SSNAP | Sentinel Stroke National Audit Programme

KING'S College LONDON

# SSNAP Dataset for Non-acute strokes

| Version | Date | Changes |
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| 1.1.1 | 01/07/2021 | Dataset helpnotes following pilot versions |

On behalf of the Intercollegiate Stroke Working Party
**SSNAP helpdesk**
Mon-Fri 09:00-17:00
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| Question no | Question | Answer options | Guidance / definitions |
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| | Team | Auto-completed on web tool | This is used for identification and analysis of individual centre data. |
| | Patient audit number | Auto-completed on web tool | A record of the patient audit number should be kept by the team for future reference. Each patient audit number is only used once (even if the same patient is later re-admitted as a new care spell, they will have a new patient audit number). This number is useful to identify records within the audit whilst observing confidentiality of patient information. |
| 1.1 | Hospital number | Free text (30 character limit) | The permanent number for identifying the patient across all departments within the hospital. |
| 1.2 | NHS number | Either 10 character NHS Number OR "No NHS Number" | If the patient does not have an NHS number (if they are an overseas visitor, prisoner, traveller or in the armed forces) please select the option for No NHS Number. Otherwise, please make every effort to find this number.<br>This is a unique national identifier for the patient. The NHS number is used for data linkage, e.g. to link the SSNAP record with Office for National Statistics to retrieve mortality data. |
| 1.3 | Surname | Free text (30 character limit) | If the patient's NHS number is not known, this must be the name used for GP registration. The patient's surname or other name used as a surname. |
| 1.4 | Forename | Free text (30 character limit) | If the patient's NHS number is not known, this must be the name used for GP registration. The patient's first personal name and, optionally, if separated by spaces, subsequent personal names. |
| 1.5 | Date of birth | dd/mm/yyyy | Please ensure:<br>i) Correct year for date of birth and use the format dd/mm/yyyy<br>ii) The patient is over 16 years of age.<br>Age associated with severity of stroke is an important predictive factor for outcome, both in terms of mortality and resulting dependency. |
| 1.6 | Gender | Male; Female | To investigate any differences between men and women in prevalence or outcomes. |
| 1.7 | Postcode of usual address | First box: 2-4 alphanumerics<br>Second box: 3 alphanumerics. The full | Please enter the full postcode of the patient’s normal place of residence.<br>The postcode is used for data linkage purposes, particularly where the NHS number is not known or potentially incorrect. |

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| | | postcode of the patient's normal place of residence. | The postcode can also be used to investigate numbers and severity of stroke in different parts of the country and whether there are any geographical inequalities in service provision, quality of care or patient outcomes.<br><br>For patients from overseas or has no fixed abode please enter the following into the postcode field: ZZ11 1ZZ. |
| 1.8 | Ethnicity | Either code A-Z OR "Not Known"<br><br>These are the categories as specified by NHS and HSCIC:<br><br><u>White</u><br>A British<br>B Irish<br>C Any other White background<br><br><u>Mixed</u><br>D White and Black Caribbean<br>E White and Black African<br>F White and Asian<br>G Any other mixed background<br><br><u>Asian or Asian British</u><br>H Indian<br>J Pakistani<br>K Bangladeshi<br>L Any other Asian background | The ethnicity of a person, as specified by the person.<br><br>Z= The person had been asked and had declined either because of refusal or genuine inability to choose.<br><br>99 'Not known' should be used where the patient had not been asked or the patient was not in a condition to be asked, e.g. unconscious.<br><br>Ethnicity can be used to investigate numbers and severity of stroke for different ethnic groups and whether there are any inequalities in service provision, quality of care or patient outcomes.<br><br>Northern Ireland teams cannot enter patient identifiable information on the webtool. Ethnicity values are different for Northern Ireland.<br>W White<br>C Chinese<br>IT Irish Traveller<br>I Indian<br>P Pakistani<br>B Bangladeshi<br>BC Black Caribbean<br>BA Black African<br>BO Black Other<br>M Mixed Ethnic Group<br>O Other Ethnic Group |

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| | | Black or Black British<br>M Caribbean<br>N African<br>P Any other Black background<br><br>Other Ethnic Groups<br>R Chinese<br>S Any other ethnic group<br>Z Not stated<br><br>99 Not known<br><br>Northern Ireland teams- please view page 11 of the import function user guide. | R Roma Traveller |
| 1.9 | What was the diagnosis? | Stroke; TIA; Other; Not-acute stroke | |
| 1.10 | Was the patient already an inpatient at the time of stroke? | Yes; No | This question is greyed out for post-acute teams |
| 1.11 | Date/time of onset/awareness of symptoms | dd/mm/yyyy hh:mm | If best estimate or stroke during sleep (for 1.11.1), the date should be the date last known to be well. The time can be the time last known to be well, or left blank if a best estimate cannot be made (and not known entered for 1.11.2).<br><br>However, for inpatients who had a stroke during sleep, enter the date/ time the patient first woke up (cannot be not known for inpatient, and should not |

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| | | | be time last well, as for inpatient strokes, standards are measured from time of onset). |
| 1.11.1 | The date given is: | Precise; Best estimate; Stroke during sleep | |
| 1.11.2 | The time given is: | Precise; Best estimate; Not known | *Cannot be "Precise" unless 1.11.1 = "Precise"*<br>*Cannot be "Not Known" if 1.10="Yes"* |
| 1.12 | Did the patient arrive by ambulance? | Yes; No | This question is greyed out for post-acute teams |
| 1.12.1 | Ambulance trust | Select from drop down options on the web tool. | This question is greyed out for post-acute teams |
| 1.12.2 | Computer Aided Despatch (CAD)/ Incident Number | Up to 11 characters or "Not known" | This question is greyed out for post-acute teams |
| 1.13 | Date/time patient arrived at first hospital/team | dd/mm/yyyy hh:mm | *Must be after 1.11 and 1.12 unless 1.10="Yes"*<br><br>On the non-acute stroke database this date and time refers to the date and time relating to the post-acute team. The date and time the patient began care under this team. |
| 1.14 | Which was the first ward the patient was admitted to at the first hospital? | MAU/ AAU/ CDU; Stroke Unit; ITU/CCU/HDU; Other | This question is greyed out for post-acute teams |
| 1.15 | Date/time patient first arrived on stroke unit | Either Date/time OR "Did not stay on stroke unit" | This question is greyed out for post-acute teams |

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| 4.1 | Date/time patient arrived at this hospital/team? | dd/mm/yyyy hh:mm | On the non-acute database this date and time is automatically populated by with the information from 1.13. |
| 4.2 | Which was the first ward the patient was admitted to in this hospital? | MAU/ AAU/ CDU; Stroke Unit; ITU/CCU/HDU; Other | This question is greyed out for post-acute teams |
| 4.3 | Date/time patient arrived on stroke unit at this hospital? | Either date/time OR "Did not stay on stroke unit" | This question is greyed out for post-acute teams |
| 4.4 | Was the patient considered to require this therapy at any point in this admission? | Yes; No (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology) | This collects whether a patient was considered by the team involved to require Occupational therapy, Physiotherapy, Speech and Language therapy and Psychology at any point during their total stay under the care of your team. SSNAP isn't measuring it for each day of the stay. If you wish to collect this data locally you can insert a comment at patient level within the webtool or use the custom fields function. Comments and custom fields are for local use and cannot be analysed centrally.<br><br>If a patient is assessed and does not need any further therapy, then the patient was not considered to require therapy at any point in this admission. Answer 'No'.<br><br>If a patient is assessed and requires further therapy, answer 'Yes'. If Yes is selected, the assessment time should be included (in minutes) as part of the total therapy time. (Assessment + Therapy sessions time = Total amount of therapy received)<br><br>NB: For Psychology this refers to delivery of care by psychologists or psychologist assistants. |

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| 4.4.1 | At what date was the patient no long er considered to require this therapy ? | dd/mm/yyyy (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology) | This should be the date that the patient was no longer considered to have a deficit for each of the 4 therapies. E.g., A date can be entered for when the patient no longer required speech and language therapy which can be before the date they no longer required other therapies.<br><br>This is NOT when patients are unable to tolerate 45 minutes of therapy, but when a patient would no longer benefit from therapy |
| 4.5 | On how many days did the patient receive this therapy across their total stay in this hospital/team? | Integer (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology) | This is the total number of days on which the patient received each type of therapy from the day their care became the responsibility of this team to their discharge date from that team. It is collected separately for each hospital/team.<br><br>*Cannot be more than the number of days they were at this teami.e. 1.13 to 7.3 or 4.1 to 7.3)*<br>*Available if 4.4.1 is Yes*<br><br>The therapy may be provided by qualified or non-registered therapy assistants, including rehabilitation assistants, under supervision. For speech and language therapy it includes dysphagia and communication therapy. For psychologists it includes activities including assessment and treatment of mood, higher cognitive function and non-cognitive behavioural problems by psychologists or assistant psychologist.<br>Therapy includes:<br>- assessment and goal-directed therapy (i.e. towards goals that have been set and agreed by the team)<br>- either individual or group therapy<br>- home visits where the patient is present<br>- Training patients and carers<br>- Speech and Language Therapy refers to communication therapy and swallowing therapy |

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| | | | - Setting up, supporting and advancing self-directed exercise programmes<br>In this definition therapy does not include<br>• time for the therapist to travel to and from the patient<br>• documentation<br>• environmental visits<br>• multidisciplinary team meetings<br>• case conferences<br>• case reviews |
| 4.6 | How many minutes of this therapy in total did the patient receive during their stay in this hospital/team? | (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology) | *Cannot be more than 300 minutes per day (300 x number of days)*<br>*Available if 4.5.1 > 0*<br><br>The therapy may be provided by qualified or non-registered therapy assistants, including rehabilitation assistants, under supervision. For speech and language therapy it includes dysphagia and communication therapy. For psychologists it includes activities including assessment and treatment of mood, higher cognitive function and non-cognitive behavioural problems by psychologists or assistant psychologist.<br><br>- The stay refers to the team answering the question. The unit of measurement is minutes. The number of minutes must be a whole number<br>- If two therapists of the same profession treat a patient at the same time, record the number of therapy minutes provided as the duration of the session e.g. 2 physiotherapists treating a patient for 45 minutes counts as 45 minutes of physiotherapy<br>- If two therapists of different professions treat a patient at the same time, record the total number of minutes for each therapy e.g. a physiotherapist and occupational therapist treating a patient for 45 |

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| | | | minutes counts as 45 minutes of physiotherapy and 45 minutes of occupational therapy<br>- If one therapy assistant works on two different therapies during a 45 minutes session, record 45 minutes for only one profession or the times can be split (e.g. 25 minutes for one, 20 minutes for the other).<br>See FAQs (ssnap.zendesk.com) for more information.<br>- |
| 4.6.1 | How many of the total therapy minutes were provided by a rehabilitation assistant? | (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology) | *Available if 4.5.1 > 0*<br><br>This is the number of the total therapy minutes recorded in 4.6 that were provided specifically by a non-registered rehabilitation or therapy assistant.<br><br>Where a session has required two members of staff (one qualified and one assistant), assume the session has been led by the qualified therapist, record all minutes as qualified and do not record any minutes as assistant provided. (i.e. Do not split minutes)<br>If one therapy assistant works on two different therapies during a 45 minutes session, record 45 minutes for only one profession or the times can be split (e.g. 25 minutes for one, 20 minutes for the other). Please refer to patient notes to accurately determine the split per each therapy. |
| 4.6.2 | How many of the total therapy minutes were delivered by the video/teletherapy? | (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology) | *Only available to non-inpatient teams*<br>*Available if 4.5.1 > 0*<br><br>This is the number of the total therapy minutes recorded in 4.6 that were provided specifically via video/teletherapy.<br><br>This is contact with the patient that is therapeutic and focused on their rehabilitation goals. Please do not include activities relating to administration (e.g. booking appointments). |

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| 4.7 | Date rehabilitation goals agreed | Either date OR "No goals" | *Cannot be before 1.11 or 1.13/4.1*<br><br>If rehabilitation goals were set without the direct involvement of the patient you can still enter the date they were agreed into 4.7, though is best practice to involve the patient and his/her family if possible. |
| 4.7.1 | If no goals agreed, what was the reason? | PR - Patient refused<br>OR - Organisational reasons<br>MU - Patient medically unwell for entire admission<br>NI - Patient has no impairments<br>NRP - Patient considered to have no rehabilitation potential<br>NK - Not known | *Available if 4.7 is Not known*<br><br>Organisational reasons mean any issues with the service which meant that the screening was not performed within 4 hours e.g. unavailability of staff.<br><br>Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff.<br><br>Rehabilitation potential should be assessed by the MDT. In those assessed as having no rehabilitation potential it is expected the rationale is clearly documented in the case notes (e.g. advanced dementia). |
| 4.8 | Was the patient considered to require nursing care any point in this admission? | Yes/No | *Only available to non-inpatient teams*<br><br>This item should only record nursing from within your service.<br><br>This relates to input provided by registered nurses and does not include care visits.<br><br>This item collects whether a patient was considered by the team involved to require nursing care at any point during their total stay under the care of your team. SSNAP is not measuring nursing care for each day of the patient's stay. If you wish to collect this data locally you can insert a comment at patient level within the webtool or use the custom fields function. Note that |

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| | | | comments and custom fields are for local use and cannot be analysed centrally. |
| 4.8.1 | If yes, at what date was the patient no longer considered to require this care? | DD/MM/YYYY | *Only available to non-inpatient teams*<br>*Must not be after date of death or discharge*<br>This should be the date that the patient was no longer considered to have a requirement for nursing care from your team.<br><br>This item should only record nursing from within your service. |
| 4.8.2 | On how many days did the patient receive nursing care across their total stay in this team? | | *Only available to non-inpatient teams*<br>*Cannot be more than the number of days they were at this team(i.e. 4.1 to 4.8.1)*<br>*Available if 4.8 is Yes*<br><br>This item should only record nursing from within your service.<br><br>This is the total number of days on which the patient received nursing care from the day their care became the responsibility of this team to their discharge date from that team. It is collected separately for each team. |
| 4.8.3 | How many minutes of nursing care in total did the patient receive during their stay in this team? | | *Only available to non-inpatient teams*<br><br>*Cannot be more than 1440 minutes per day (1440 x number of days)*<br>*Available if 4.8.2 > 0*<br>- The stay refers to the team answering the question. The unit of measurement is minutes. The number of minutes must be a whole number |

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| | | | - If two nurses treat a patient at the same time, record the number of minutes provided as the duration of the session e.g. 2 nurses treating a patient for 45 minutes counts as 45 minutes of nursing care<br><br>This item should only record nursing from within your service. |
| 4.9 | Date patient screened for mood using a validated tool | DDMMYY; Not Screened | *Only available to non-inpatient teams*<br><br>*Cannot be before 4.1*<br><br>A validated tool for mood is one which has been approved for use within the trust/health board such as HADS, BASDEC, PHQ9 or for a person with aphasia, a more accessible one such as SAD-Q, BOA or DISCS.<br><br>See FAQs (ssnap.zendesk.com) for more information. (https://ssnap.zendesk.com/hc/en-us/categories/360003164058-FAQs-) |
| 4.9.1 | If not screened, what was the reason? | NK = Not known<br>OR = Organisational Reasons<br>PR = Patient Refused<br>MU = Patient medically unwell for entire admission | *Unavailable if date is entered for 4.9*<br><br>Patient medically unwell should be answered if the patient was deemed to be unable to tolerate mood screening by clinical staff.<br><br>Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. There is no “Patient had no relevant deficit” answer option as this is a screening, and the screening is required to determine if the patient had a deficit. |

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| 4.10 | Date patient screened for cognition using a simple standardised measure? | DDMMYY; Not screened | *Only available to non-inpatient teams*<br><br>*Cannot be before 1.11 or 1.13/4.1*<br><br>Cognition measure is one which has been approved for use within the trust/ health board such as MOCA/OCS.<br><br>A standardised measure is one with evidenced validity and efficacy for use in stroke. Locally developed screening tools are not applicable.<br><br>See FAQs (ssnap.zendesk.com) for more information. |
| 4.10.1 | If not screened, what was the reason? | NK = Not known<br>OR = Organisational Reasons<br>PR = Patient Refused<br>MU = Patient medically unwell for entire admission | *Unavailable if date is entered for 4.10*<br><br>Patient medically unwell should be answered if the patient was deemed to be unable to tolerate cognition screening by clinical staff.<br><br>Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff.<br><br>There is no "Patient had no relevant deficit" answer option as this is a screening, and the screening is required to determine if the patient had a deficit. |
| 7.1 | The patient: | Died; Was discharged to a care home; Was discharged home; Was discharged to somewhere else; Was transferred to another inpatient care team; Was transferred to an | Please note that on the non-acute stroke database, the transfer in question 7.1 will not allow you to transfer the patient record to the next team. On this database it only acts as a way for teams to indicate where the patient went upon discharge.<br><br>'Somewhere else' is a discharge from the care pathway to a place which is neither a care home nor the patient's home (e.g. this might be to a relative's |

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| | | ESD/community team;<br>Was transferred to another inpatient care team, not participating in SSNAP<br>Was transferred to an ESD/community team, not participating in SSNAP | home). 'Somewhere else' should be selected when the patient has left the stroke care pathway.<br><br>'Inpatient care team' is any team (team as defined within SSNAP) which treats patients in an inpatient setting (e.g. an acute hospital, a community hospital, a bed based rehabilitation setting, an intermediate care setting)<br><br>'ESD/ community team' is for stroke/neurology specific or non-specialist Early Supported Discharge teams and community rehabilitation teams (i.e. treating patients outside of an inpatient setting).<br><br>'Was transferred to an inpatient/ESD/community team' should only be selected if the inpatient/ESD/community team the patient was transferred to is set up on the SSNAP webtool to receive SSNAP record transfers.<br><br>If the team is not set up on SSNAP then 'Was transferred to an inpatient care team, not participating in SSNAP' or 'Was transferred to an ESD/community team, not participating in SSNAP' should be selected.<br><br>We encourage any teams which transfer patients to ESD/community teams that are not currently registered on SSNAP to contact those teams to encourage them to register to take part in the audit; if the inpatient/ESD/community team registers soon after, this can be changed so that the record can be transferred to them. The fact that the patient was discharged with ESD/community rehab team support will be noted in question 7.7 or 7.8.<br><br>See FAQs (ssnap.zendesk.com) for more information. |
| 7.1.1 | If patient died, what was the date of death? | dd/mm/yyyy | *Cannot be before 1.11 or 1.13/4.1*<br>*Available if 7.1 is "Died whilst under this team"* |

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| 7.1.2 | Did the patient die in a stroke unit? | Yes; No | This question is greyed out for post-acute teams |
| 7.1.3 | Which hospital/team was the patient transferred to? | Enter team code here | *Available if 7.1 = "Was transferred to another inpatient care team" or "Was transferred to an ESD / community team"*<br><br>To find out the hospital/team code please go to Support > Resources > Team Codes Lists on the webtool. If the team the patient has been transferred to is not included in the lists, please contact the SSNAP helpdesk.<br><br>Inactive teams<br>This message appears:<br>If a team is no longer accepting records on SSNAP (service reconfiguration etc).<br>OR<br>The team has been set up recently and is not currently participating (eg newly set up post acute team).<br><br>Please have an agreement for local pathways as to when teams become active and transfers can begin. New teams should aim to start submitting records as soon as possible.<br><br>If a team is unlikely to submit data soon, especially close to deadlines, it is appropriate to enter 'discharged somewhere else' in 7.1, then lock to discharge. If the record is already locked, please send through a request to the helpdesk, stating the reason for the unlock. |
| 7.2 | Date/time of discharge from stroke unit | dd/mm/yyyy / hh:mm | This question is greyed out for post-acute teams |

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| 7.3 | Date/time of discharge/transfer from team | dd/mm/yyyy / hh:mm | *Cannot be before 1.11 or 1.13/4.1 or 1.15/4.3*<br>*Unavailable if 7.1 = "Died whilst under this team" Cannot be before any dates/times in sections 1-6* |
| 7.3.1 | Date patient considered by the multidisciplinary team to no longer require inpatient care? | dd/mm/yyyy / hh:mm | *Cannot be before 1.11 or 1.13/4.1 or 1.15/4.3 and cannot be after 7.3*<br>*Unavailable if 7.1 = "Died whilst under this team" OR "Was transferred to another inpatient care team" OR "Was transferred to an ESD / community team"* |
| 7.4 | Modified Rankin Scale score at discharge/transfer | 0-6 | *0-5 if 7.1 is not died, 6 if 7.1 is died*<br><br>Defaults to 6 if 7.1 is died *whilst under this team*<br>0: No symptoms at all<br>1: No significant disability despite symptoms; able to carry out all usual duties and activities<br>2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance<br>3: Moderate disability; requiring some help, but able to walk without assistance<br>4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance<br>5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention<br>6: Dead<br><br>See FAQs (ssnap.zendesk.com) for more information. |
| 7.5 | If discharged to a care home, was the patient: | Either "Previously a resident" OR "Not previously a resident" | *Available if 7.1 = "Was discharged to a care home"* |

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| 7.5.1 | If not previously a resident, is the new arrangement: | Either "Temporary" OR "Permanent" | *Available if 7.5 = "Not previously a resident"* |
| 7.6 | If discharged home, is the patient: | Living alone; Not living alone; Not known | *Available if 7.1 = "Was discharged home"* |
| 7.7 | Was the patient discharged with an Early Supported Discharge multidisciplinary team? | Yes, stroke/neurology specific; Yes, non-specialist; No | *Unavailable if 7.1 = "Died whilst under this team " OR "Was transferred to another inpatient care team"*<br><br>Early supported discharge team refers to a multidisciplinary team which provides rehabilitation and support in a community setting with the aim of reducing the duration of hospital care for stroke patients. A stroke/neurology specific team is one which treats stroke/neurology patients solely. A non-specialist team treats other patients in addition to stroke and neurology patients. |
| 7.8 | Was the patient discharged with a multidisciplinary community rehabilitation team? | Yes, stroke/neurology specific; Yes, non-specialist; No | *Unavailable if 7.1 = "Died whilst under this team " OR "Was transferred to another inpatient care team"*<br><br>These would typically be part of a community neuro-rehabilitation team. Non-specialist team would typically be part of a generic intermediate rehabilitation team. |
| 7.9 | Did the patient require help with activities of daily living (ADL)? | Yes; No | This question is greyed out for post-acute teams |
| 7.9.1 | What support did they receive? | Paid carers; Informal carers; Paid and informal carers; Paid care services unavailable; Patient refused | This question is greyed out for post-acute teams |

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| 7.9.2 | At point of discharge, how many visits per week were social services going to provide? | Either numeric 0-100 OR "Not known" | This question is greyed out for post-acute teams |
| 7.10 | Is there documented evidence that the patient is in atrial fibrillation on discharge? | Yes; No | This question is greyed out for post-acute teams |
| 7.10.1 | If yes, was the patient taking anticoagulation (non-antiplatelet agent) on discharge or discharged with a plan to start anticoagulation within the next month? | Yes; No; No but | This question is greyed out for post-acute teams |
| 7.11 | Is there documented evidence of joint care planning between health and social care for post discharge management? | Yes; No; Not applicable | This question is greyed out for post-acute teams |
| 7.12 | Is there documentation of a named person for the patient and/or carer to contact after discharge? | Yes; No | This question is greyed out for post-acute teams |
| 7.13 | Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)? | - Yes<br>- No<br>- Not Known/not tested | For non-inpatient teams this this refers to the patient stay within your team<br><br>Confirmed = a positive test (of any kind) OR a negative test but diagnosed with COVID clinically and treated as such.<br>This question refers to the patient's particular stay at this team. As the question is referring to confirmed diagnosis |

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| 7.13.1 | If Yes, was COVID-19 | - Present on admission (i.e. the admission COVID test was positive)<br>- Confirmed subsequently during the patient's stay | *Unavailable if 7.13 is "No" OR "Not Known/not tested"* |
| 7.14 | 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? | - Yes, patient gave consent<br>- No, patient refused consent<br>- Patient not asked | SSNAP currently has approval under Section 251 to collect patient level data on the first six months of patient care, and **so it is not a requirement that the patient is asked for consent at this stage**. If the patient was not asked for consent, please record "patient not asked".<br><br>Patient identifiable information is not collected in Northern Ireland and so consent does not need to be sought. Northern Ireland teams should record "Not asked" for this question.<br><br>If the patient refuses consent, all patient identifiable information will be wiped from the webtool<br>If patient medically unwell and cannot be asked, indicate 'patient not asked' |
| 8.1 | Did this patient have a follow-up assessment at 6 months post admission (plus or minus 2 months)? | Yes; No; No but; No, patient died within 6 months of admission | On the non-acute stroke dataset, this question is required on order to lock the record. Indicate 'no' if the 6month assessment was not done by your team.<br>This is in the CCG Outcome Indicator Set for Domain 3 (Improving recovery from stroke) people who have had a stroke who receive a follow-up assessment between 4-8 months after initial admission.<br>The National Stroke Strategy recognises that people, who have had a stroke, either living at home or in care homes, should be offered a review of their health and social care status and secondary prevention needs. Reviews should be a multifaceted assessment of need and should encompass: |

| Question no | Question | Answer options | Guidance / definitions |
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| | | | • Medicines/general health needs<br>• Ongoing therapy and rehabilitation needs<br>• Mood, memory cognitive and psychological status<br>• Social care needs, carer wellbeing, finances and benefits, driving, travel and transport.<br><br>Patients/carers should be given a copy of the outcome of the review and provided with contact details of who to contact for more information.<br><br>No but should be answered:<br><br>• For patients who decline the assessment or who do not attend an appointment offered<br>• 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.<br>• For patients who have another stroke after being discharged from inpatient care and are readmitted into hospital<br><br>~ CCG Outcomes Indicator Set for Domain 3; 'Improving recovery from stroke' |
| 8.1.1 | What was the date of follow-up? | dd/mm/yyyy | *Must be >4 months after 1.13*<br>*Available if 8.1 = "Yes"* |
| 8.1.2 | How was the follow-up carried out: | In person; By telephone; Online; By post | *Available if 8.1 = "Yes"* |

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|---|---|---|---|
| 8.1.3 | Which of the following professionals carried out the follow-up assessment: | GP; Stroke coordinator; Therapist; District/community nurse; Voluntary services employee; Secondary care clinician; Other | *Available if 8.1 = "Yes"*<br><br>Six month review should be undertaken by an individual with stroke specialist competencies and training. |
| 8.1.4 | If other, please specify | | Available if 8.1.3 = "Other" |
| 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 unless 8.1 = "Yes"*<br><br>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. 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 hasn't 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 are comparatively high rate of patient not asked option chosen the RCP would seek assurance from the teams in question that there is an action plan in place to improve this. |
| 8.2 | Was the patient screened for mood, behaviour or cognition since discharge using a validated tool? | Yes; No; No but | *Available if 8.1 = "Yes"*<br><br>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.<br><br>'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. |

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|---|---|---|---|
| 8.2.1 | Was the patient identified as needing support? | Yes; No | *Available if 8.2 = "Yes"* |
| 8.2.2 | Has the patient received psychological support for mood, behaviour or cognition since discharge? | Yes; No; No but | *Available if 8.2 = "Yes"*<br><br>Mood, behaviour or cognitive disturbance could include anxiety, emotionalism, depression, adjustment, denial and difficulty coping emotionally and psychologically, which impedes recovery, problems with orientation and memory and inappropriate behaviour.<br><br>Psychological support can be provided by any professional or voluntary sector service specifically trained in psychological support. |
| 8.3 | Where is the patient living? | Home; Care home; Other | *Available if 8.1 = "Yes"* |
| 8.3.1 | If other, please specify | Free text (30 character limit) | *Available if 8.3 = "Yes"* |
| 8.4 | What is the patient's modified Rankin Scale score? | 0-6 | *Available for manual entry if 8.1 = "Yes"*<br><br>0: No symptoms at all<br>1: No significant disability despite symptoms; able to carry out all usual duties and activities<br>2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance<br>3: Moderate disability; requiring some help, but able to walk without assistance<br>4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance<br>5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention<br>6: Dead |

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| 8.5 | Is the patient in persistent, permanent or paroxysmal atrial fibrillation? | Yes; No | *Available if 8.1 = "Yes"*<br><br>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.<br><br>Persistent atrial fibrillation means episodes lasting longer than 7 days (spontaneous termination of the arrhythmia is unlikely to occur after this time).<br><br>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 | Is the patient taking: | | |
| 8.6.1 | Antiplatelet | Yes; No | *Available if 8.1 = "Yes"* |
| 8.6.2 | Anticoagulant | Yes; No | |
| 8.6.3 | Lipid Lowering | Yes; No | |
| 8.6.4 | Antihypertensive | Yes; No | . |
| 8.7 | Since their initial stroke, has the patient had any of the following: | | |
| 8.7.1 | Stroke | Yes; No | *Available if 8.1 = "Yes"* |
| 8.7.2 | Myocardial infarction | Yes; No | |

| Question no | Question | Answer options | Guidance / definitions |
|---|---|---|---|
| 8.7.3 | Other illness requiring hospitalisation | Yes; No | |
| 8.8 | Employment status prior to stroke | Working full-time;<br>Working part-time;<br>Retired;<br>Studying or Training;<br>Unemployed;<br>Other | Prior to stroke = the time directly prior to stroke<br>Full-time is the equivalent of 35 hours a week<br>Full-time and part-time work includes paid, unpaid and voluntary work |
| 8.8.1 | Employment status currently | Working full-time;<br>Working part-time;<br>Retired;<br>Studying or Training;<br>Unemployed;<br>Other | Full-time is the equivalent of 35 hours a week<br>Full-time and part-time work includes paid, unpaid and voluntary work<br><br>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/<br>There should be only ONE response for each dimension<br>Missing values are preferably coded as '9'<br>Ambiguous values (e.g. two boxes are ticked for a single dimension) should be treated as missing values |
| a | Mobility | Value range: 1-5 | 1: I have no problems in walking about<br>2: I have slight problems in walking about<br>3: I have moderate problems in walking about<br>4: I have severe problems in walking about<br>5: I am unable to walk about<br>9: Ambiguous or missing value |
| b | Self-Care | Value range: 1-5 | 1: I have no problems washing or dressing myself<br>2: I have slight problems washing or dressing myself<br>3: I have moderate problems washing or dressing myself<br>4: I have severe problems washing or dressing myself<br>5: I am unable to wash or dress myself |

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| | | | 9: Ambiguous or missing value |
| c | Usual activities (work, study, etc.) | Value range: 1-5 | 1: I have no problems doing my usual activities<br>2: I have slight problems doing my usual activities<br>3: I have moderate problems doing my usual activities<br>4: I have severe problems doing my usual activities<br>5: I am unable to do my usual activities<br>9: Ambiguous or missing value |
| d | Pain/discomfort | Value range: 1-5 | 1: I have no pain or discomfort<br>2: I have slight pain or discomfort<br>3: I have moderate pain or discomfort<br>4: I have severe pain or discomfort<br>5: I have extreme pain or discomfort<br>9: Ambiguous or missing value |
| e | Anxiety/Depression | Value range: 1-5 | 1: I am not anxious or depressed<br>2: I am slightly anxious or depressed<br>3: I am moderately anxious or depressed<br>4: I am severely anxious or depressed<br>5: I am extremely anxious or depressed<br>9: Ambiguous or missing value |
| f | How is your health today? | Value range: 1-100 | 100 means the best health you can imagine<br>0 means the worst health you can imagine<br>Missing values should be coded as 999<br>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 |

**Comprehensive Question:**

| Question no | Question | Answer options | Guidance / definitions |
|---|---|---|---|
| 7.101 | Barthel score at discharge | 0-20 | Barthel should be measured on 20 point scale.<br>This score looks at functional level at discharge. A measure of disability after stroke and the outcome of rehabilitation. |