SSNAP Core Six Month Assessment Dataset Help Notes

Introduction

The Sentinel Stroke National Audit Programme (SSNAP) is the national stroke audit based in the School of Population Health and Environmental Sciences at King's College London. It measures the quality and organisation of stroke care in the NHS across England, Wales and Northern Ireland. The National Stroke Audit was first conducted at the Royal College of Physicians (RCP) in 1998 and 1999 as part of the Stroke Programme. The audit demonstrated that although there were widespread variations in standards across the country, much was being done at local level to change services. Improvements were demonstrated in each of the subsequent rounds of the audit. The Stroke Improvement National Audit Programme (SINAP) began in 2010; this continued to demonstrate improvements in acute care and identified areas for improvement. The audit programme remained at the RCP until in 2017 it was decided that in order to maximise the impact and longevity of SSNAP, particularly in relation to research potential it would be hosted by King's College London. The latest contract commenced on 01 April 2023.

The SSNAP core dataset is based on standards agreed by the representatives of the Colleges and professional associations of the disciplines involved in the management of stroke (current membership of the ICSWP is listed at https://www.strokeaudit.org/About/Our-governance/Oversight.aspx.
The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients and the public on how well stroke care is being delivered.

SSNAP

- Prospectively collects a minimum dataset for every stroke patient
- Follows every patient's care through the entire stroke pathway from acute care to the community and 6 month follow-up assessment
- Collects outcome measures
- Provides regular, routine, reliable data to
  - benchmark services nationally and regionally
  - monitor progress against a background of change
  - support clinicians in identifying where improvements are needed, lobbying for change and celebrating success
  - empower patients to ask searching questions.

Planning SSNAP

This is a multidisciplinary audit. Involving all the disciplines at the planning stage of the audit will help with subsequent stages of the audit,

particularly when it comes to taking action on the results. In order to have consistent and reliable results, anyone completing the audit should have access to this help booklet. We would encourage participants to enter data prospectively rather than retrospectively gathering the data from patient records.

Audit web tool

The audit data is collected via a web tool to provide good quality data, and to speed up the analysis and reporting. There are in-built data validation checks.

Data collection time frame

Data collection will be continuous until at least 31 March 2026.

Clinical involvement and supervision

Each hospital should designate a clinical lead for SSNAP who will have overall responsibility for data quality and will sign off that the processes for collecting and entering the data are robust. A deputy (second lead) should also be designated (who may or may not be a clinician). The second lead should be the user most responsible for the day to day submission of SSNAP data. This user will also serve as the first point of contact for SSNAP.

Inclusion Criteria for the audit

- All stroke patients admitted to hospital or who suffer acute stroke whilst in hospital
- Optional: TIA patients (inpatients and outpatients) and patients who elicit a response from the stroke team (stroke mimics)

Exclusion Criteria

- Subarachnoid haemorrhage (I60)
- Subdural and extradural haematoma (I62)
- Patient had the stroke episode more than 28 days before presenting at hospital
- Optional (i.e. you can exclude but do not have to exclude): A patient who had a stroke in another country and were initially admitted to a hospital abroad

From 1 October 2024, the datasets for inpatient and community teams separated to allow for each dataset to be more closely tailored to the differing requirements of the inpatient and community settings and so two datasets were created: the Core Inpatient Dataset and the Core Community Dataset. The SSNAP Core Dataset previously included section 8 (Six month follow-up assessment), however this is now available in a standalone document. These help notes refer to the **Core Six Month Assessment Dataset.**

Question no	Question	Answer options	Guidance/definitions
8.1	Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?	Yes; No; No but; No, patient died within 6 months of admission	It is vital that even if patients do not get a review because a service is not in place, that teams reflect this by selecting "No" in Q8.1 and locking the record to six months. 'No but' should be answered: • For patients who decline the assessment or who do not attend an appointment offered • Where an attempt is made to contact the patient, but they cannot be contacted as they are not registered with a GP or have moved overseas. • For patients who have another stroke after being discharged from inpatient care and are readmitted into hospital
8.1.1	What was the date of the follow-up?	Dd/mm/yyyy	
8.1.2	How was the follow-up carried out?	In person; By telephone; Online; By post	
8.1.3	Which of the following professionals carried out the assessment?	GP; Stroke coordinator; Therapist; District/community nurse; Voluntary services employee; Secondary care clinician; Other	If a stroke nurse carried out the 6 month assessment you should select 'stroke coordinator' if he/she is a stroke nurse coordinator. If he/she is not a stroke nurse coordinator you should enter 'secondary care clinician' when the nurse is working in secondary care or 'district/community nurse' if he/she is working in the community.
8.1.4	If other, please specify	Free text	
8.1.5	Did the patient give consent for their identifiable information to be included in SSNAP?	Yes, patient gave consent; No, patient refused consent; Patient was not asked	*Unavailable if 3.9 or 7.14 in inpatient dataset or 7.10 in community dataset is "No, patient refused consent"* This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board.

Question no	Question	Answer options	Guidance/definitions
			If the patient refuses consent, all patient identifiable information will be wiped from the webtool. Every effort should be made to seek consent. However, if this has not occurred, we will still want the 6 month follow up information collected, this is why the dataset has the 'patient not asked' option. Where there is a comparatively high rate of 'patient not asked' option selected, SSNAP may seek assurance from the teams in question that there is an action plan in place to improve this.
8.2a	Has the patient been screened for mood since hospital discharge using a validated tool?	Yes; No; No but	The term 'discharge' here is referring to discharge from an inpatient setting, not discharge from the entire stroke pathway. A validated tool for mood is one which has been approved for use within the trust/health board such as HADS, PHQ9 or for a person with aphasia a more accessible one such as SAD-Q or DISCS. 'No but' should be answered if a problem has already been detected and there is an action plan in place.
8.2a.1	If yes, was the patient identified as needing support?	Yes; No	*Available if 8.2a = "Yes"*
8.2a.2	If yes, has this patient received psychological support for mood since hospital discharge?	Yes; No; No but	*Available if 8.2a = "Yes"* Psychological support can be provided by any professional or voluntary sector service specifically trained in psychological support.
8.2b	Has the patient been screened for cognition since hospital discharge using a validated tool?	Yes; No; No but	The term 'discharge' here is referring to discharge from an inpatient setting, not discharge from the entire stroke pathway. A validated tool for cognition is one which has been approved for use within the trust/ health board such as MOCA/OCS. A validated tool is one with evidenced validity and efficacy for use in stroke. Locally developed screening tools are not applicable.

Question no	Question	Answer options	Guidance/definitions
			'No but' should be answered if a problem has already been detected and there is an action plan in place e.g. premorbid dementia or post-stroke cognitive impairment. 'No but' can also be used if screening/assessment had already been completed during hospital admission and due consideration had been given regarding the value of repeating screens as per national clinical guidelines.
8.2b.1	If yes, was the patient identified as needing support?	Yes; No	*Available if 8.2b = "Yes"*
8.2b.2	If yes, has this patient received psychological support for cognition since hospital discharge?	Yes; No; No but	*Available if 8.2b = "Yes"*
8.2c	Has the patient been screened for visual impairment since hospital discharge using a standardised tool?	Yes; No; No but	The term 'discharge' here is referring to discharge from an inpatient setting, not discharge from the entire stroke pathway. A standardised tool is one that is completed the same way by all users, covering all required domains of impairment and activity limitation. A published screen such as VISA, or a locally developed tool, agreed by your orthoptist dept for use with all patients, by staff with appropriate training are applicable 'No but' should be answered if screening had been completed during the patient's hospital stay.
8.2c.1	If yes, was the patient identified as needing support?	Yes; No	*Available if 8.2c = "Yes"*
8.2c.2	If yes, has this patient received treatment for visual impairment since hospital discharge?	Yes; No; No but	*Available if 8.2c = "Yes"*
8.3	Where is this patient living?	Home; Care home; Other	

Question no	Question	Answer options	Guidance/definitions
8.3.1	If other, please specify	Free text	*Available if 8.3 is "Other"*
8.4	What is the patient's modified Rankin Scale score?	0-6	0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention
8.5	Is the patient in persistent, permanent or paroxysmal atrial fibrillation?	Yes; No	Paroxysmal atrial fibrillation means episodes that last longer than 30 seconds but less than 7 days (often less than 48 hours) and are self-terminating and recurrent. Persistent atrial fibrillation means episodes lasting longer than 7 days (spontaneous termination of the arrhythmia is unlikely to occur after this time). Permanent atrial fibrillation (AF) means AF that fails to terminate using cardioversion, or is terminated but relapses within 24 hours, or longstanding AF (usually longer than 1 year) in which cardioversion has not been indicated or attempted (sometimes called accepted permanent AF).
8.6 (8.6.1-8.6.4)	Is the patient taking: Antiplatelet, Anticoagulant, Lipid Lowering, Antihypertensive?	Yes; No	
8.7 (8.7.1-8.7.3)	Since their initial stroke, has the patient had any of the following: stroke, myocardial infarction,	Yes; No	

Question no	Question	Answer options	Guidance/definitions
	other illness requiring hospitalisation?		
8.8	Employment status currently	Working full-time; Working part-time; Retired; Studying or Training; Unemployed; Other	Full-time is the equivalent of 35 hours a week Full-time and part-time work includes paid, unpaid and voluntary work This question aims to identify if the stroke survivor is back at work and in meaningful employment to the extent that they were before their stroke. If the survivor is employed but not yet ready to return to work, please record this as 'Other'.
8.9	EQ5D-5L score six months after stroke:		https://euroqol.org/publications/user-guides/ There should be only ONE response for each dimension Missing values are preferably coded as '9' Ambiguous values (e.g. two boxes are ticked for a single dimension) should be treated as missing values
a	Mobility	Value range: 1-5 OR 9	1: I have no problems in walking about 2: I have slight problems in walking about 3: I have moderate problems in walking about 4: I have severe problems in walking about 5: I am unable to walk about 9: Ambiguous or missing value
b	Self-Care	Value range: 1-5 OR 9	1: I have no problems washing or dressing myself 2: I have slight problems washing or dressing myself 3: I have moderate problems washing or dressing myself 4: I have severe problems washing or dressing myself 5: I am unable to wash or dress myself 9: Ambiguous or missing value
c	Usual activities (work, study, etc.)	Value range: 1-5 OR 9	1: I have no problems doing my usual activities 2: I have slight problems doing my usual activities 3: I have moderate problems doing my usual activities 4: I have severe problems doing my usual activities 5: I am unable to do my usual activities 9: Ambiguous or missing value

Question no	Question	Answer options	Guidance/definitions
d	Pain/discomfort	Value range: 1-5 OR 9	1: I have no pain or discomfort 2: I have slight pain or discomfort 3: I have moderate pain or discomfort 4: I have severe pain or discomfort 5: I have extreme pain or discomfort 9: Ambiguous or missing value
e	Anxiety/Depression	Value range: 1-5 OR 9	1: I am not anxious or depressed 2: I am slightly anxious or depressed 3: I am moderately anxious or depressed 4: I am severely anxious or depressed 5: I am extremely anxious or depressed 9: Ambiguous or missing value
f	How was your health today?	Value range: 1-100 OR 999	100 means the best health you can imagine 0 means the worst health you can imagine Missing values should be coded as 999 If there is a discrepancy between where the respondent has placed the X and the number he/she has written in the box, administrators should use the number in the box
8.10	Since discharge, has the patient required help with personal activities of daily living (ADL)?	Yes; No	Please include all formal care visits provided by social services, via external reablement services, self-funded or care visits provided by community rehabilitation teams. Personal activities of daily living (PADL) refer to a range of basic activities such as washing, dressing, bathing, going to the toilet, eating and drinking. Help means physical assistance. This is not applicable if the person is able to be independent in PADL with the use of aids and adaptations.
8.10.1	As of now, how many visits per day does the patient require?	One; Two; Three; Four; 24 hour care; Not known	*Available if 8.10 = "Yes"*
8.10.2	As of now, how many carers	One carer; Two carers	*Available if 8.10 = "Yes"*

Question no	Question	Answer options	Guidance/definitions
8.11	Please state if the patient gave consent for their information to be included in research using SSNAP data?	Yes, patient gave consent; No, patient refused consent; Patient not asked	Please record if the patient has given or refused consent specifically for the use of their data in research. It is not a requirement to ask this question however if the patient has been asked or has given or refused consent for research without being asked then this should be recorded here. If the patient refuses consent, none of their data will be used for research. This question refers specifically to the use of data in research and not for audit purposes. If the patient has given or refused consent for the use of their patient identifiable data in SSNAP, this should be recorded in the appropriate question in the dataset. If the patient was not asked for consent, please record “patient not asked”. If patient medically unwell and cannot be asked, indicate “patient not asked”.