Sentinel Stroke National Audit Programme

UPCARE: 1.0 Programme name - please do not change this field.*	Sentinel Stroke National Audit Programme
1.1 Abbreviation	SSNAP
1.2 Audit or non-audit	Audit
1.3 HQIP commissioned*	Yes
1.4 Programme unique identifier*	HQIP115
Contract status	Ongoing
HQIP AD	DS
HQIP PM	SB
1.5 Lead organisation*	Kings College London
1.6 Programme homepage*	https://www.strokeaudit.org/
1.7 Programme summary	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme based in the School of Life Course and Population Sciences at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2023 National Clinical Guideline for Stroke. 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 so it can be used as a tool to improve the quality of care that is provided to patients.
2.1 Organogram	https://www.strokeaudit.org/SupportFiles/Documents/Oversight/SSNAP-organogram.aspx
2.2 Organisations involved in delivering the programme	King's College London, https://www.kcl.ac.uk, Host Organisation Athera Health Care (formally known as Net Solving) - subcontracted to host the online data capture tool which facilitates data collection and analysis, https://atherahealthcare.com/, Web Developer

2.3 Governance arrangements

The following governance groups (including representatives from all key stakeholders) are responsible for oversight of the project:

Project team: Responsible for daily management and delivery of the programme. Project management staff are employed to ensure data definitions and support areas are kept up-to-date and to chase teams with poor participation/data quality. The team of analysts are embedded within the project team, and are involved throughout the audit.

Management group: Responsible for resource, contract and finance monitoring. Responsible for day-to-day oversight of deliverables and operations, serving as the primary mechanism for which advisory groups and satellite reference groups feed into the top-level governance groups. The group is chaired by Professor Martin James. Membership includes: SSNAP Programme Managers, King's College London contracts, finance and research management representatives.

Project group: Responsible for operational oversight of functions as they relate to the hosting organisation (King's College London). The group meets twice a year and is chaired by Dr Iain Marshall. Membership includes: SSNAP Clinical Director, Stroke Programme Manager, Head of Department (Population Health Sciences) and School Manager (School of Life Course and Population Sciences).

Programme board: Responsible for oversight of all strategic and governance issues related to the programme. Also governs and oversees all external and stakeholder relationships. The group meets annually and is chaired by Professor Mark Barber. Membership includes representatives from King's College London, SSNAP, NHS Wales, NHS England, Stroke Association, PPV and HQIP.

External Reference Group (ERG): SSNAP seeks consultation from the ERG to review and provide constructive advice and criticism to the programme team to help deliver the aims of the programme. The group meets annually and is chaired by Dr Ajay Bhalla. Membership includes representatives from: SSNAP, NICE, International audits, Welsh Implementation Group, NIMAST, Royal College of Physicians, Public Health England and NCDs for Stroke, Cardiac, Cardiovascular Prevention and Mental Health.

Intercollegiate Stroke Working Party (ICSWP): A multi-speciality, multi-disciplinary national expert group committed to sustained long-term quality improvement in the care and treatment of people with stroke and their families and carers. Responsible for monitoring the progress of the audits, including monitoring trends in results, and annual dataset reviews. The group meets three times a year and is chaired by Professor Martin James. Membership includes: https://www.strokeaudit.org/About/Our-governance/Oversight.aspx

Scientific Advisory Group: Responsible for providing expert guidance on internal research priorities, external data requests and advising on quality improvement methodologies as they relate to national audit. The group is chaired by Professor Chris Price. Membership includes representatives from: SSNAP, Department of Population Health Sciences and PPV representative.

2.4 Stakeholder engagement

The Intercollegiate Stroke Working Party (ICSWP) is vital in involving feedback from a wide variety of stakeholders. This comprises members from healthcare professions in the stroke care pathway; patient and carer representative organisations; patients; and representatives from King's College London (KCL). Meeting every 4 months, it monitors progress of the audit, including monitoring trends in results, and annual dataset reviews.

Patient involvement continues to develop with close working with the Stroke Association, Stroke Research Patients and Family Group, Speakeasy. The work with patient groups is represented in lay outputs and accessible formats using data visualisation and is kept under review by the patient groups working closely with SSNAP. SSNAP aims to enable stroke patients and the general public to ask searching questions.

Since its inception SSNAP has had significant patient, carer and family engagement in addition to close collaboration with the Stroke Association. Patient representation will remains embedded in SSNAP governance and delivery through:

- Representation on the ICSWP, which includes three stroke survivors and two Stroke Association representatives;
- Representation on the SSNAP Programme Board;
- A PPV focus group, including stroke charities, stroke research participants, and patient and carer representatives;
- Collaborating with KCL's PPV experts, including the stroke research patients and family group and the 'Improving the Lives of Stroke Survivors with Data' programme grant team.

Through these channels, patients play a central role in developing, agreeing and finalising improvement goals and measures. Specifically, they are closely involved in:

- Discussions around SSNAP's Healthcare Improvement Strategy and QI initiatives;
- Consultation on information governance and fair use of patient data (e.g. recent PPV work to support exemption from the National Data Opt-Out);
- Co-producing outputs for patients and public including infographics and Easy Access versions;
- Disseminating and 'road testing' audit outputs within their own networks.

SSNAP's existing Easy Access Versions (EAVs) of audit results were developed in response to feedback from and in collaboration with stroke survivors and carers. They were and will continue to be developed with survivors themselves, particularly the SSNAP PPV focus group and the Stroke Research Patient and Family Group, based at King's College London.

SSNAP also benefits from four clinical leads with extensive and successful experience in stroke care, audit and clinical improvement: a Clinical Director (Professor Martin James), and associate Clinical Directors Dr Ajay Bhalla, Ms Louise Clark and Dr Rebecca Fisher. They provide day-to-day clinical direction of the audit, assist the delivery team in addressing issues raised by teams, review and interpret results and develop clinical commentary for outputs. They also routinely advise on the design of new outputs and continue to be instrumental in SSNAP's ability to rapidly respond to new evidence e.g the emerging use of thrombectomy.

2.5 Conflict of interest policy

Regularly updated lists of membership of the steering group (ICSWP) are available on the SSNAP website (https://www.strokeaudit.org/About/Our-governance/Oversight.aspx).

The ICSWP follows the NICE declarations of interest policy (https://www.nice.org.uk/Media/Default/About/Who-we-are/Policies-and-procedures/declaration-of-interests-policy.pdf).

When discussion occurs in relation to a declared competing interest of a member, that member is required to verbally reiterate his/her interest and depending on the type and level of interest (as judged by the chair of the ICSWP), that member is excluded from contributing to the discussion.

3.1 Quality improvement goals

The overarching QI objectives of SSNAP are to:

- Review and adjust metrics, to support national policies and priorities following on from the published NHS England National Stroke Service Model, Integrated Community Stroke Service Model and GIRFT recommendations
- Identify areas across the patient pathway for action through facilitation and stimulation of QI in relation to delivery and outcomes of care
- Assess whether stroke patients receive high quality, timely and equitable care and services when measured against adherence to agreed guidance and standards
- Ensure that all process measures have an aspirational % quoted for participating units to aim for
- Reduce unwarranted variation through benchmarking of performance and outcome measures
- Report outlier identification and management using the appropriate guidance
- Measure and report health inequality in relation to impact on the specified audit measures
- Maximise the potential for data collected to drive improvements in care at local (trust), network (ISDN), regional and national levels, involving patients and their families/carers in service improvement in a developmental way
- Share best practice and QI examples, and signposting to resources available in the wider stroke pathway landscape
- Adapt QI priorities in line with new evidence-based practice and guidance
- Enable data to support stroke policy development and quality control/assurance functions at funder level.

The SSNAP data driven healthcare quality improvement (QI) 3 year aims are to:

- Contribute to the improvement of the thrombolysis rate to 14.5% (with a NHS LTP target of 20% by 2029) for all patients who could benefit from it
- Contribute to the improvement of the mechanical thrombectomy rate to 8%-10% by 2029, including data and reporting to enable measurement for quality improvement through the communities of practice
- Ensure stroke patients spend 90% of their admission on a specialised stroke unit
- Ensure ongoing dynamic development of Integrated Stroke Delivery Networks (ISDNs) data dashboards to support ISDNs and Integrated Care/Health Boards and regional directorates.
- Evolve the post-acute care data set to enable community care and life after stroke services to measure for quality improvement including 6-month review, patient experience and outcome data
- Ensure workforce and organisational data in acute and post-acute care pathways is available to benchmark and inform processes for improved outcomes in stroke care
- Where possible, extend the audit to assess the quality of care delivered to patients who have had a stroke but are treated in non-stroke specific settings such as A&E or outpatient settings
- Understand the processes of care given to patients that have been managed by stroke teams but are missing from national stroke data sets

	including patients who have had TIAs (transient ischemic attacks), minor strokes and/or stroke mimics.
3.3a Methods for stimulating quality improvement*	Peer review programme; Sharing good practice repository; On-line Quality Improvement guides; Workshops; NHS England improvement programme; Getting It Right First Time (GIRFT)
4a) Please add the most recent date that you have reviewed and updated an online version of UPCARE (Programme section) on your project's website (click into the response to see pop-up guidance).	29/01/2025
4b) Please add a hyperlink to UPCARE (Programme section) on your website (click into the response to see pop-up guidance).*	https://www.strokeaudit.org/About/About-SSNAP.aspx

Sentinel Stroke National Audit Programme

UPCARE: Programme name - please do not change this field.*	Sentinel Stroke National Audit Programme
Workstream name (if applicable) - please do not change this field.*	Not applicable
Contract status	Ongoing
Audit or non-audit	Audit
HQIP commissioned*	Yes
HQIP AD	DS
HQIP PM	SB
1.0 Included in current NHS Quality Accounts*	Yes
1.1a Geographical coverage - HQIP agreement*	England; Wales
1.1b Geographical coverage - External agreement*	Northern Ireland; Isle of Man; Jersey
1.2a Topic - please select which ONE of the following best describes the topic area for the programme or workstream. If more than one apply, please select 'Other' and add comment to the next question.*	Neurological
1.2b If you selected 'Other' above, please provide details.*	Stroke
1.3a Healthcare setting*	NHS secondary or tertiary care; NHS community care; NHS ambulance care
1.4 Inclusion and exclusion criteria*	**Patients:** All patients with a primary diagnosis of stroke coded as I61, I63 and I64 should be submitted to SSNAP. The minimum age for patient submission is 16.

Stroke services: Any stroke service in England, Wales or Northern Ireland which treats at least 10 patients per year are eligible to participate in SSNAP. All acute hospitals in these countries that provide stroke care are actively submitting data to SSNAP with increasing numbers of post-acute care providers registering and participating in SSNAP.

1.5 Methods of data submission*	Bespoke data submission by healthcare provider; Extraction from existing data source(s)
1.6a 2023/24 data submission closes - please indicate date, series of dates or frequency.*	Quarterly results data-locking deadlines: April-June 2023 - 8 August 2023 July-September 2023 - 6 November 2023 October-December 2023 - 5 February 2024 January-March 2024 - 7 May 2024 Annual results data-locking deadline: April 2023-March 2024 - 7 May 2024
1.6b 2024/25 data submission closes - please indicate date, series of dates or frequency.*	Quarterly results data-locking deadlines: April-June 2024 - 5 August 2024 July-September 2024 - 4 November 2024 October-December 2024 - 3 February 2025 January-March 2025 - 6 May 2025 Annual results data-locking deadline: April 2024-March 2025 - 6 May 2025
1.6c 2025/26 data submission closes - please indicate date, series of dates or frequency.*	Quarterly results data-locking deadlines: April-June 2025 - 4 August 2025 July-September 2025 - 3 November 2025 October-December 2025 - 2 February 2026 January-March 2026 - 5 May 2026 Annual results data-locking deadline: April 2025-March 2026 - 5 May 2026
1.7 Data flow diagram	https://www.strokeaudit.org/SupportFiles/Documents/Legal/SSNAP-data-flow-diagram.aspx
1.8 Data quality & analysis plan	**Data analysis**

Full data analysis and methodology for the clinical audit is available here: **https://www.strokeaudit.org/Audits/Clinical-audit-information/Data-analysis-and-methodology.aspx**

Information on SSNAP scoring is available here: https://www.strokeaudit.org/Audits/Clinical-audit-information/Domains,-key-indicators-and-scoring.aspx

Results and reports created by SSNAP are available here: https://www.strokeaudit.org/Audits/Clinical-audit-information/Results-and-reports.aspx

Data quality

The webtool has built in validations, prompts and a system of “locking” which ensures that the data inputted is logically consistent (e.g. the date/time of discharge from a stroke unit must be after arrival at the stroke unit). In addition, in-depth casemix data is reported back to teams regularly highlighting any anomalous fields so that they can be reviewed to determine if it is a genuine difference in casemix or a data entry error. These comprehensive validations ensure as much as is possible that complete, robust data are collected.

The success of SSNAP depends on complete and timely data being submitted so that there is rapid turnaround of reporting to facilitate change.

SSNAP provides an “audit compliance” score for each participating team in order to ensure that the data are complete, of high data quality and produced as close to the time the patients were admitted or discharged as possible. Individual teams are provided with a weighted audit compliance score to provide a context in which to interpret their process of care results and identify areas of improvement.

The audit compliance score includes measures of high usage of “unknown” data items, in particular the elements of the NIHSS. In response to feedback from post-acute teams, some measures of speed of data entry and data transfer were added to ensure that these teams are able to complete their sections in a timely way so that the rapid turnaround of results can be maintained. Full details of this score can be found here - https://ssnap.zendesk.com/hc/en-us/articles/115003840345-Audit-Compliance-How-is-it-calculated-

Data linkage

SSNAP have permission to link patient-level data with other national databases on a case-by-case basis, only for the agreed purpose outlined in the section 251 agreement. SSNAP holds current Data Sharing Agreements with NHS England (previously NHS Digital) that grants permission for SSNAP to link data collected in England and Wales with Hospital Episode Statistics (HES) and Office of National Statistics (ONS) data. NHS England are the data controllers of HES and ONS data i.e. they are the organisation in control of processing the data. Linkage with HES data enables SSNAP to compare the number of records submitted to SSNAP with the number recorded retrospectively in HES to ensure high data quality. This linkage also enables analyses on the associations between stroke and other medical conditions. Linking with ONS data allows SSNAP to report all-cause mortality rates in the first 30 days after patients are admitted to hospital with stroke. Aggregate level mortality data is reported at hospital level annually and, once reviewed by all hospitals, are made available in the public domain.

1.9 Outlier policy

SSNAP stroke mortality outlier policy: https://ssnap.zendesk.com/hc/en-us/articles/115004491389-Outlier-policy-SSNAP-stroke-mortality-reporting

2.1 Outcome measures

- 30 day mortality data reporting (reported annually)
- Institutionalisation rates (reported quarterly)
- Modified Rankin Scale (MRS) at 3 time points (reported quarterly)
- In-hospital mortality (reported annually)
- 6 month outcomes after stroke (reported quarterly)
- NIHSS after Intra-arterial treatment (IAT) and Thrombolysis (tPA) (reported annually)
- Pneumonia and infection rates (reported quarterly)

2.2 Process measures

The SSNAP clinical audit primarily reports on process metrics, such as initial process of care timings and whether various assessments are achieved. Every 3 months and annually SSNAP reports on a large variety of process metrics, all of which are publicly available here: https://www.strokeaudit.org/Results2/Clinical-audit.aspx, additional focus is put upon Key Indicators which are used for scoring trusts, a list of which is available here: https://www.strokeaudit.org/Audits/Clinical-audit-information/Domains,-key-indicators-and-scoring.aspx.

2.3 Organisational measures

A combined acute and post-acute organisational audit will run twice a year from 2025, collecting information on the organisation and structure of stroke services. Previous separate organisational audits were run for acute and post-acute services, the acute was ran every 2 years until 2021 and the post-acute was run in 2015 and 2021.

Full information on the previous acute and post-acute audits are available here:

https://www.strokeaudit.org/Audits/Acute-organisational-audit-information/About.aspx

https://www.strokeaudit.org/Audits/Post-acute-organisational-audit-information/About.aspx

2.4 Patient reported outcome measures

EQ5D-5L after stroke was added to the 6 month assessment dataset from 1 July 2021.

EQ5D5L data is included in annual reports, and will be added to quarterly reporting with the new 2024 dataset.

2.6a Do measures align with any of the following sources of evidence (select all that apply)

NICE clinical guideline; NICE quality standard; Royal College

2.6b Evidence supplemental information

The results from the SSNAP clinical audit compare delivery of care with standards derived from systematically retrieved and critically appraised research evidence and agreed by experts in all disciplines involved in the management of stroke. The strength of evidence is outlined in the guidelines. All evidence and standards used in the SSNAP audits are available in the following:

- National clinical guideline for stroke 6th edition (2023): https://www.strokeguideline.org/
- Stroke and transient ischaemic attack in over 16s: diagnosis and initial management [NG128] (NICE, 2019): https://www.nice.org.uk/guidance/ng128
- Stroke rehabilitation in adults [NG236] (NICE 2023): https://www.nice.org.uk/guidance/ng236
- NICE Quality Standard for Stroke 2016: https://www.nice.org.uk/guidance/qs2

An outline of the key evidence for each of the domains of care in the SSNAP Clinical Audit are provided below. These domains are the areas on which SSNAP teams are scored.

Hyperacute assessment domain

National Clinical Guideline for Stroke, 2023

3.4 B Patients with suspected acute stroke should receive brain imaging as soon as possible (at most within 1 hour of arrival at hospital).

3.4 E Patients with stroke with a delayed presentation for whom reperfusion is potentially indicated should have CT or MR perfusion as soon as possible (at most within 1 hour of arrival at hospital). An alternative for patients who wake up with stroke is MRI measuring DWI-FLAIR mismatch.

6.2 B Acute stroke services should provide:

- urgent brain imaging for patients with suspected acute stroke, including the 24/7 provision of CT angiography and perfusion;

2.4 B People with suspected acute stroke (including people already in hospital) should be admitted directly to a hyperacute stroke unit and be assessed for emergency stroke treatments by a specialist clinician without delay.

3.10 E Patients with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within four hours of arrival at hospital and before being given any oral food, fluid or medication.

Specialist pathway domain

National Clinical Guideline for Stroke, 2023

2.4 B People with suspected acute stroke (including people already in hospital) should be admitted directly to a hyperacute stroke unit and be assessed for emergency stroke treatments by a specialist clinician without delay.

2.5 A People with stroke should be treated in a specialist stroke unit throughout their hospital stay unless their stroke is not the predominant clinical problem.

2.3 B People with an acute neurological presentation suspected to be a stroke should be admitted directly to a hyperacute stroke unit that cares predominantly for patients with stroke, with access to a designated thrombectomy centre 24 hours a day, 7 days a week for consideration of mechanical thrombectomy.

2.3 C Acute hospitals receiving medical admissions that include people with suspected stroke should have arrangements to admit them directly to a hyperacute stroke unit on site or at a designated neighbouring hospital as soon as possible to monitor and regulate basic physiological functions such as neurological status, blood glucose, oxygenation, and blood pressure.

2.3 D Acute hospitals that admit people with stroke should have prioritised access to a specialist stroke rehabilitation unit on site or at a neighbouring hospital.

2.5 M A facility that provides treatment for inpatients with stroke should include:

- a geographically-defined unit;
- a co-ordinated multi-disciplinary team that meets at least once a week for the exchange of information about in-patients with stroke;
- information, advice and support for people with stroke and their family/carers;
- management protocols for common problems, based upon the best available evidence;
- close links and protocols for the transfer of care with other in-patient stroke services, early supported discharge teams and community services;
- training for healthcare professionals in the specialty of stroke.

2.8 A Hospital inpatients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge

2.8 B Patients undergoing rehabilitation after stroke who are not eligible for early supported discharge should be referred to community stroke rehabilitation if they have ongoing rehabilitation needs when transferred from hospital.

2.8 C Early supported discharge and community stroke rehabilitation should be provided by a service predominantly treating people with stroke.

NICE Quality Standard for Stroke, 2016

Statement 1: Adults presenting at an accident and emergency (A&E) department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

Reperfusion doman

National Clinical Guideline for Stroke, 2023

3.5 A Patients with acute ischaemic stroke, regardless of age or stroke severity, in whom treatment can be started within 4.5 hours of known onset, should be considered for thrombolysis with alteplase or tenecteplase.

3.5 B Patients with acute ischaemic stroke, regardless of age or stroke severity, who were last known to be well more than 4.5 hours earlier, should be considered for thrombolysis with alteplase if:

- treatment can be started between 4.5 and 9 hours of known onset, or within 9 hours of the midpoint of sleep when they have woken with symptoms

AND

- they have evidence from CT/MR perfusion (core-perfusion mismatch) or MRI (DWI-FLAIR mismatch) of the potential to salvage brain tissue (see Table 3.5.1). This should be irrespective of whether they have a large artery occlusion and require mechanical thrombectomy.

3.5 D Thrombolysis should only be administered within a well-organised stroke service with:

- processes throughout the emergency pathway to minimise delays to treatment, to ensure that thrombolysis is administered as soon as possible

after stroke onset;
- staff trained in the delivery of thrombolysis and monitoring for post-thrombolysis complications;
- nurse staffing levels equivalent to those required in level 1 or level 2 nursing care with training in acute stroke and thrombolysis;
- immediate access to imaging and re-imaging, and staff appropriately trained to interpret the images;
- protocols in place for the management of post-thrombolysis complications.

2.4 F Acute stroke services should have protocols for the monitoring, referral and transfer of patients to thrombectomy centres for mechanical thrombectomy and regional neurosurgical centres where available for decompressive hemicraniectomy, surgical management of intracranial haemorrhage and the management of symptomatic hydrocephalus including external ventricular drain insertion.

3.5 H Patients with acute anterior circulation ischaemic stroke and a contraindication to intravenous thrombolysis but not to thrombectomy, who were previously independent (mRS 0-2), should be considered for intra-arterial clot extraction (using a stent retriever and/or aspiration techniques) if they have a proximal intracranial large artery occlusion causing a disabling neurological deficit (NIHSS score of 6 or more) and the procedure can begin within 6 hours of known onset.

3.5 K Patients with acute ischaemic stroke in the posterior circulation within 12 hours of onset should be considered for mechanical thrombectomy (combined with thrombolysis if eligible) if they have a confirmed intracranial vertebral or basilar artery occlusion and their NIHSS score is 10 or more, combined with a favourable PC-ASPECTS score and PonsMidbrain Index. Caution should be exercised when considering mechanical thrombectomy for patients presenting between 12 and 24 hours of onset and/or over the age of 80 owing to the paucity of data in these groups.

MDT assessment domain

National Clinical Guideline for Stroke, 2023

4.8 B People with limitations of personal activities of daily living after stroke should:

- be referred to an occupational therapist with knowledge and skills in neurological rehabilitation. Assessment should include consideration of the impact of hidden deficits affecting function including neglect, executive dysfunction and visual impairments;
- be assessed by an occupational therapist within 24 hours of admission to a stroke unit;
- be offered treatment for identified problems (e.g. feeding, work) by the occupational therapist, in discussion with other members of the specialist multidisciplinary team.

4.26 B Until a safe swallowing method is established, patients with swallowing difficulty after acute stroke should:

- be immediately considered for alternative fluids;
- have a comprehensive specialist assessment of their swallowing completed by a specialist in dysphagia management within 24 hours of admission;
- be considered for nasogastric tube feeding within 24 hours;

- be referred to a dietitian for specialist nutritional assessment, advice and ongoing monitoring;
- receive adequate hydration, nutrition and medication by alternative means;
- be referred to a pharmacist to review medication formulation.

4.43 A People should be assessed early after stroke for communication difficulties by a speech and language therapist to diagnose the problem, devise and implement a treatment programme and explain the nature and implications to the person, their family/carers and the multidisciplinary team.

4.17 B People with weakness after stroke sufficient to limit their activities should be assessed within 24 hours of admission by a therapist with knowledge and skills in neurological rehabilitation.

Therapy intensity domain

NICE Stroke rehabilitation in adults, 2023

1.2.16 Offer needs-based rehabilitation to people after stroke. This should be for at least 3 hours a day, on at least 5 days of the week, and cover a range of multidisciplinary therapy including physiotherapy, occupational therapy and speech and language therapy.

Therapy frequency domain

National Clinical Guideline for Stroke, 2023

4.2 A People with motor recovery goals undergoing rehabilitation after a stroke should receive a minimum of 3 hours of multidisciplinary therapy a day (delivered or supervised by a therapist or rehabilitation assistant focused on exercise, motor retraining and/or functional practice), at least 5 days out of 7, to enable the range of required interventions to be delivered at an effective dose.

- Rehabilitation programmes should be individualised to account for comorbidities, baseline activity levels, post-stroke fatigue, tolerance, goals and preferences. Therapy can be paced throughout the day, to accumulate at least 3 hours of motor/functional therapy;
- For people unable to tolerate 3 hours of therapy a day, the barriers to doing so should be fully assessed and actively managed with strategies to ensure they are able to participate in therapy and be active as far as possible;
- People undergoing rehabilitation after a stroke should be supported to remain active for up to 6 hours a day (including therapist-delivered therapy), for example through the use of open gyms, self-practice, carer-assisted practice, engaging in activities of daily living, and activities promoting cardiovascular fitness

NICE Stroke rehabilitation in adults, 2023

1.2.17 Where it is agreed with the person after stroke that they are unable, or do not wish, to participate in rehabilitation therapy for at least 3 hours a day, on at least 5 days of the week, ensure that any therapy needed is still offered for a minimum of 5 days per week.

Standards by discharge domain

National Clinical Guideline for Stroke, 2023

4.9 D Patients with acute stroke who are at risk of malnutrition or who require tube feeding or dietary modification should be referred to a dietitian for specialist nutritional assessment, advice and monitoring.

2.11 E Services for people with stroke should provide screening for mood and cognitive disturbance within six weeks of stroke (in the acute phase of rehabilitation and at the transfer of care into post-acute services) and at six and 12 months using validated tools and observations over time.

4.39 Q People with severe, persistent, or atypical symptoms of emotional disturbance after stroke, and those with complex presentations where emotional disturbance, cognitive and language deficits co-exist, should receive specialist assessment and treatment from a clinical psychologist/neuropsychologist to facilitate formulation and treatment planning within the multidisciplinary team.

4.48 A People with stroke should be screened for visual changes by a professional with appropriate knowledge and skills, using a standardised approach.

2.8 M Before the transfer of care for a person with stroke from hospital to home (including a care home) they should be provided with:

- a named point of contact for information and advice;
- personalised written information in an appropriate format about their diagnosis, medication and management plan.

NICE Stroke rehabilitation in adults, 2023

1.8.1 Offer people who are in hospital after stroke a specialist orthoptist assessment as soon as possible. If this cannot be done before discharge, offer the person an urgent outpatient appointment.

3.1 Results visualisation	Interactive online portal (run charts not available); Static data files; Annual report; Patient report
3.2a Levels of reporting*	National; Trust or health board; Hospital or specialist unit; Integrated care system (ICS); NHS region or other geographic area; Other (please describe in next question)
3.2b If you selected 'Other' above, please provide details*	Ambulance trust
3.3 Timeliness of results feedback	Within 3 months
3.4 Link to dynamic reporting*	https://www.strokeaudit.org/Results2/Clinical-audit.aspx; https://www.strokeaudit.org/Results2/Organisational.aspx; https://www.strokeaudit.org/Results2/PostAcute2021.aspx
2023/24 Dataset covers the period FROM/TO (within financial year 01/04 to 31/03)*	01/04/2023 - 31/03/2024
2024/25 Dataset covers the period FROM/TO (within financial year 01/04 to 31/03)*	01/04/2024 - 31/03/2025

2025/26 Dataset covers the period FROM/TO (within financial year 01/04 to 31/03)*	01/04/2025 - 31/03/2026
Dataset #1 name	Clinical Dataset
Dataset #1 type*	Clinical audit
Dataset #1 population coverage*	All eligible patients
Dataset #1 use of existing national datasets	Hospital episode statistics (HES); Office for National Statistics (ONS)
Dataset #1 specification	Full core dataset available here: https://www.strokeaudit.org/Audits/Clinical-audit-information/Dataset-and-helpnotes.aspx Full helpnotes for questions within the dataset are available here: https://www.strokeaudit.org/Audits/Clinical-audit-information/Dataset-and-helpnotes.aspx Further detail, including FAQs and detailed technical information (such as how each indicator is calculated) are available via our Help centre - ssnap.zendesk.com specifically the Simplified Technical Guidance section: https://ssnap.zendesk.com/hc/en-us/categories/360003171177-Simplified-Technical-Guidance The dataset for pre-hospital data is available to download here: https://ssnap.zendesk.com/hc/en-us/articles/22204016016413-Ambulance-dataset-and-help-notes
Dataset #2 name	Organisational audit
Dataset #2 type*	Organisational audit
Dataset #2 specification	2021 dataset available here: https://www.strokeaudit.org/Audits/Acute-organisational-audit-information/Dataset-and-helpnotes.aspx 2021 dataset available here: https://www.strokeaudit.org/Audits/Post-acute-organisational-audit-information/Dataset-and-helpnotes.aspx
Dataset #3 name	Not applicable
Dataset #4 name	Not applicable
When was your healthcare quality improvement plan (referred to as a QI Plan) last reviewed? Please upload under	27/10/2023

'Files' below using the HQIP naming convention (click on response to see pop-up help text).	
When were your clinical performance indicators (referred to as metrics) signed off by funders? Please upload under 'Files' below using the HQIP template and naming convention (click on response to see pop-up help text).	06/08/2024
Please add the hyperlink to where your clinical performance indicators (referred to as metrics) are published on your project website.*	https://www.strokeaudit.org/Audits/Clinical-audit-information/Domains,-key-indicators-and-scoring.aspx
National report publication date (within calendar year 01/01 - 31/12/2023)*	09/11/2023
Published/planned national report publication date (within calendar year 01/01 - 31/12/2024)*	14/11/2024
Planned national report publication date (within calendar year 01/01 - 31/12/2025)*	13/11/2025
Please add the most recent date that you have reviewed and updated an online version of UPCARE Workstream section(s) on your project's website (click into the response to see pop-up guidance).	29/01/2025
Please add a hyperlink to UPCARE	https://www.strokeaudit.org/About/About-SSNAP.aspx

Workstream section(s) on your website (click into the response to see pop-up guidance).*

Files 20231027_SSNAP_HIplan.pdf

20240806 SSNAP metrics.xlsx