Timeline

Which patients are affected by the changes?

The changes will be implemented for patients with a clock start of the live date onwards (e.g. if the changes go live on the 1 July, then all patients with a clock start of 1 July 2021 onwards will have the new questions). For the six month assessment changes, the changes will be seen for all patients with a clock start 8 months prior to the live date (e.g. if the changes go live on the 1 July, then all patients with a clock start of 1 November 2020 onwards will have the new questions). We will inform teams of the final date once confirmed.

Section 2: Casemix – First 24hs

If you do CT & CTA & CTP together, do you still report the time of the beginning of the first of those?

As usual, please record the time of the first brain imaging in Q2.4. This should not change from your current practice.

If a more advanced method of imaging was undertaken during the patient's first visit to the Radiology Department/scanner, this should be recorded in Q2.4.1. For example, if a patient had a plain CT followed by a CT angiogram (CTA) followed by a CT perfusion (CTP) on the same first visit, the time of the plain CT would be recorded in Q2.4 and then "CT perfusion" will be chosen in Q2.4.1. If a patient only had a plain CT, the time of the plain CT would be recorded in Q2.4 and then "plain CT" will be chosen in Q2.4.1.

Teams will not lose their best practice tariff as they continue to record the time in Q2.4 in the same way as usual. For Q2.4.1, we are interested in the proportion of patients having more than a plain CT on their first visit.

Does the diagnosis of dementia need to be from a consultant or any other doctor?

This must be a formal diagnosis of dementia made by a specialist

Will the thrombectomy dataset changes in pilot 2021 be included in the dataset changes?

Yes, the thrombectomy changes will be included in the dataset update. The new thrombectomy questions will be circulated alongside the other changes.

Section 3: Assessments – First 24hs

What happens to patients who are too unwell to give consent within the first 72 hours?

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 or they could not give consent, please record "patient not asked".*

Patient identifiable information is not collected in Northern Ireland and so consent ***does not*** *need to be sought. Northern Ireland teams should record "patient not asked" for this question.*

Section 4: Acute and Community Therapy

Why are the rehab assistant minutes divided up by therapy professions when many work across the therapy disciplines in an integrated manner? Will the rehabilitation assistant minutes need to be inputted for each of the therapies and nursing?

SSNAP has always asked teams (both inpatient and non-inpatient) to record rehabilitation assistant minutes per discipline, including this in the total minutes and days for therapy in Section 4.

- *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*
- *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 minutes counts as 45 minutes of physiotherapy and 45 minutes of occupational therapy*
- *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)*

Do therapy TIs count as rehabilitation assistants or therapists?

This should include all non-registered rehabilitation or therapy assistants.

Most of our assistants provide therapy sessions alongside therapists. How would we break this down into individual minutes for the purpose of recording?

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)

Should the number of teletherapy minutes added to the therapist and assistant minutes equal to the total therapy minutes or is it a standalone figure?

The total number of minutes should be recorded in 4.6. This should include face-to-face and teletherapy, as well as therapy by qualified therapists and non-registered therapy assistants. In 4.6.1, teams should record how many of the total minutes in 4.6 were delivered by a rehabilitation assistant. In 4.6.2, teams should record how many of the total minutes in 4.6 were delivered by teletherapy.

Will the capture of the nursing minutes be for community settings only or also for non-routinely admitting sites (i.e., inpatient rehab settings)?

This will only be collected for non-inpatient teams.

Is community nursing intervention for nurses within the team or any nursing intervention?

This item should only record nursing from within your service. This relates to input provided by registered nurses and does not include care visits.

For the community nursing minutes - are these just the minutes relating to post-stroke care or including any ongoing nursing interventions from previous conditions (e.g.: chronic leg ulcers, etc)?

This item should only record nursing from within your service.

Community stroke teams in Northern Ireland usually only have stroke nurse specialists. Do we add specialist input/contacts alongside any district nursing minutes or should these be separate?

This item should only record nursing from within your service, and not from other sources of community nursing, including district nurses. Northern Ireland should record the stroke nurse specialists as "nursing minutes" but not nursing minutes from nurses outside the team.

Nursing - is this for actual nursing tasks? Our community stroke co-ordinators happen to be nurses at the moment but their role could be done by an AHP for example.

This relates to input provided by qualified nurses and does not include care visits.

For mood and cognition screens for community teams, will the webtool pre-populate with dates of the screens if already completed during the acute stay?

No, this data will not carry over from the acute teams. It is expected that the post-acute teams perform a mood and cognition screen.

Section 7: Discharge/Transfer

If the patient doesn't consent to share patient identifiable information, how is the record transferred to community providers?

You can still transfer the record on SSNAP and contact the community team to let them know that this patient does not have identifiable information. The patient will still have a unique SSNAP ID that can be used to search the patient on the SSNAP webtool.

Does consent, if given, overrule the national NHS data opt-out?

If a patient has agreed to a specific use of data, after being fully informed, then the national data opt-out does not apply. Even patients who have registered a national data opt-out can agree to take part in a specific research project or clinical trial, by giving their explicit consent.
https://digital.nhs.uk/services/national-data-opt-out/understanding-the-national-data-opt-out#do-you-have-explicit-consent-for-the-use-or-disclosure-

Does asking/not asking for consent affect scoring?

Consent will not be used in scoring.

Are there patient information leaflets available to download and give to patients when discussing consent?

Patient information sheets are available here: https://www.strokeaudit.org/PatientInfo.aspx

How do you anonymise the patient identifiable data on SSNAP?

Once "No, patient refused consent" is chosen for a consent question, the webtool will remove all patient identifiable information. The team does not need to do anything else. This includes: name, NHS number, hospital number, date of birth and postcode. The patient will still have a unique SSNAP ID that can be used to search the patient on the SSNAP webtool.

Section 8: Six-month assessment tool

Should there be an option for people who are still employed but not yet ready to return to work at the 6-month point?

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'.

Is there some training on the EQ5D that can be recommended?

The EuroQol website has resources and user guides: https://euroqol.org/eq-5d-instruments/eq-5d-5l-about/

Will the EQ-5D-5L be collected at any point on the pathway before 6 months?

For SSNAP purposes, EQ5D-5L will only be collected at 6 months.

Will we be using the Barthel at 6 months as a SSNAP measures?

In the current update, the Barthel is not included. Teams can use the custom fields function to record the Barthel score: https://ssnap.zendesk.com/hc/en-us/articles/115003834909-Custom-Fields

If the community team does not use the EQ5D-5L routinely, are we now asking them to start doing it as an extra tool?

EQ5D-5L will be mandatory on the webtool and will need to be answered for each 6 month assessment performed.

Post-acute providers can start records

If patients had their stroke and a prolonged stay abroad, with only limited inpatient care in the UK, and foreign data is limited. Is it better to start their record with the community team?

Due to the design of the webtool, records can only be started at the beginning of the pathway and cannot be started by teams later on. It is often the case that patients who suffered a stroke overseas and were transferred to a UK hospital cannot be entered on SSNAP, especially those that received prolonged care abroad. In these cases where the acute provider is not able to start a record on SSNAP, the post-acute provider will be permitted to start a record.

If the patient simply had the stroke abroad and was transferred to the UK for acute stroke care, the acute team can start the record as usual and then transfer to the community team.

Should post-surgery strokes be included on SSNAP?

Patients with a primary diagnosis of stroke coded as I61, I63 or I64 should be added onto SSNAP. Additionally, any patient who follows the stroke care pathway should be included on SSNAP. If a patient has a serious co-morbidity that would prevent them from following the stroke care pathway, these patients should be excluded from the SSNAP dataset.

The minimum age for patient submission to SSNAP is 16.

If a community provider adds a new record will all the acute questions be greyed out as we will not have access to this information?

The dataset for post-acute providers will be similar to sections 1, 4 and 7 in the existing dataset. All questions relevant only to acute providers will be greyed out.

If a patient does not have a SSNAP record due to only presenting in A&E/TIA clinic and not being admitted or their hospital bed was not in a stroke bed. Would this mean that community teams can start a record for this patient?

Every effort should be made by the acute team to start a record on SSNAP for patients who are admitted, even if they did not stay on the stroke unit (patients who are not admitted to hospital cannot be entered onto SSNAP). If the record has not been started by the acute team, then the post-acute provider can start the record.

Miscellaneous

Currently it is difficult to transfer patients back to acute when transferred incorrectly into the community. Will that process be made any easier for us?

The process will still remain the same: the acute team will need to contact the helpdesk (ssnap@kcl.ac.uk) and we can revoke the record back to them.

Data collection is more effective when easily accessible- any scope of SSNAP working with some electronic records providers like SystemOne to make this data collection easier?

SSNAP do have an import function allowing teams to input data via uploading a .csv file. Currently, only the first team that has seen a patient can upload the data for this team. We will keep this under constant review.

I'm from a community team, referrals are often sent late to our team and even if we see the patients the same day it looks like there is a gap of a few days because on SSNAP it goes by discharge date from the acute sector. Are there any plans to add in another question about delayed referrals?

We do not collect referral date on SSNAP. SSNAP are able to differentiate between the date the patient was discharged and the date that the record was transferred on SSNAP. A key component of audit compliance for inpatient teams is the: Number of days from patient transferred to next team to when the record is transferred on the webtool. If an acute team is taking an extended time to transfer the records to your team or they are not entering the right discharge date, you can contact our helpdesk (ssnap@kcl.ac.uk) for support.

ESD team struggles GP support, is there any plan to monitor GP input?

There are no plans to monitor GP input.

How is continence management monitored for SSNAP please?

Q6.5 asks for the date the urinary continence plan was drawn up

Can you please advise as more trusts move to ambulatory pathways for stroke patients, should these now be recorded on SSNAP?

All patients with a primary diagnosis of stroke coded as I61, I63 or I64 should be added onto SSNAP. The team that first admits the patient should start the SSNAP record. If your team is later down the pathway, you should request the first admitting team start the record and transfer you the record. If no acute record exists, the record can be started by the post-acute team using the new webtool function.

There is no appropriate way to reflect care given at an acute hospital if the first 72 hours is not recorded by the first hospital.

*The team that **first admits** the patient should start the SSNAP record and due to the design of the webtool records cannot be started by teams further down the pathway. Please email the SSNAP helpdesk ssnap@kcl.ac.uk to discuss further why the first hospital is not starting records.*