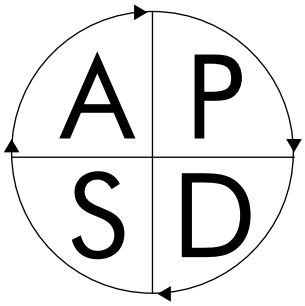
Completed By: _____ **Date:** _____

MODEL FOR IMPROVEMENT

CYCLE: 3 DATE: February 2010

OBJECTIVE FOR THIS PDSA CYCLE:

Community Nurses and the use of SPARRA



PLAN:
Arrange suitable time for case conference for Mrs A and invite family member _____ and other key members of the team _____ to be present.
DO:
Mrs A's Case Conference went ahead on_____. There was initial resistance from a family member as to the need for a care review but another son was able to attend the meeting with his mother. This took place _____ and those present included _____ .
STUDY:
Social Care review – input from home care – 1 hour twice daily, 7 days a week for personal care and food preparation. Carer reported that the lady was often reluctant to wash or change her clothes when she visited but this had not previously been fed back to the home care manager. **Pharmacy review** – Family pick up medication from pharmacist weekly. Medication that was lying on floor to be removed from house. A glass of water and two analgesics were left at the lady's bed at bedtime so she could safely medicate during the night if needed. **CPN** – although still on caseload had not visited recently. **Family** – It appeared that a family member had been using Mrs A's benefits as his own. **Nursing/Medical review** – A full medication review was carried out. A full blood check and a continence assessment had been carried out.

ACT:

- Change of home carer to one with greater experience and understanding of needs of people with dementia
- Bag of medication was removed by family
- CPN visits recommenced – outcomes of visits report awaited
- The vulnerable adult policy was invoked by the social worker and the finances are now managed by another son and the social worker. This allowed the heating to be used without financial worry and ultimately helped with joint pain
- Continence Pad delivery scheme now in place
- Regular visits to check bloods in line with QOF requirements
- Following the case conference, family continued to provide informal support and help with collecting medication and weekly shopping
- Care management now transferred to social worker as all health issues now stable. There have been no further hospital admissions since Mrs A entered the Care Management Programme six months ago

Completed By: _____ **Date:** _____

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