SSNAP Core Community Dataset 4.0.0 for Teams in Northern Ireland

Introduction to this dataset

The only difference in this dataset for teams in Northern Ireland is that patient identifiable information cannot be entered onto the webtool. This is due to the different legal requirements for Northern Ireland. Teams in Northern Ireland are encouraged to keep note of the patient identifiable information alongside the patient audit number (assigned by the webtool when a new record is created) within their trust, so that it is easier to refer back to patient notes if necessary.

This dataset was previously called the SSNAP Dataset for ESD/Community Rehab Teams (CRT). 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 (this document). The SSNAP Dataset for ESD/Community Rehab Teams (CRT) previously included section 8 (Six month follow-up assessment), however this is now available in a standalone document.

Community teams are required to complete sections 2 and 3 of this dataset. When a record has been transferred on the webtool to a community team, section 1 will transfer allowing the next team to record and lock their data for sections 2 and 3.

The SSNAP webtool has multiple validations (based on information supplied by teams in the preceding pathway and in preceding questions) and so some fields will either be pre-populated and/or unavailable to answer because they are not relevant.

The provider performing the six month assessment completes section 8 of the dataset.

A log of changes made to the SSNAP Core Dataset can be found at the end of this document, available here.

Starting records in the community

ESD or CRT teams are able to start SSNAP records for patients who: do not have a previous acute record, were not treated by an acute team; the record cannot be transferred; or the patient was re-referred within 6 months of stroke. This function must only be used after the community team have ensured that the patient does not already have a record.

If a record is eventually transferred to the community team, you should contact the SSNAP helpdesk (ssnap@kcl.ac.uk) to request that the record be deleted from the non-acute stroke section. The community team will then have to re-enter their data on the record that was transferred from the acute team.

When an ESD or CRT team start a record, they will have to answer sections 2 and 3 as usual but are also required to input some patient information normally done by the acute team in section 1.

More information and contacts

For queries, please contact ssnap@kcl.ac.uk
Webtool for data entry: www.strokeaudit.org

Hospital / Team	Auto-completed on web tool
Patient Audit Number	Auto-completed on web tool

Section 1: Demographics

When a record is started by an ESD or CRT team the following questions in section 1 must be answered by the ESD or CRT team.

If the record has been transferred from another team, you will not need to enter them onto the webtool as they will have been entered already by the first team treating the patient.

Teams in Northern Ireland are encouraged to keep note of the patient identifiable information alongside the patient audit number (assigned by the webtool when a new record is created) within their trust, so that it is easier to refer back to patient notes if necessary.

1.1. Hospital Number ***(not available to answer on webtool for teams in Northern Ireland)***

1.2. NHS Number ***(not available to answer on webtool for teams in Northern Ireland)***

1.3. Surname ***(not available to answer on webtool for teams in Northern Ireland)***

1.4. Forename ***(not available to answer on webtool for teams in Northern Ireland)***

1.5. Date of birth ***(not available to answer on webtool for teams in Northern Ireland)***

Age on arrival [16-120]

(teams in Northern Ireland must put age on arrival instead)

1.6. Gender Male ○ Female ○ Indeterminate ○

1.7. Postcode of usual address [2-4 alphanumeric]

1.8. Ethnicity [A – Z (select radio button)] or Not Known ○

1.9. What was the diagnosis? Stroke ○ TIA ○ Other ○ Not acute stroke ○

1.10. Date/time of onset/awareness of symptoms [dd] [mm] [yyyy] [hh] [mm]

1.10.1. The date given is: Precise ○ Best estimate ○ Stroke during sleep ○

1.10.2. The time given is: Precise ○ Best estimate ○ Not known ○

1.11. Date/ time patient arrived at this team [dd] [mm] [yyyy] [hh] [mm]

1.12. What is the reason for starting this record?

Not seen by acute team ○

Seen by acute team but no SSNAP record – not admitted to hospital ○

Seen by acute team but no SSNAP record – stroke outside the UK ○

Seen by acute team but no SSNAP record – other reason ○

1.12.1 If other, please specify: Free text (30 character limit)

Seen by acute team in different UK region and so record cannot be transferred ○

Re-referral within 6 months of stroke onset ○

1.12.2 If re-referred, what is the patient's previous SSNAP ID: 7 numbers

Section 4: Duration (or stay) with your team *(this section must be completed by every community team)*

2.1. Date/time patient received first face-to-face assessment from this service | dd | mm | yyyy | hh | mm |

2.2. Modified Rankin Scale score at first assessment by this service [0-5]

2.3. EQ5D-5L score at first assessment by this service:

a. Mobility [1-5, unknown]
b. Self-Care [1-5, unknown]
c. Usual activities (work, study, etc.) [1-5, unknown]
d. Pain/discomfort [1-5, unknown]
e. Anxiety/Depression [1-5, unknown]
f. How is your health today? [0-100, unknown]

2.4. Barthel score at first assessment by this service [0-20]

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.5. Was the patient considered to require this care or treatment at any point during this stay?	Yes○ No○	Yes○ No○	Yes○ No○	Yes○ No○	Yes○ No○	Yes○ No○	Yes○ No○

Period 1: first 4 weeks

Start date: [auto-populate]

End date: [auto-populate]

2.6a. During this period was the patient: Discharged from this service ○ Died ○ Still receiving input from this service ○

2.6.1a Date/time of discharge from this service dd mm yyyy hh mm

2.6.2a Date of death dd mm yyyy

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.7a. On how many days did the patient receive this care/treatment during this 4 week period?							
2.8a How many minutes of this care/treatment in total did the patient receive during this 4 week period?							
2.9a How many of these minutes were delivered by a rehabilitation assistant?							
2.10a How many of these minutes were delivered by video/telerehabilitation?							
2.11a How many of these minutes were delivered in a group session?							

Period 2: second 4 weeks

Start date: [auto-populate]

End date: [auto-populate]

2.6b. During this period was the patient: Discharged from this service ○ Died ○ Still receiving input from this service ○

2.6.1b Date/time of discharge from this service dd mm yyyy hh mm

2.6.2b Date of death dd mm yyyy

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.7b. On how many days did the patient receive this care/treatment during this 4 week period?							
2.8b How many minutes of this care/treatment in total did the patient receive during this 4 week period?							
2.9b How many of these minutes were delivered by a rehabilitation assistant?							
2.10b How many of these minutes were delivered by video/telerehabilitation?							
2.11b How many of these minutes were delivered in a group session?							

Period 3: third 4 weeks

Start date: [auto-populate]

End date: [auto-populate]

2.6c. During this period was the patient: Discharged from this service ○ Died ○ Still receiving input from this service ○

2.6.1c Date/time of discharge from this service dd mm yyyy hh mm

2.6.2c Date of death dd mm yyyy

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.7c. On how many days did the patient receive this care/treatment during this 4 week period?							
2.8c How many minutes of this care/treatment in total did the patient receive during this 4 week period?							
2.9c How many of these minutes were delivered by a rehabilitation assistant?							
2.10c How many of these minutes were delivered by video/telerehabilitation?							
2.11c How many of these minutes were delivered in a group session?							

Period 4: fourth 4 weeks

Start date: [auto-populate]

End date: [auto-populate]

2.6d. During this period was the patient: Discharged from this service ○ Died ○ Still receiving input from this service ○

2.6.1d Date/time of discharge from this service dd mm yyyy hh mm

2.6.2d Date of death dd mm yyyy

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.7d. On how many days did the patient receive this care/treatment during this 4 week period?							
2.8d How many minutes of this care/treatment in total did the patient receive during this 4 week period?							
2.9d How many of these minutes were delivered by a rehabilitation assistant?							
2.10d How many of these minutes were delivered by video/telerehabilitation?							
2.11d How many of these minutes were delivered in a group session?							

Period 5: fifth 4 weeks

Start date: [auto-populate]

End date: [auto-populate]

2.6e. During this period was the patient: Discharged from this service ○ Died ○ Still receiving input from this service ○

2.6.1e Date/time of discharge from this service dd mm yyyy hh mm

2.6.2e Date of death dd mm yyyy

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.7e. On how many days did the patient receive this care/treatment during this 4 week period?							
2.8e How many minutes of this care/treatment in total did the patient receive during this 4 week period?							
2.9e How many of these minutes were delivered by a rehabilitation assistant?							
2.10e How many of these minutes were delivered by video/telerehabilitation?							
2.11e How many of these minutes were delivered in a group session?							

Period 6: sixth 4 weeks

Start date: [auto-populate]

End date: [auto-populate]

2.6f. During this period was the patient: Discharged from this service ○ Died ○ Still receiving input from this service ○

2.6.1f Date/time of discharge from this service dd mm yyyy hh mm

2.6.2f Date of death dd mm yyyy

	1. Motor function	2. Psychological function	3. Communication/swallowing	4. Vocational rehabilitation	5. Healthy living and lifestyle management	6. Social care needs and care delivery	7. Other
2.7f. On how many days did the patient receive this care/treatment during this 4 week period?							
2.8f How many minutes of this care/treatment in total did the patient receive during this 4 week period?							
2.9f How many of these minutes were delivered by a rehabilitation assistant?							
2.10f How many of these minutes were delivered by video/telerehabilitation?							
2.11f How many of these minutes were delivered in a group session?							

Complete stay

2.12. Date rehabilitation goals agreed: dd mm yyyy or No goals ○

2.12.1 If no goals agreed, what was the reason?

- Patient refused ○
- Organisational reasons ○
- Patient medically unwell for entire admission ○
- Patient has no impairments ○
- Not known ○

2.13 Date patient screened for mood using a validated tool dd mm yyyy
or Not Screened ○

2.13.1 If not screened, what was the reason?

- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Not known ○

2.14 Date patient screened for cognition using a validated tool dd mm yyyy
or Not Screened ○

2.14.1 If not screened, what was the reason?

- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Not known ○
- Not clinically required ○

2.15. Date patient screened for visual impairment using a standardised tool dd mm yyyy
or Not screened ○

2.15.1 If not screened, what was the reason?

- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Not known ○
- Screened by previous team ○

Section 7: Discharge / Transfer (from community services)

3.1. The patient:

Died	○
Was discharged from this team	○
Was discharged to somewhere else	○
Was transferred to an inpatient care team	○
Was transferred to another ESD / community team	○
Was transferred to an inpatient care team, not participating in SSNAP	○
Was transferred to another ESD/community team, not participating in SSNAP	○
Completed their SSNAP record at 6 months but continues to receive care/treatment from this team	○

3.1.1 If patient died, what was the date of death? dd mm yyyy

3.1.2 What hospital/team was the patient transferred to? Enter team code

3.1.3 On discharge, where is the patient living? Home ○ Care home ○ Other ○

3.2. Date/time of discharge/transfer from team dd mm yyyy hh mm

3.3. Modified Rankin Scale score at discharge/transfer [0-6] *(defaults to 6 if 7.1 is died)*

3.4. EQ5D-5L score on discharge from this service

a. Mobility [1-5, unknown]
b. Self-Care [1-5, unknown]
c. Usual activities (work, study, etc.) [1-5, unknown]
d. Pain/discomfort [1-5, unknown]
e. Anxiety/Depression [1-5, unknown]
f. How is your health today? [0-100, unknown]

3.5. Barthel score on discharge from this service [0-20]

3.6. If living in a care home, was the patient: Previously a resident ○ Not previously a resident ○

3.6.1 If not previously a resident, is the new arrangement: Temporary ○ Permanent ○

3.7. If living at home, is the patient: Living alone ○ Not living alone ○ Not known ○

3.8. Did the patient require help with personal activities of daily living (ADL)? Yes ○ No ○

If yes:

3.8.1 What support did they receive?

Paid carers	○
Informal carers	○
Paid and informal carers	○
Paid care services unavailable	○
Patient refused	○

3.8.2 At point of discharge, how many visits per day did the patient require?

One ○ Two ○ Three ○ Four ○ 24 hour care ○
Not known ○

7.8.3 How many carers? One carer ○ Two carers ○ Not known ○

3.9. What was the patient's employment status on discharge from this service?
Working full-time ○

Working part-time	○
Retired	○
Studying or training	○
Unemployed	○
Other	○

3.10. It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?
(not available to answer on webtool for teams in Northern Ireland)

3.11. Please state if the patient gave consent for their information to be included in research using SSNAP data?
(not available to answer on webtool for teams in Northern Ireland)

Changes to the SSNAP Core Community Dataset

Version	Date	Changes
1.1.1	12 Dec 2012	- Document created
2.1.1	04 Apr 2014	- Additional fields added after core dataset updated
2.1.2	17 Feb 2015	- Added introduction specific for ESD/CRT teams - Reformatted questions which will not be available to answer by ESD/CRT teams
3.1.1	01 Jul 2021	- Additional fields added after core dataset updated
4.0.0	01 Oct 2024	– Introduction updated as core dataset split into three core datasets: (1) inpatient, (2) community, and (3) six months, and community dataset becomes separate to the inpatient dataset – Questions previously in core dataset and not available to answer for ESD/CRT teams have been removed – All questions numbers have been reset and may differ from previous question numbers for the same question – 4.1 – question wording updated to Date/time patient received first face-to-face assessment from this service (from Date/time patient arrived at this hospital/team) – 4.2 – question added (Modified Rankin Scale score at first assessment by this service) – 4.3 – question added (EQ5D-5L score at first assessment by this service) – 4.4 – question added (Barthel score at first assessment by this service) – 4.4-4.6.2 and 4.8-4.8.3 replaced with 4.5-4.11. Rehabilitation data collection changed from Physiotherapy, Occupational therapy, Speech and language therapy, and Psychology to Motor function, Psychological function, Communication/swallowing, Vocational rehabilitation, Healthy living and lifestyle management, Social care needs and care delivery and Other. 4.6-4.11 are repeated in six blocks. – 4.4.1 – question removed (At what date was the patient no longer considered to require this therapy?) – 4.11 – question added (How many of these minutes were delivered in a group session?) – 4.7 – question number updated to 4.12 (Date rehabilitation goals agreed) – 4.7.1 (now 4.12.1) – answer option removed: Patient considered to have no rehabilitation potential (If no goals agreed, what was the reason?) – 4.9 – question number updated to 4.13 (Date patient screened for mood using a validated tool) – 4.10 – question number updated to 4.14 (Date patient screened for cognition using a validated tool) – 4.14 - question wording updated to Date patient screened for cognition using a validated tool (from Date patient screened for cognition using a simple standardised measure) – 4.14.1 – answer option added: Not clinically required (Date patient screened for cognition using a validated tool) – 4.15 – question added (Date patient screened for visual impairment using a standardised tool) – 4.15.1 – question added (If not screened, what was the reason?) – 7.1 – answer option removed: Was discharged to a care home (The patient:) – 7.1 – answer option removed: Was discharged home (The patient:) – 7.1 – answer option added: Was discharged from this team (The patient:) – 7.1 – answer option added: Completed their SSNAP record at 6 months but continued to receive care/treatment from this team (The patient:) – 7.1 – answer option updated to Was transferred to an inpatient care team (from Was transferred to another inpatient care team) (The patient:) – 7.1 – answer option updated to Was transferred to another ESD / community team (from Was transferred to an ESD / community team) (The patient:) – 7.1 – answer option updated to Was transferred to an inpatient care team, not participating in SSNAP (from Was transferred to another inpatient care team, not participating in SSNAP) (The patient:) – 7.1 – answer option updated to Was transferred to another ESD / community team, not participating in SSNAP (from Was transferred to an ESD/community team, not participating in SSNAP) (The patient:) – 7.1.3 – question number updated to 7.1.2 (What hospital/team was the patient transferred to?)

		– 7.1.3 – question added (On discharge, where is the patient living?) – 7.3 – question number updated to 7.2 (Date/time of discharge/transfer from team) – 7.4 – question number updated to 7.3 (Modified Rankin Scale score at discharge/transfer) – 7.4 – question added (EQ5D-5L score on discharge from this service) – 7.5 – question added (Barthel score on discharge from this service) – 7.5 – question number updated to 7.6 (If living in a care home, was the patient:) – 7.6 – question wording updated to If living in a care home, was the patient: (from If discharged to a care home, was the patient:) – 7.5.1 - question number updated to 7.6.1 (If not previously a resident, is the new arrangement:) – 7.7 – question removed (Was the patient discharged with an Early Supported Discharge multidisciplinary team?) – 7.6 – question number updated to 7.7 (If living at home, is the patient:) – 7.7 – question wording updated to If living at home, is the patient: (from If discharged home, is the patient:) – 7.8 - question removed (Was the patient discharged with a multidisciplinary community rehabilitation team?) – 7.8 – question added (Did the patient require help with personal activities of daily living (ADL)?) – 7.8.1 – question added (What support did they receive?) – 7.8.2 – question added (At point of discharge, how any visits per day did the patient require?) – 7.8.3 – question added (How many carers?) – 7.9 – question added (What was the patient's employment status on discharge from this service?) – 7.11 – question added (Please state if the patient gave consent for their information to be included in research using SSNAP data?) – 7.13 – question removed (Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?) – 7.13.1 – question removed (If yes, was COVID-19) – Questions 4 and 7 amended to 2 and 3