Royal College of Physicians | SSNAP

# Sentinel Stroke National Audit Programme (SSNAP)

Clinical audit August-November 2016

Public Report

## National results

**March 2017**

**Based on stroke patients admitted to and/or discharged from hospital between August-November 2016**

**Prepared by**

Royal College of Physicians, Clinical Effectiveness and Evaluation Unit on behalf of the Intercollegiate Stroke Working Party

Clinical audit

| | |
|---|---|
| Document purpose | To disseminate results for the process of stroke care for patients admitted and/or discharged in the period between August-November 2016. |
| Title | Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit August-November 2016 Public Report |
| Author | Royal College of Physicians, Clinical Effectiveness and Evaluation Unit on behalf of the Intercollegiate Stroke Working Party |
| Publication | March 2017 |
| Target audience | General public, stroke survivors and carers, health and social care professionals, stroke researchers |
| Description | This is a public report on the clinical component (process of care) of the national stroke audit, the Sentinel Stroke National Audit Programme (SSNAP). It publishes national and named team results on the quality of stroke care for patients admitted and/or discharged between 1 August and 30 November 2016. It covers many processes of care across the entire inpatient stay including comparisons with most recent reporting periods. The report findings enable the processes of stroke services at national level to be compared with national standards outlined in the fifth edition of the National Clinical Guideline for Stroke (2016) published by the Intercollegiate Stroke Working Party, the NICE (National Institute for Health and Clinical Excellence) Clinical Guidelines, the National Stroke Strategy 2007 and the NICE Quality Standards for Stroke (2016). |
| Supersedes | SSNAP Clinical Audit April-July 2016 public report |
| Related publications | National clinical guideline for stroke 5th edition (Royal College of Physicians, 2016): www.strokeaudit.org/guideline<br>National clinical guideline for stroke 5th edition patient version http://www.strokeaudit.org/Guideline/Patient-Guideline.aspx<br>SSNAP Clinical audit public report – April-July 2016 http://www.strokeaudit.org/results/National-Results.aspx<br>SSNAP Post-Acute Stroke Service Provider Audit https://www.strokeaudit.org/results/PostAcute/National.aspx<br>SSNAP Acute Organisational Audit Report – November 2016 https://www.strokeaudit.org/results/Organisational/National-Organisational.aspx<br>NICE Quality Standard for Stroke 2016: https://www.nice.org.uk/guidance/qs2<br>National Stroke Strategy (Department of Health, 2007): http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062<br>Department of Health: Progress in improving stroke care (National Audit Office, 2010): http://www.nao.org.uk/publications/0910/stroke.aspx<br>National Cardiovascular Outcomes Strategy: https://www.gov.uk/government/publications/improving-cardiovascular-disease-outcomes-strategy<br>CCG Outcomes Indictor Set 2015-16 https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/ |
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# Foreword

This report on the Sentinel Stroke National Audit Programme (SSNAP) uses data collected between August-November 2016. It includes named hospital results for the entire inpatient care pathway, where the numbers of patients entered in SSNAP for this period make this viable.

In this reporting period, 41 teams achieved an overall 'A' score in SSNAP, which indicates a world-class stroke service. That services are continually improving the stroke care provided to patients is evident from the fact for the January-March 2016 reporting period only 25 teams achieved an A grade.

The improvements in results are symptomatic of the continued efforts made by teams to use SSNAP data as a tool for continuously improving the quality of the stroke services they provide to patients. The genuine commitment to submitting timely and complete data each reporting period and acting on audit results to improve clinical care should be celebrated. Even more teams would have scored an 'A' if they had not been marked down because of issues around the timeliness and quality of data submission, which should be fairly easily solvable. These latest audit results reinforce our belief that although SSNAP has set stringent, aspirational targets the top score is achievable and sustainable over time.

It is encouraging to see that steady and continuous improvements are being made across each scoring level and there has been yet another decrease in the number of services scoring an 'E' across the reporting period. SSNAP reports audit results in absolute terms which means that all teams are capable of showing improvement. The quality of data submitted to SSNAP, measured in terms of audit compliance, has also improved each reporting period, which is essential in providing meaningful audit results.

At national level, we are seeing improvements period-on-period in the results for stroke care, both in the acute processes of care, including rapid scanning, thrombolysis provision, and access to a stroke unit, and in the standards and processes of care by discharge. However, there is unacceptable variation across the country. Six month assessments after stroke are not available to all patients and the number of cases completed to six months remains low when compared to the levels of case ascertainment in the acute phase of SSNAP. This is concerning and something that should be continuously monitored. Section 7 reports on six month assessment provision in more detail.

Congratulations to everyone who has contributed to the data presented in this report. It is a fantastic achievement that roughly 27,000 patient records are available for analysis this reporting period. We estimate that approximately 80,000 patients are admitted to hospital with stroke per year so we are achieving very high levels of case ascertainment. Complete and high quality data will be extremely powerful in shaping the future developments in stroke care in England, Wales and Northern Ireland. They will enable a much stronger case to be made for improvements and greatly help patients, commissioners and clinicians alike get the best out of the services.

We have received numerous case studies from stroke care providers outlining how they have used the data to improve their services. It is motivating and encouraging to see that our reporting outputs are valued and we hope to see continued improvements in results in future reporting periods.

**Professor Anthony Rudd FRCP CBE**
Clinical Director of RCP Stroke Programme

# Introduction to SSNAP

The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit and post-acute organisational audit. This document outlines findings from the clinical audit and through clinical commentary, contextualises this data. This report presents a national overview of stroke care across England, Wales and Northern Ireland and is intended to be accessed by members of the public with an interest in stroke care as well as by health care professionals.

## How to read this report

**National results (out of all patients submitted to the audit in England, Wales, Northern Ireland and the Islands):** In this report national results are presented as percentages, medians and interquartile ranges (IQR). The median is the middle point of the data; 50% of patients' results lie on either side. The interquartile range is the middle half of values; the bottom 25% of patients' results are below this range and the top 25% of patients' results are above this range. Unless otherwise stated in the report, 100% is the optimal performance and the higher the percentage, the higher the quality of care. For timings, the shorter the median time to intervention the better the care.

**Clinical Commentary:** This report contains clinical commentary from the Stroke Programme Clinical Director, Professor Tony Rudd.

**No, but…answers**: The diversity of effects from a stroke creates difficulties for clinical management and for determining overall standards of care. The audit therefore designated specified circumstances where standards would not be applicable. The full wording of questions can be found in Appendix 2.

**Compliance rates**: The compliance rate is recorded as a percentage, with 100% being optimal (unless otherwise stated). The denominators for the compliance rates are those cases for whom the standards applied, i.e. any *No, but…* exceptions have not been included in the calculations of compliance. There are some time-points along the stroke pathway at which the concept of applicability is not relevant (i.e. when all patients are deemed applicable for a standard). Please see the technical guidance on the final tab of the 'Full results portfolio' for more details (www.strokeaudit.org/results/national).

**Reference numbers:** These refer to the position in the accompanying MS Excel spreadsheets where individual team level results for standards and indicators can be found.

**'Patient-centred' and 'team-centred' results:** SSNAP reports on the processes of care and patient outcomes in two ways; 'patient centred' and 'team centred'. 'Patient centred' attribute the results to every team which treated the patient at any point in their care. A team's patient-centred results demonstrate the quality of care that their patients received across the whole inpatient care pathway, regardless of how many teams each patient went to, or which of the teams provided each aspect of care. 'Team centred' attribute the results to the team considered to be most appropriate to assign the responsibility for the measure to. In Section 1 (national level domains and scoring), it is clearly stated whether team- or patient-centred results are being presented. In Section 8 (domains and scoring by named team), both team- and patient-centred results are provided.

Both patient-centred and team-centred results are presented on separate tabs in the accompanying full results portfolio. For the majority of cases, the national level results in this PDF report will match those in *both* the patient-centred and team-centred results tab in the portfolio. One exception is therapy provision, where the national level patient-centred and team-centred results differ. National level results for therapy intensity in Section 5 of this report are patient centred. For comparisons between an individual team's performance (team-centred results) with the national, please refer to the team-centred national results in the post 72 hour 'team centred' tab of the portfolio.

## Background

The Sentinel Stroke National Audit Programme (SSNAP) has been collecting and reporting on the processes of stroke care since June 2013. The Clinical Effectiveness and Evaluation Unit (CEEu) in the Care Quality and Improvement Department of the Royal College of Physicians first conducted the National Sentinel Stroke Audit (NSSA) in 1998 (www.rcplondon.ac.uk/sentinel) and subsequently a total of 7 rounds were undertaken with 100% participation achieved since 2006. SSNAP combines the NSSA and the Stroke Improvement National Audit Programme (SINAP) which audited care in the first 72 hours after stroke between 2010 and 2012. (www.rcplondon.ac.uk/sinap).

### Aims of this report

- To publish national and team level results for the entire inpatient stroke care pathway in the public domain.
- To allow comparisons to be made between the latest results and the previous three reporting periods.
- To describe the methods for calculating the pre-existing or upcoming national measures for stroke in England: the CCG Outcomes Indicator Set; and NICE Quality Standard for Stroke measures.

### Organisation of this report

- Summary of overall performance by domains and key indicators (Section 1)
- National level results for patient casemix (Section 2)
- National level results for processes of care in the first 72 hours (Section 3)
- National level results for processes of care by discharge (Section 4)
- National level results for therapy intensity (Section 5)
- Early Supported Discharge and Community Rehabilitation Results (Section 6)
- Six month follow-up assessments (Section 7)
- SSNAP Performance Tables (by named team) (Section 8)

### Supplementary reporting outputs

With the exception of Section 8, this PDF report presents national level results. Detailed results by named teams are available on the SSNAP Reporting Portal www.strokeaudit.org/Results/National including:

- **Summary results spreadsheet:** An overview of performance by reporting 44 Key Indicators within 10 domains of care by named team.
- **Full results portfolio:** A very detailed reference document which includes 72 hour and discharge results for SSNAP data item by named team in addition to information about casemix, patient cohorts and pathways, and inter-team variation.

- **Regional slideshows:** Hospital and ESD/CRT results are grouped by region and presented in graphs.
- **Dynamic maps:** Allow you to find information about stroke services for your local provider. You can compare different standards of care within your team, and compare your local provider to other providers and against regional and national averages. www.strokeaudit.org/results/Clinical-audit/maps

## Key indicators, domains and scoring

**44 Key Indicators** have been chosen by the ICSWP as representative of high quality stroke care. These include data items included in the CCG Outcomes Indicator Set and NICE Quality Standards (covering England only). The key indicators are grouped into **10 domains** covering key aspects of the process of stroke care. Both patient-centred domain scores (whereby scores are attributed to every team which treated the patient at any point in their care) and team-centred domain scores (whereby scores are attributed to the team considered to be most appropriate to assign the responsibility for the measure to) are calculated.

## Evidence based standards and indicators

SSNAP is the single source of data for stroke in England and Wales. It provides the data for all other statutory data collections in England including the NICE Quality Standard and is the chosen method for collection of stroke measures in the NHS Outcomes Framework and the CCG Outcomes Indicator Set. SSNAP metrics are aligned with those in the Cardiovascular Disease Outcomes Strategy. SSNAP data are being used as risk indicators for Care Quality Commission's Intelligent Monitoring and for the Stroke Care in England NHS Marker.

The results from this 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. No references have been quoted in this report for reasons of space. All relevant evidence and standards are available in the following:

- National clinical guideline for stroke 5th edition (Royal College of Physicians, 2016) www.strokeaudit.org/guideline
- National clinical guideline for diagnosis and initial management of acute stroke and transient ischaemic attack (NICE, 2008) https://www.nice.org.uk/guidance/CG68
- Stroke rehabilitation: Long-term rehabilitation after stroke (NICE 2013): www.nice.org.uk/CG162
- NICE Quality Standard for Stroke 2016 https://www.nice.org.uk/guidance/qs2

## Datasets and methodology

A core, minimum dataset (Appendix 2) was developed by the ICSWP in collaboration with key stakeholders. Prospective data were collected via a secure web-based tool provided by Net Solving Ltd. Security and confidentiality are maintained through the use of passwords and a person specific registration process. Detailed help notes and FAQs are provided to ensure standard interpretation of the dataset questions across all participants. Data are analysed by the Stroke Programme at the Royal College of Physicians.

Only 'locked' data are included in SSNAP analysis. The process of locking ensures high data quality and signifies that the data have been signed off by the lead clinician and are ready for central analysis.

To view the SSNAP core dataset and help-notes, and for more details about the methods of data collection, submission and analysis, please visit https://www.strokeaudit.org/Support/Datasets.aspx

## Eligibility and audit scope

SSNAP aims to measure the quality of stroke care along the patient pathway from initial admission, through all subsequent locations, up to and including six month assessment. Teams which treat at least 10 stroke patients a year at any point up to six months are eligible to participate. Data are therefore collected by different types of teams along the stroke pathway. These include:

- Routinely admitting acute teams (teams which admit stroke patients directly for acute stroke care)
- Non-routinely admitting acute teams (teams which do not generally admit stroke patients directly but continue to provide care in an acute setting when patients have been transferred from place of initial treatment)
- Non-acute inpatient teams (teams which provide inpatient rehabilitation in a post-acute setting e.g. community hospitals)
- Post-acute non inpatient teams (these teams include early supported discharge and community rehabilitation teams)
- Six month assessment providers.

100% of routinely admitting teams and non-routinely admitting acute teams in England, Wales, Northern Ireland, and the Islands are registered on SSNAP. Recruitment of post-acute teams and teams providing six month assessments is continuing. Given the fact that these teams have not previously participated in national stroke audit there has been a slower uptake but more post-acute teams are submitting data to the audit each reporting period.

# Section 1: Summary of domain and key indicator results

This section provides a summary of performance at national level. It is based upon results for **44 key indicators** which are grouped into **10 domains** covering key aspects of stroke care (for more information see the section at the end of the report).

The section begins with the **overall SSNAP score** calculated as follows:

- **Domain levels** are combined into separate patient-centred and team-centred **total key indicator scores**
- A **combined total key indicator score** is derived from the average of these two scores
- This combined score is adjusted for **case ascertainment** and **audit compliance**

Themes covered by the SSNAP domains:

- Domain 1: Scanning
- Domain 2: Stroke unit
- Domain 3: Thrombolysis
- Domain 4: Specialist assessments
- Domain 5: Occupational therapy
- Domain 6: Physiotherapy
- Domain 7: Speech & language therapy
- Domain 8: MDT working
- Domain 9: Standards by discharge
- Domain 10: Discharge processes

Unless otherwise stated, 100% is the optimal performance. For timings, the shorter the median time to intervention the better. More information is available in the technical annex of the full results portfolio.

## SSNAP Level

**Distribution of SSNAP levels across inpatient teams**

| | Three month reporting | | | | | | Four month reporting | |
|---|---|---|---|---|---|---|---|---|
| **SSNAP levels:** | **Oct – Dec 2014 204 teams** | **Jan – Mar 2015 201 teams** | **Apr - Jun 2015 206 teams** | **Jul – Sep 2015 206 teams** | **Oct – Dec 2015 215 teams** | **Jan-Mar 2016 213 teams** | **Apr-Jul 2016 228 teams** | **Aug-Nov 2016 218 teams** |
| A | 16 (8%) | 11 (5%) | 14 (7%) | 36 (17%) | 26 (12%) | 25 (12%) | 42 (18%) | 41 (19%) |
| B | 27 (13%) | 36 (18%) | 41 (20%) | 43 (21%) | 56 (26%) | 46 (22%) | 59 (26%) | 60 (28%) |
| C | 43 (21%) | 39 (19%) | 48 (23%) | 38 (18%) | 47 (22%) | 50 (23%) | 53 (23%) | 64 (29%) |
| D | 89 (43%) | 92 (46%) | 82 (40%) | 73 (35%) | 72 (33%) | 77 (36%) | 62 (27%) | 49 (22%) |
| E | 29 (15%) | 24 (12%) | 21 (10%) | 16 (8%) | 14 (7%) | 15 (7%) | 12 (5%) | 4 (2%) |

### Explanation of grading:

A = First class service

B = good or excellent in many aspects

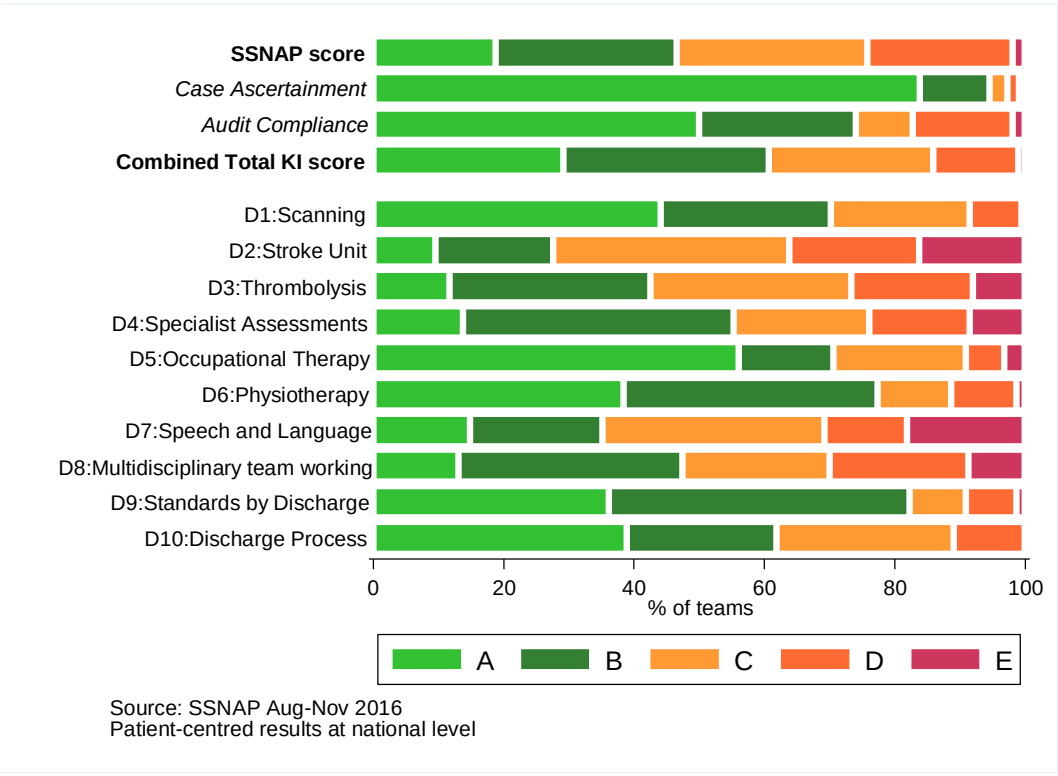
C = reasonable overall - some areas require improvement

D = several areas require improvement

E = substantial improvement required

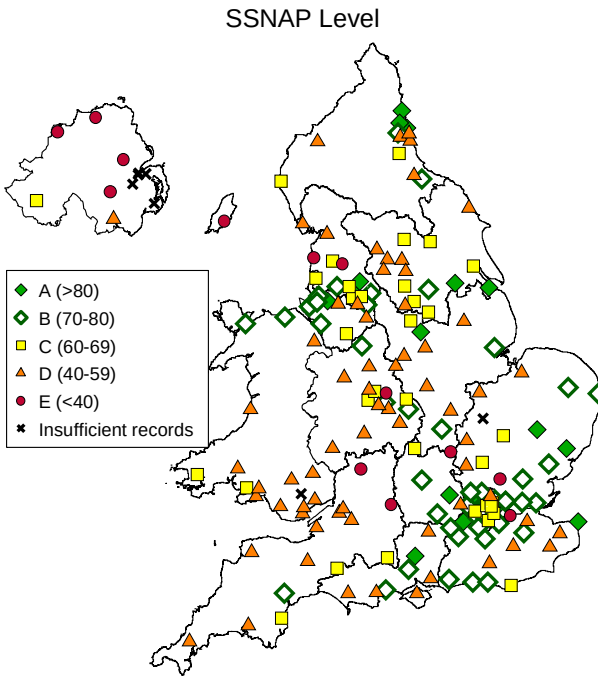
### National expectation:

Teams are expected to achieve an A or B SSNAP grade, such scores are indicative of world-class stroke care and a good or excellent service in many aspects respectively. A SSNAP score of a C or less would suggest that some or several areas of care require improvement.

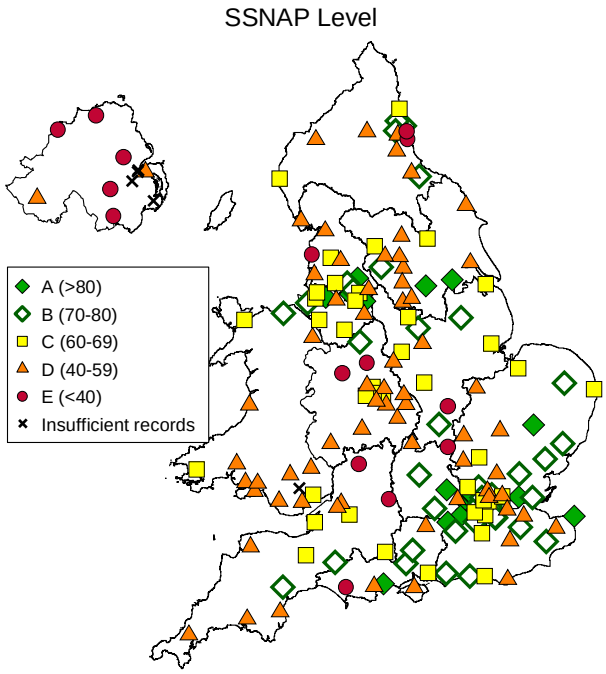



Source: SSNAP Aug-Nov 2016
Patient-centred results at national level

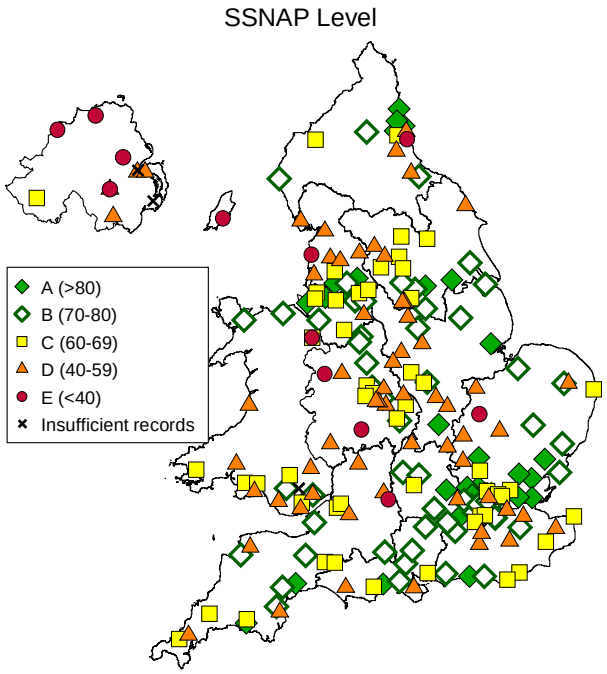
The maps below show the SSNAP level achieved by all *inpatient teams* in England, Wales, and Northern Ireland for the last four reporting periods. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or no records are highlighted with an **X**.



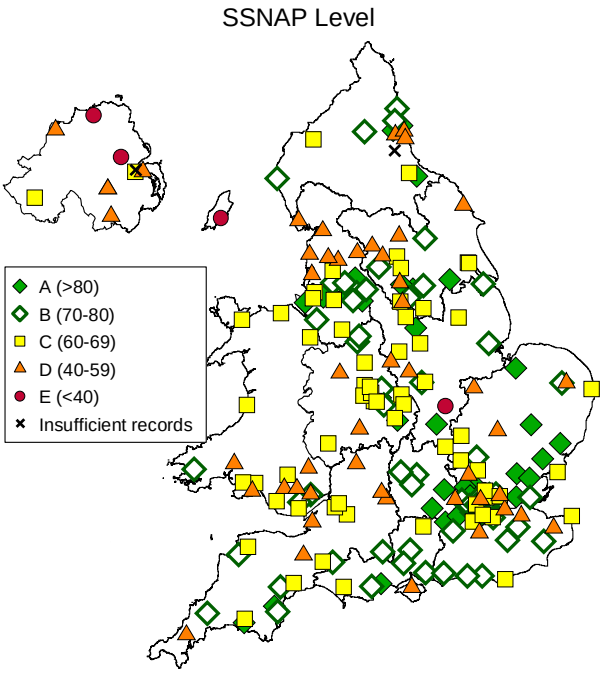

Source: SSNAP Oct-Dec 2015




Source: SSNAP Jan-Mar 2016




Source: SSNAP Apr-Jul 2016




Source: SSNAP Aug-Nov 2016

You may also be interested in…

SSNAP domain and key indicator results are also available in the form of interactive maps on the SSNAP Reporting Portal (www.strokeaudit.org/results/Clinical-audit/maps). These dynamic maps enable comparisons between standards of care within teams, and compare local providers against regional and national averages.

## Domain 1: Scanning

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.3.1**

**E** Acute stroke services should have continuous access to brain imaging including CT angiography and should be capable of undertaking immediate brain imaging when clinically indicated.

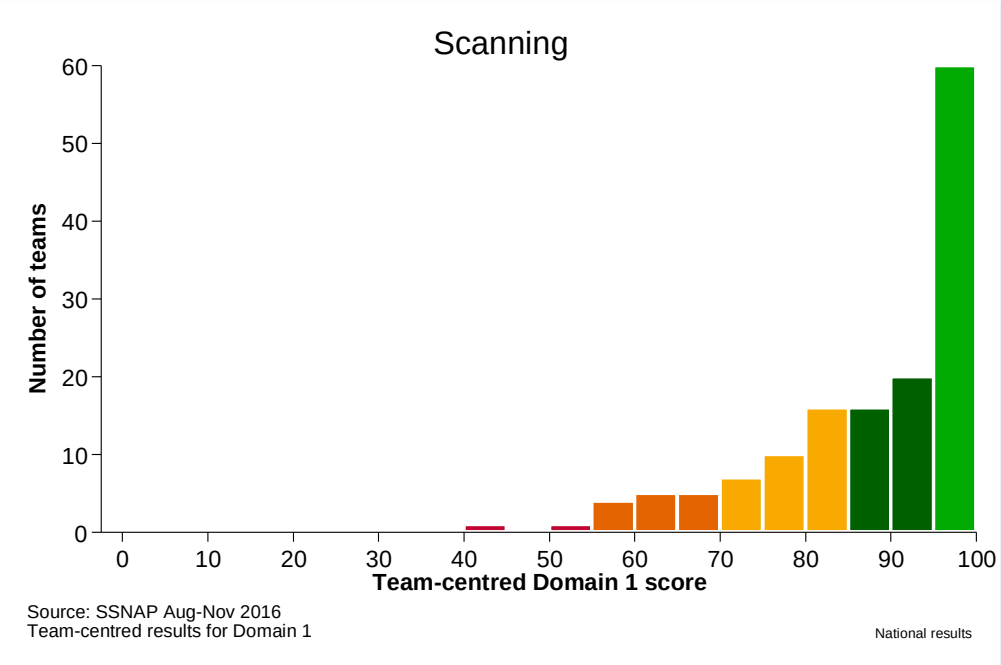
**3.4.1**

**B** Patients with suspected acute stroke should receive brain imaging urgently and at most within 1 hour of arrival at hospital.

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Domain 1: Brain Scanning – Key indicators** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients scanned within 1 hour of clock start* | 48.2% | 48.4% | 50.8% | 50.7% |
| Percentage of patients scanned within 12 hours of clock start | 91.8% | 92.6% | 93.2% | 93.5% |
| Median time between clock start and scan | 1h 04m | 1h 04m | 59m | 59m |

*The RCP 2016 National Clinical Guideline for Stroke outlined that all patients should be scanned within 1 hour

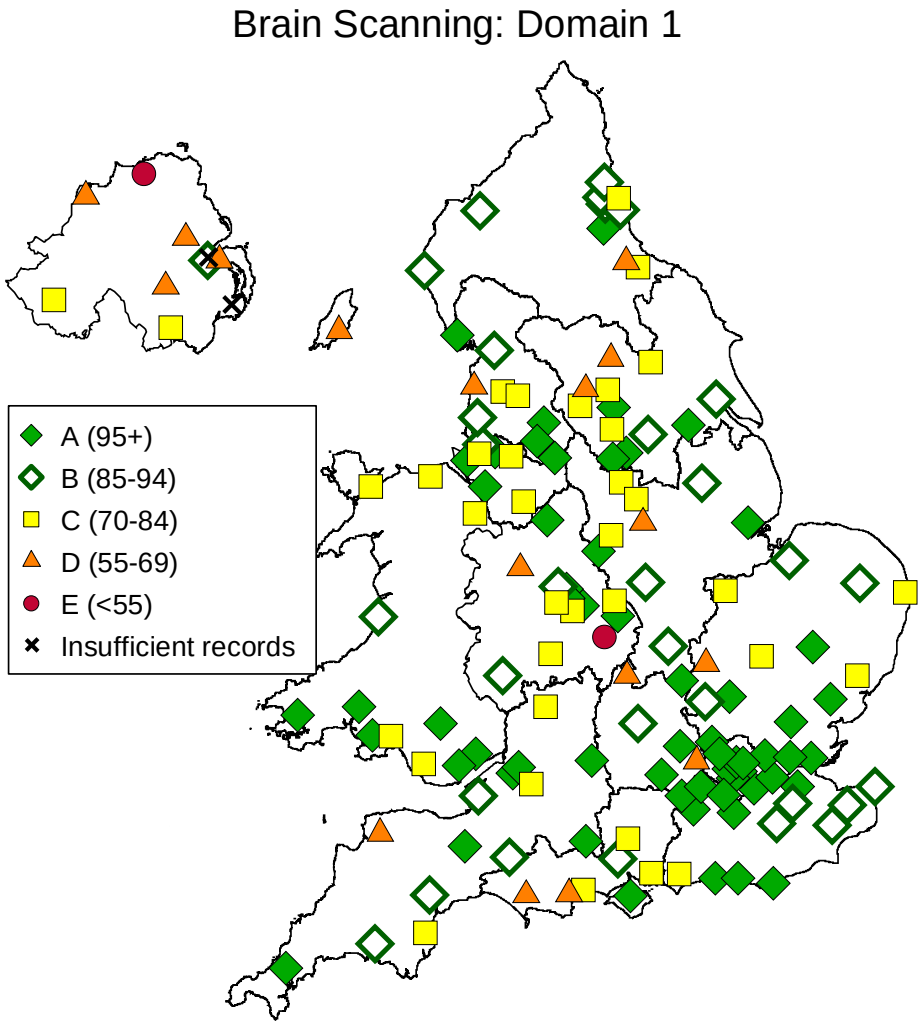
**Distribution of scores across all routinely admitting teams for Domain 1 (147 teams)**



| SSNAP D1 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 53 teams (35%) | 51 teams (35%) | 60 teams (41%) | 60 teams (42%) |
| B | 31 teams (20%) | 33 teams (22%) | 32 teams (22%) | 35 teams (24%) |
| C | 34 teams (22%) | 38 teams (26%) | 36 teams (24%) | 34 teams (24%) |
| D | 22 teams (14%) | 17 teams (12%) | 17 teams (12%) | 13 teams (9%) |
| E | 12 teams (8%) | 8 teams (5%) | 2 teams (1%) | 2 teams (1%) |

Over half of teams are now achieving A or B levels for scanning, and only 2 teams are currently in band E.

The map below shows the team centred performance of all *routinely admitting teams* for Domain 1. Each symbol represents a team, colour coded by the overall score achieved.




Source: SSNAP Apr-Jul 2016 (Team Centred)

Scanning is necessary for a diagnosis. There is no benefit in delaying a scan and it is more cost effective to scan immediately, so it is encouraging to see that more people are having a scan more quickly. The 2016 guideline now recommends brain scanning within one hour of arrival in hospital so improvements in scan availability will need to continue.

## Domain 2: Stroke Unit

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.2.1**

**B** People with an acute neurological presentation suspected to be a stroke should be admitted directly to a hyperacute stroke unit which cares predominantly for stroke patients.

**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 neighbouring hospital, to monitor and regulate basic physiological functions such as neurological status, blood glucose, oxygenation, and blood pressure.
**D** Acute hospitals that admit people with stroke should have immediate access to a specialist stroke rehabilitation unit on site or at a neighbouring hospital.

**2.3.1**

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

**2.4.1**

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

**K** A facility that provides treatment for in-patients 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.

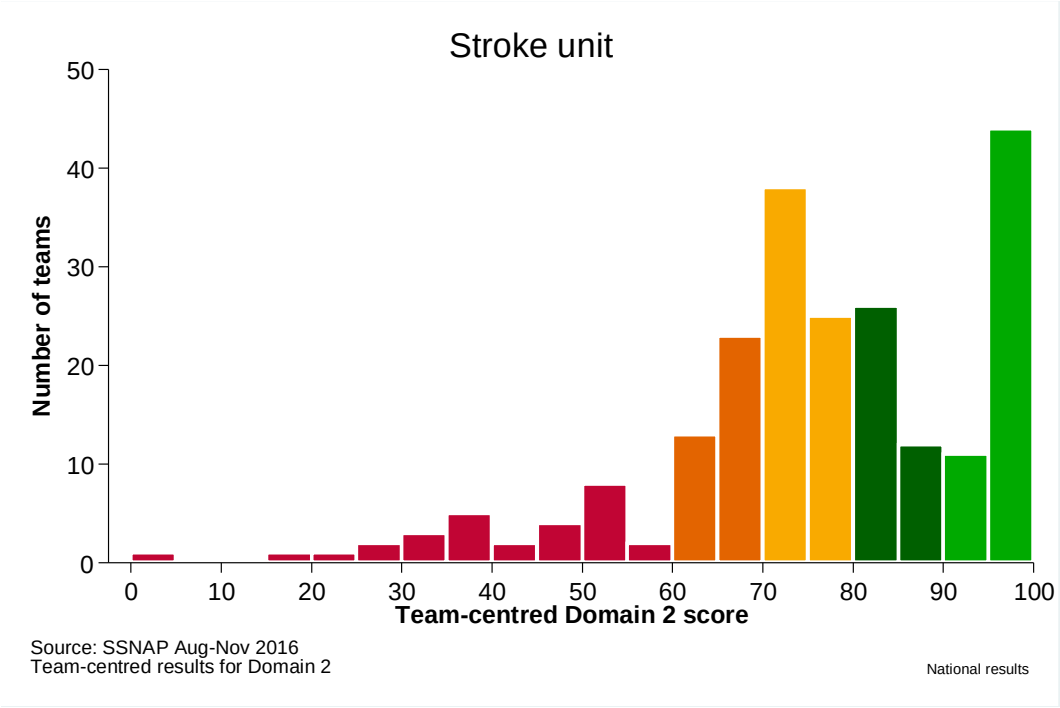
*NICE Quality Standards*

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.

[2010, updated 2016]

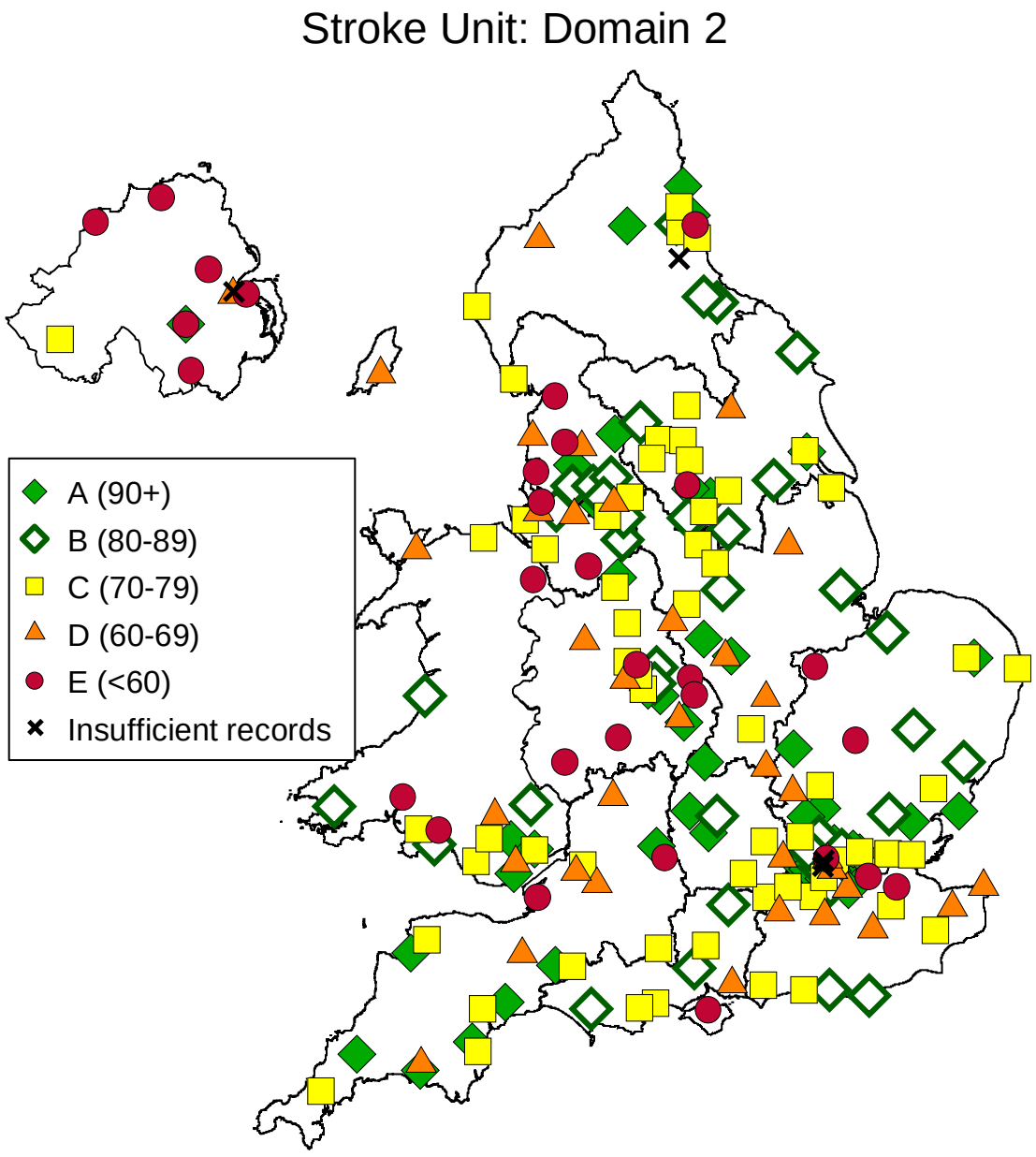
| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key indicators: Stroke unit** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients directly admitted to a stroke unit within 4 hours of clock start (CCG OIS) | 59.8% | 54.0% | 59.3% | 58.5% |
| Median time between clock start and arrival on stroke unit | 3h 35m | 3h 51m | 3h 35m | 3h 38m |
| Percentage of patients who spent at least 90% of their stay on stroke unit | 84.4% | 82.4% | 84.0% | 84.8% |

**Distribution of scores across all inpatient teams for Domain 2 (220 teams)**



| D2 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 49 teams (22%) | 46 teams (21%) | 59 teams (26%) | 55 teams (25%) |
| B | 39 teams (18%) | 32 teams (15%) | 42 teams (18%) | 38 teams (17%) |
| C | 67 teams (31%) | 50 teams (23%) | 58 teams (25%) | 62 teams (28%) |
| D | 35 teams (16%) | 38 teams (18%) | 38 teams (17%) | 36 teams (16%) |
| E | 28 teams (13%) | 49 teams (23%) | 31 teams (14%) | 29 teams (13%) |

The map below shows the team centred performance of all *inpatient teams* for Domain 2. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.




Source: SSNAP Aug-Nov 2016 (Team Centred)

## Domain 3: Thrombolysis

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

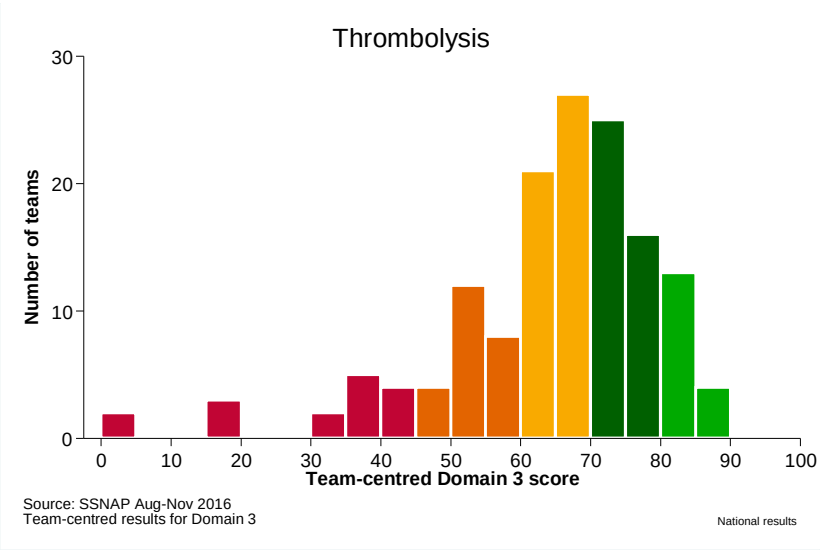
**3.5.1A** Patients with acute ischaemic stroke, regardless of age or stroke severity, in whom treatment can be started within 3 hours of known onset should be considered for treatment with alteplase.

**3.5.1E** Alteplase 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.

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key indicators: Thrombolysis** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of all stroke patients given thrombolysis (all stroke types) (CCG OIS C3.6) | 11.0% | 11.4% | 11.9% | 11.5% |
| Percentage of eligible patients given thrombolysis (according to the Royal College of Physicians (RCP) guideline minimum threshold) | 85.6% | 85.7% | 87.7% | 88.1% |
| Percentage of patients who were thrombolysed within 1 hour of clock start, if thrombolysed | 57.9% | 58.6% | 61.4% | 63.0% |
| Percentage of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given | 59.4% | 53.7% | 58.9% | 58.1% |
| Median time between clock start and thrombolysis (minutes) | 55m | 54m | 52m | 51m |

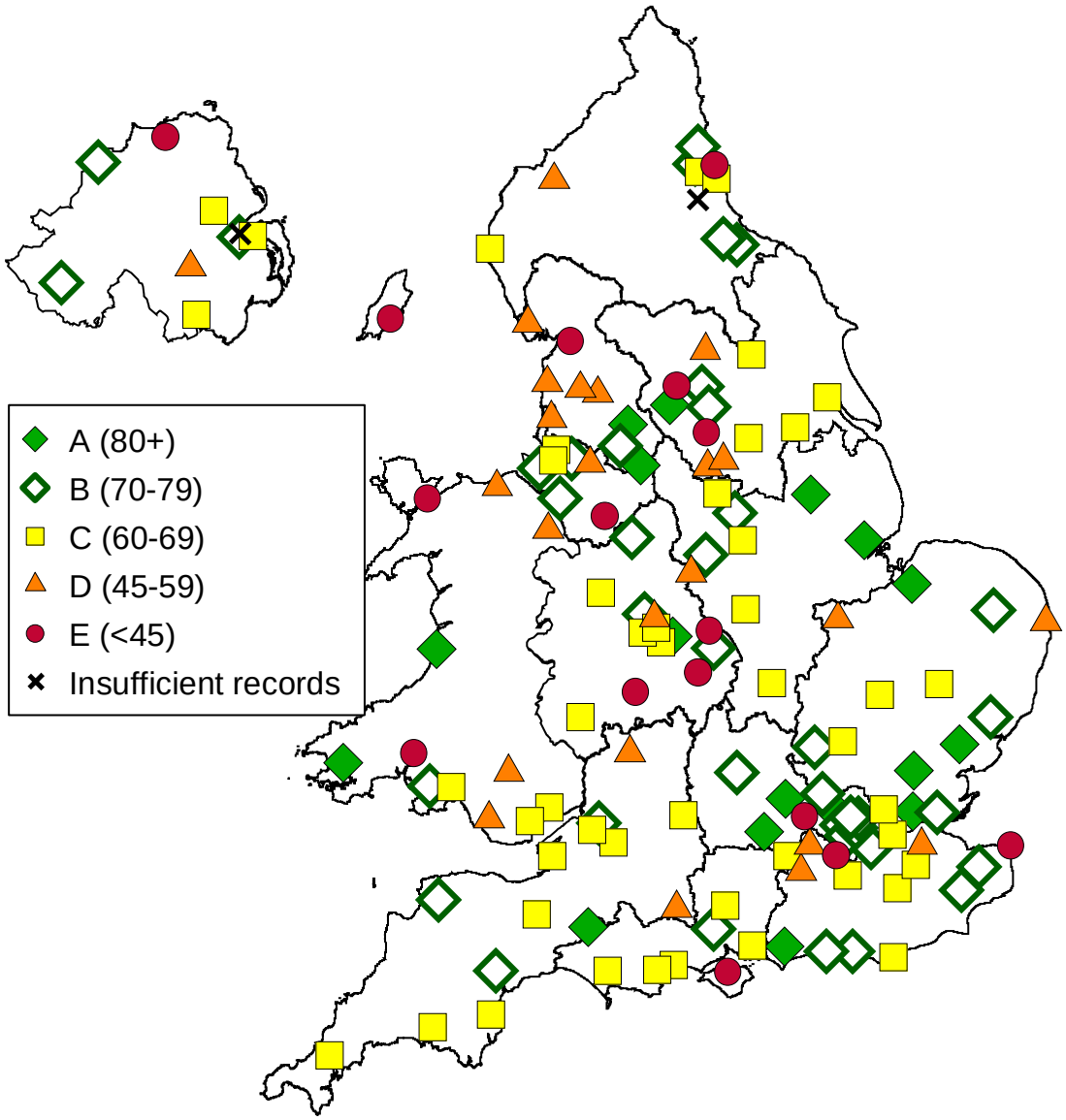
**Distribution of Domain 3 level across routinely admitting teams (143 teams)**




| D3 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 10 teams (7%) | 11 teams (8%) | 13 teams (9%) | 17 teams (12%) |
| B | 38 teams (26%) | 36 teams (25%) | 45 teams (31%) | 39 teams (27%) |
| C | 41 teams (28%) | 39 teams (27%) | 38 teams (26%) | 47 teams (33%) |
| D | 37 teams (25%) | 42 teams (29%) | 36 teams (25%) | 24 teams (17%) |
| E | 21 teams (14%) | 18 teams (12%) | 13 teams (9%) | 16 teams (11%) |

The map below shows the team centred performance of all *routinely admitting teams* for Domain 3. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.

## Thrombolysis: Domain 3




Source: SSNAP Aug-Nov 2016 (Team Centred)

## Domain 4: Specialist Assessments

### What should be done?

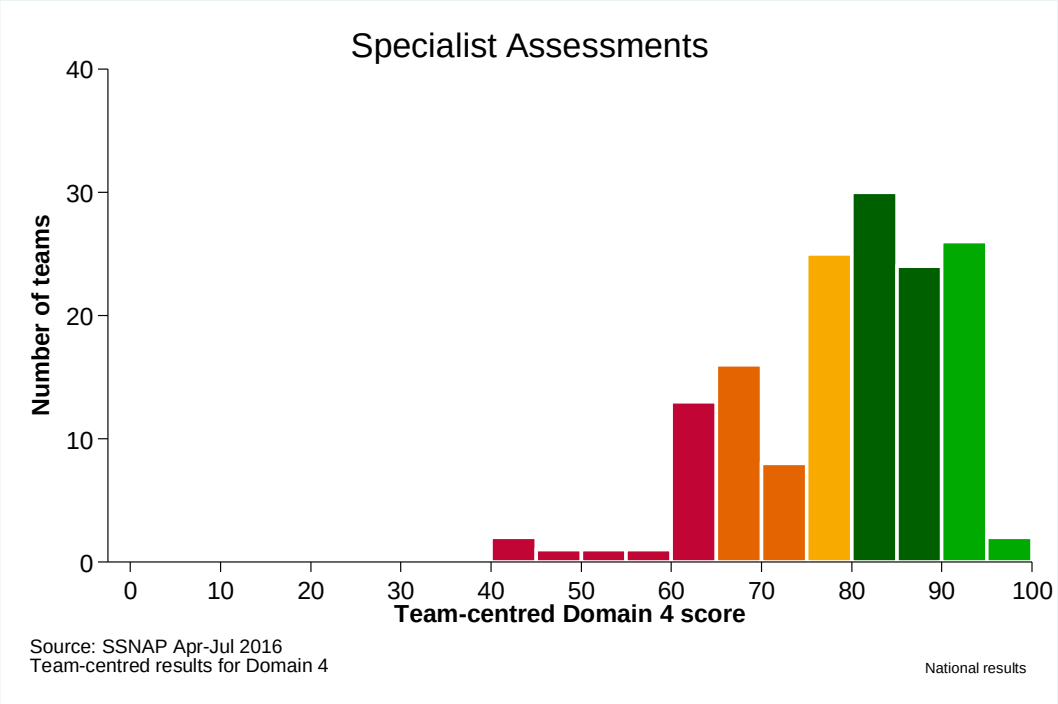
*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.3.1B** People with suspected acute stroke (including when occurring in people already in hospital) should be admitted directly to a hyperacute stroke unit and be assessed for emergency stroke treatments by a specialist physician without delay.

**3.10.1E** 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.

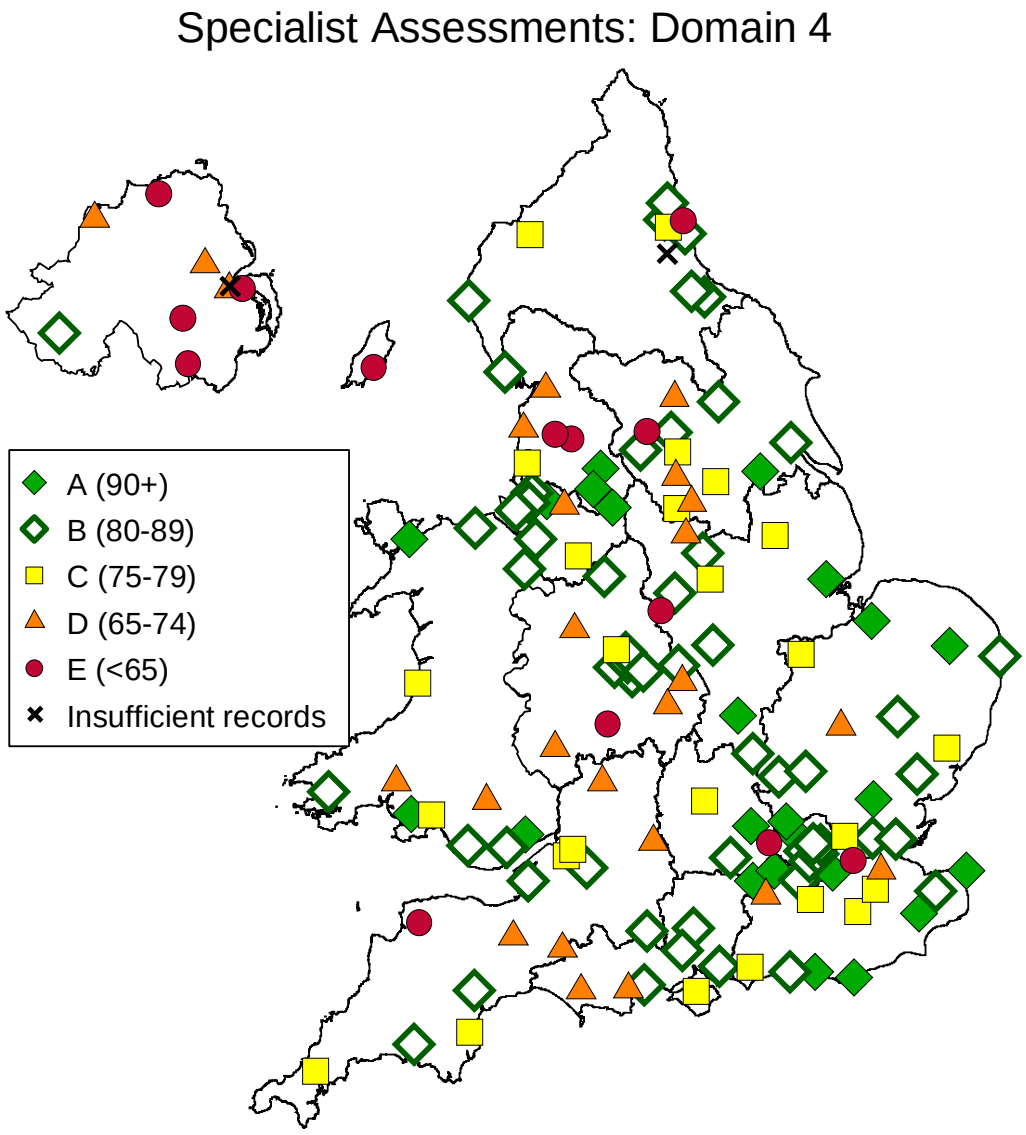
| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Specialist Assessments** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients who were assessed by a stroke specialist consultant physician within 24h of clock start | 78.7% | 79.1% | 80.5% | 81.9% |
| Median time between clock start and being assessed by stroke consultant | 12h 17m | 12h 03m | 11h 29m | 11h 09m |
| Percentage of patients who were assessed by a nurse trained in stroke management within 24h of clock start | 88.8% | 89.0% | 89.8% | 90.1% |
| Median time between clock start and being assessed by stroke nurse | 1h 26m | 1h 30m | 1h 15m | 1h 16m |
| Percentage of applicable patients who were given a swallow screen within 4h of clock start | 72.0% | 71.2% | 74.4% | 74.0% |
| Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start | 83.8% | 84.5% | 87.5% | 87.2% |

**Distribution of Domain 4 level across routinely admitting teams (144 teams)**




| D4 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 20 teams (13%) | 17 teams (12%) | 28 teams (19%) | 23 teams (16%) |
| B | 46 teams (30%) | 52 teams (35%) | 52 teams (35%) | 57 teams (40%) |
| C | 22 teams (14%) | 25 teams (17%) | 25 teams (17%) | 25 teams (17%) |
| D | 38 teams (25%) | 33 teams (22%) | 24 teams (16%) | 25 teams (17%) |
| E | 26 teams (17%) | 20 teams (14%) | 18 teams (12%) | 14 teams (10%) |

The map below shows the team centred performance of all *routinely admitting teams* for Domain 4. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol




Source: SSNAP Aug-Nov 2016 (Team Centred)

## Domain 5: Occupational Therapy

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.11.1A** People with stroke should accumulate at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.

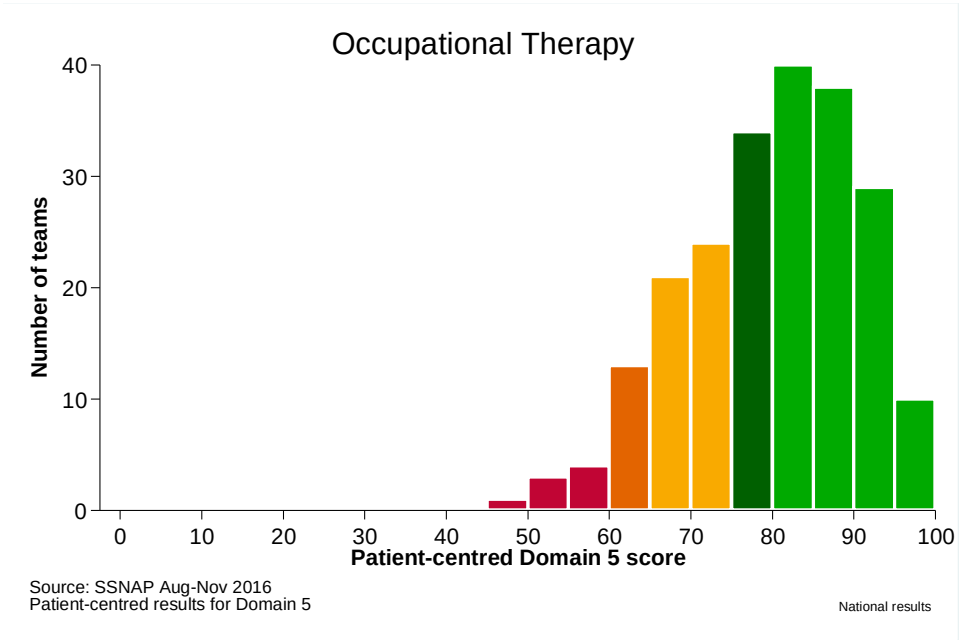
*NICE Quality Standards*

Statement 2: Adults having stroke rehabilitation in hospital or in the community are offered at least 45 minutes of each relevant therapy for a minimum of 5 days a week.

[2010, updated 2016]

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Occupational Therapy** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients reported as requiring occupational therapy | 83.6% | 83.6% | 83.5% | 83.6% |
| Median number of minutes per day on which occupational therapy is received | 41.3 mins | 40.0 mins | 40.0 mins | 40.7 mins |
| Median % of days as an inpatient on which occupational therapy is received | 63.5% | 61.7% | 62.3% | 64.9% |
| Proxy for 2016 NICE Quality Standard Statement 2: % of the minutes of occupational therapy required (according to 2016 NICE QS-S2) which were delivered | 85.1% | 80.2% | 80.9% | 85.9% |

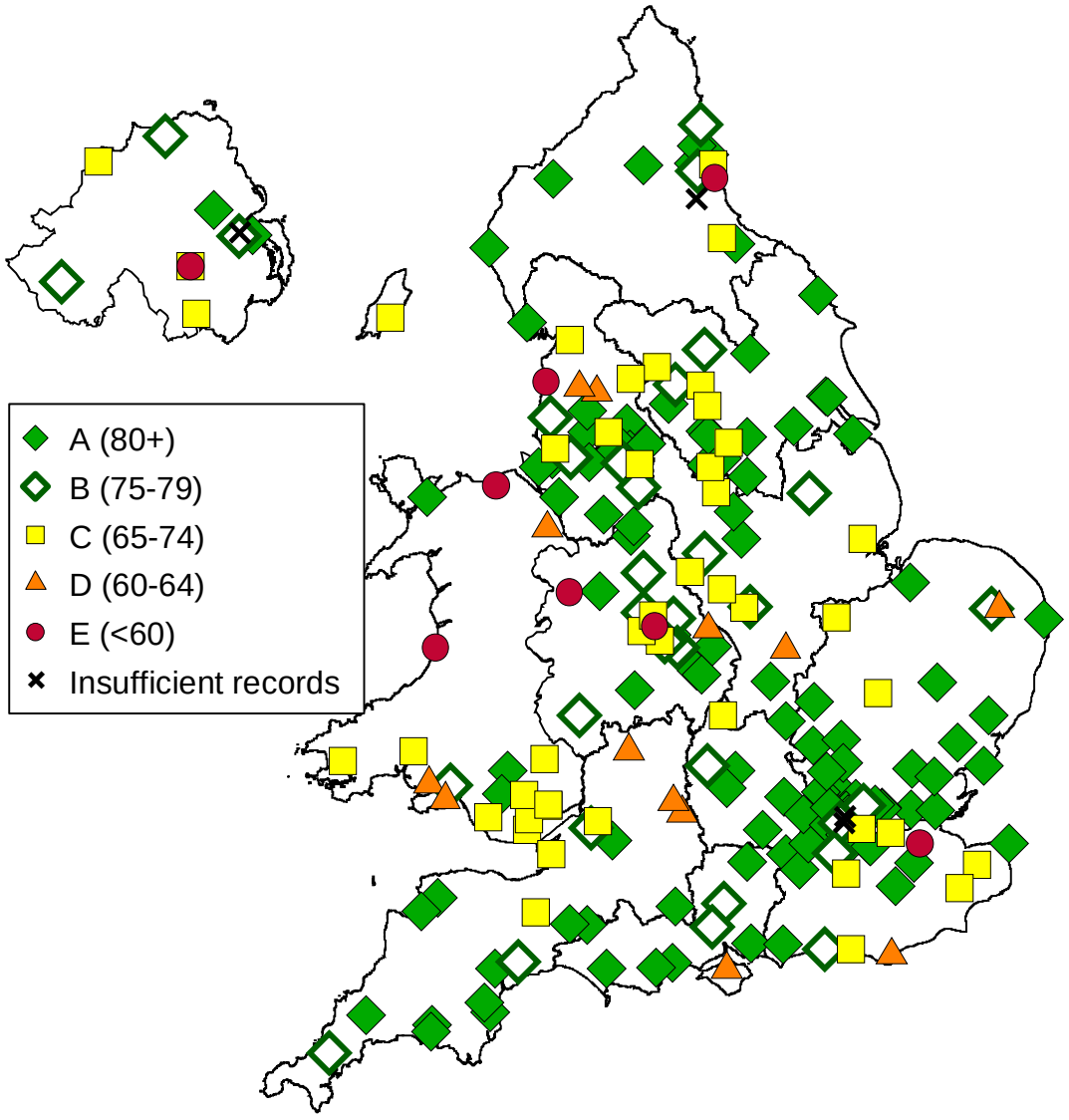
**Distribution of Domain 5 level across all inpatient teams (221 teams)**



| D5 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 118 teams (55%) | 104 teams (49%) | 119 teams (52%) | 123 teams (56%) |
| B | 38 teams (18%) | 39 teams (18%) | 32 teams (14%) | 32 teams (14%) |
| C | 38 teams (18%) | 48 teams (23%) | 50 teams (22%) | 45 teams (20%) |
| D | 13 teams (6%) | 14 teams (7%) | 14 teams (6%) | 13 teams (6%) |
| E | 8 teams (4%) | 8 teams (4%) | 13 teams (6%) | 8 teams (4%) |

The map below shows the patient centred performance of all *inpatient teams* for Domain 5. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.

## Occupational Therapy: Domain 5




Source: SSNAP Aug-Nov 2016 (Patient Centred)

## Domain 6: Physiotherapy

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.11.1A** People with stroke should accumulate at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.

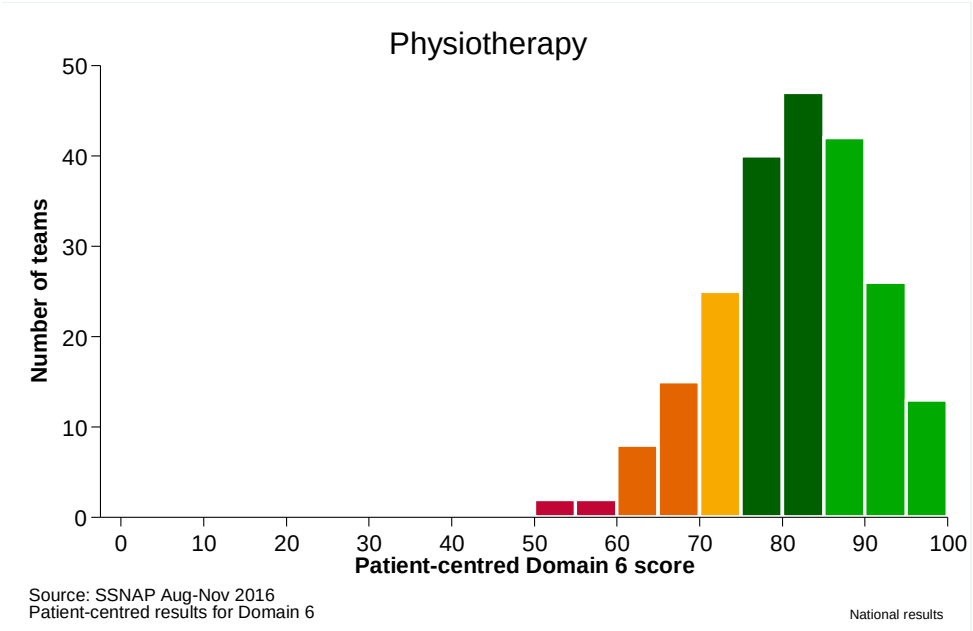
*NICE Quality Standards*

Statement 2: Adults having stroke rehabilitation in hospital or in the community are offered at least 45 minutes of each relevant therapy for a minimum of 5 days a week.

[2010, updated 2016]

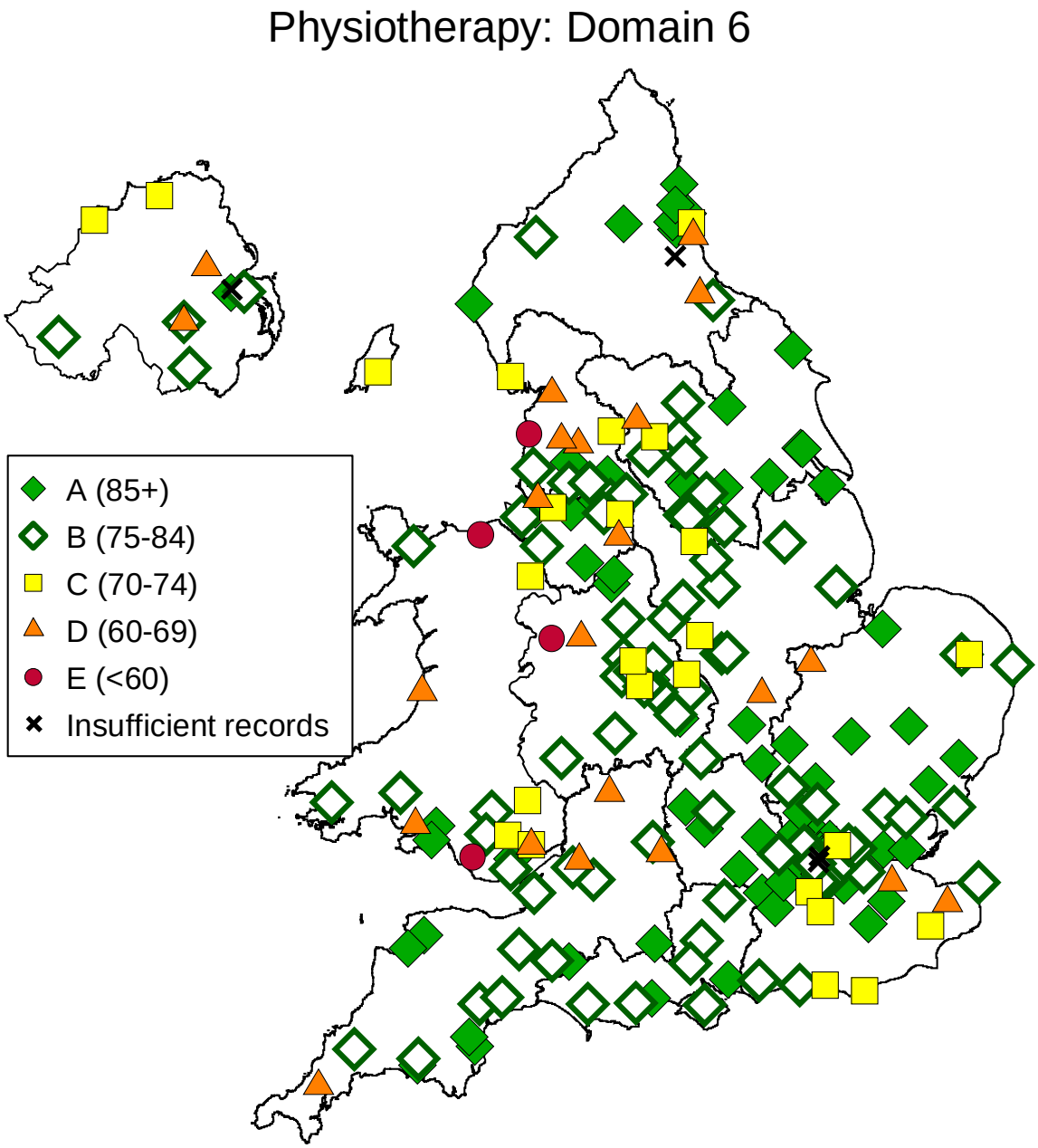
| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Physiotherapy** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients reported as requiring physiotherapy | 85.4% | 85.0% | 85.3% | 85.1% |
| Median number of minutes per day on which physiotherapy is received | 34.5 mins | 33.8 mins | 34.5 mins | 35 mins |
| Median % of days as an inpatient on which physiotherapy is received | 71.6% | 69.7% | 70.7% | 73.7% |
| Proxy for 2016 NICE Quality Standard Statement 2: % of the minutes of physiotherapy required (according to 2016 NICE QS-S2) which were delivered | 77.2% | 73.2% | 76.3% | 80.3% |

**Distribution of Domain 6 level across all inpatient teams (221 teams)**



| D6 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 75 teams (35%) | 65 teams (31%) | 78 teams (34%) | 85 teams (38%) |
| B | 81 teams (38%) | 83 teams (39%) | 85 teams (37%) | 85 teams (38%) |
| C | 29 teams (13%) | 26 teams (12%) | 33 teams (14%) | 25 teams (11%) |
| D | 24 teams (11%) | 32 teams (15%) | 25 teams (11%) | 22 teams (10%) |
| E | 6 teams (3%) | 7 teams (3%) | 7 teams (3%) | 4 teams (2%) |

The map below shows the patient centred performance of all *inpatient teams* for Domain 6. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.




Source: SSNAP Aug-Nov 2016 (Patient Centred)

## Domain 7: Speech and Language Therapy

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.11.1A** People with stroke should accumulate at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.

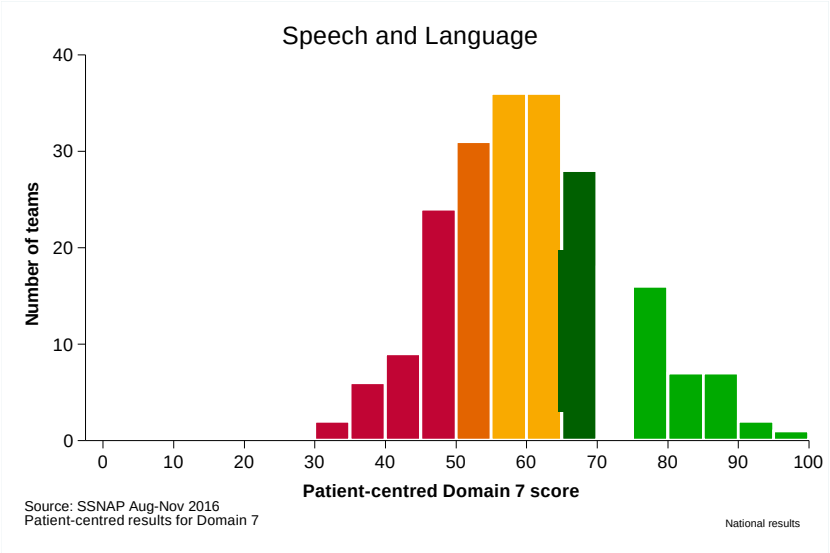
*NICE Quality Standards*

Statement 2: Adults having stroke rehabilitation in hospital or in the community are offered at least 45 minutes of each relevant therapy for a minimum of 5 days a week.

[2010, updated 2016]

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Speech and Language Therapy** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients reported as requiring speech and language therapy | 49.4% | 48.8% | 50.0% | 50.7% |
| Median number of minutes per day on which speech and language therapy is received | 32.5 mins | 31.5 mins | 32.0 mins | 31.5 mins |
| Median % of days as an inpatient on which speech and language therapy is received | 44.7% | 45.0% | 45.3% | 48.1% |
| Proxy for 2016 NICE Quality Standard Statement 2: % of the minutes of speech and language therapy required (according to 2016 NICE QS-S2) which were delivered | 44.7% | 43.0% | 45.1% | 47.8% |

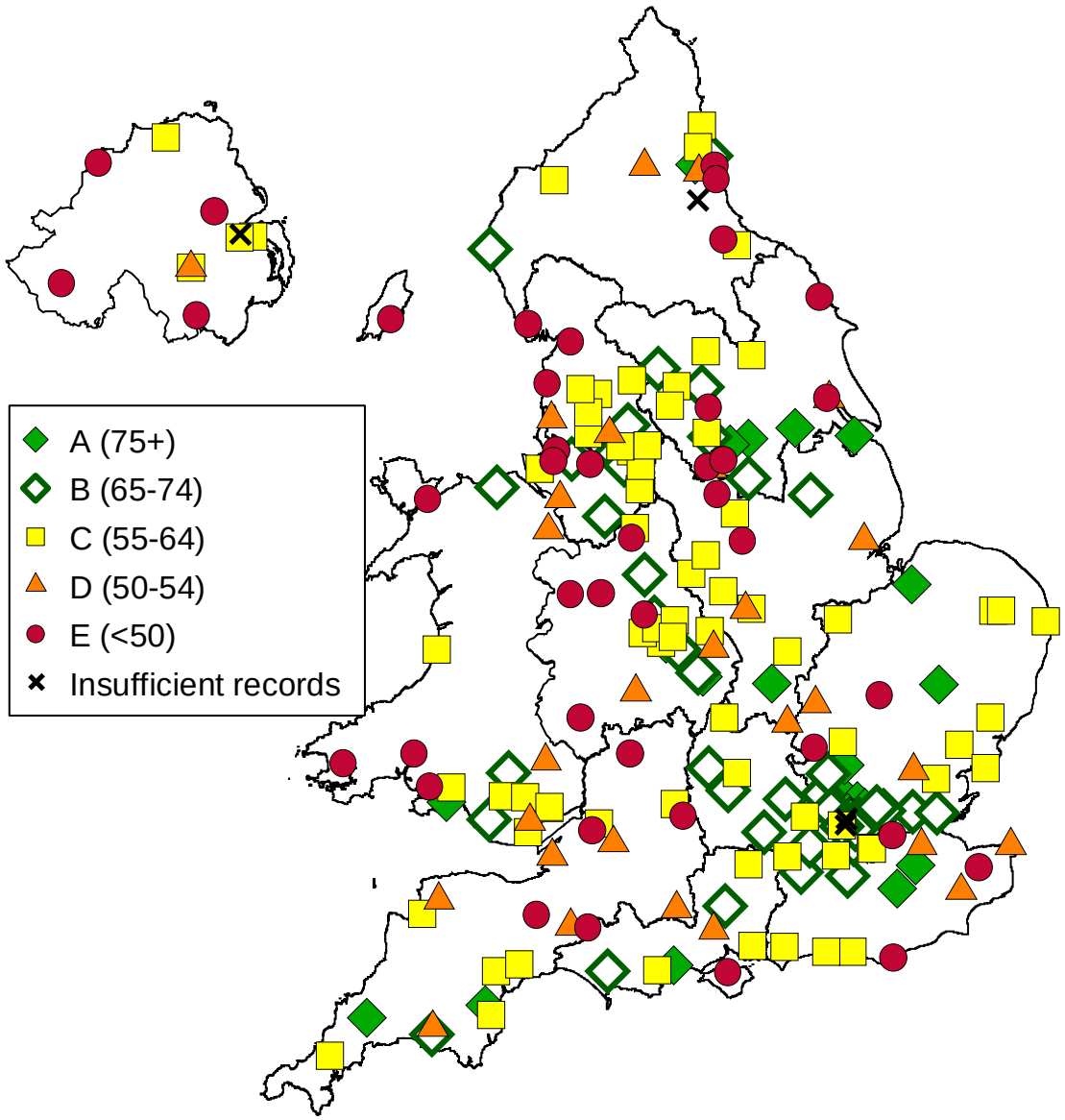
**Distribution of Domain 7 level across all inpatient teams (221 teams)**




| D7 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 33 teams (15%) | 31 teams (15%) | 32 teams (14%) | 33 teams (15%) |
| B | 31 teams (14%) | 30 teams (14%) | 42 teams (18%) | 45 teams (20%) |
| C | 52 teams (24%) | 69 teams (32%) | 68 teams (30%) | 74 teams (33%) |
| D | 43 teams (20%) | 28 teams (13%) | 27 teams (12%) | 28 teams (13%) |
| E | 56 teams (26%) | 55 teams (26%) | 59 teams (26%) | 41 teams (19%) |

The map below shows the patient centred performance of all *inpatient teams* for Domain 7. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.

## Speech and Language Therapy: Domain 7




Source: SSNAP Aug-Nov 2016 (Patient Centred)

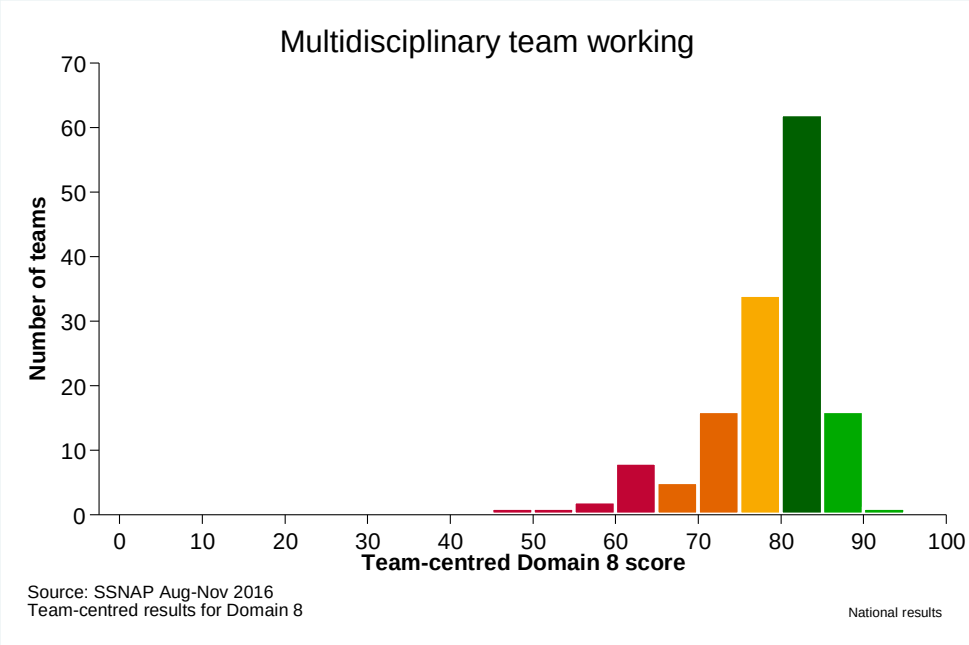
## Domain 8: Multidisciplinary team working

*RCP National Clinical Guideline for Stroke, 5th Edition*

**4.4.1.1A** People with communication problems after stroke should be assessed by a speech and language therapist to diagnose the problem and to explain the nature and implications to the person, their family/carers and the multidisciplinary team. Reassessment in the first four months should only be undertaken if the results will affect decision making or are required for mental capacity assessment.

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key indicators: Multidisciplinary team working** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of applicable patients who were assessed by an occupational therapist within 72h of clock start | 90.3% | 90.7% | 91.2% | 91.7% |
| Median time between clock start and being assessed by occupational therapist | 22h 08m | 22h 00m | 21h 58m | 21h 44m |
| Percentage of applicable patients who were assessed by a physiotherapist within 72h of clock start | 94.1% | 94.2% | 94.5% | 95.1% |
| Median time between clock start and being assessed by physiotherapist | 21h 11m | 21h 25m | 21h 07m | 20 52m |
| Percentage of applicable patients who were assessed by a speech and language therapist within 72h of clock start | 85.1% | 86.4% | 88.3% | 89.0% |
| Median time between clock start and being assessed by speech and language therapist | 24h 01m | 23h 39m | 23h 12m | 23h 00m |
| Percentage of applicable patients who have rehabilitation goals agreed within 5 days of clock start | 90.1% | 90.2% | 90.0% | 91.9% |
| Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days | 57.4% | 57.8% | 58.7% | 61.8 |

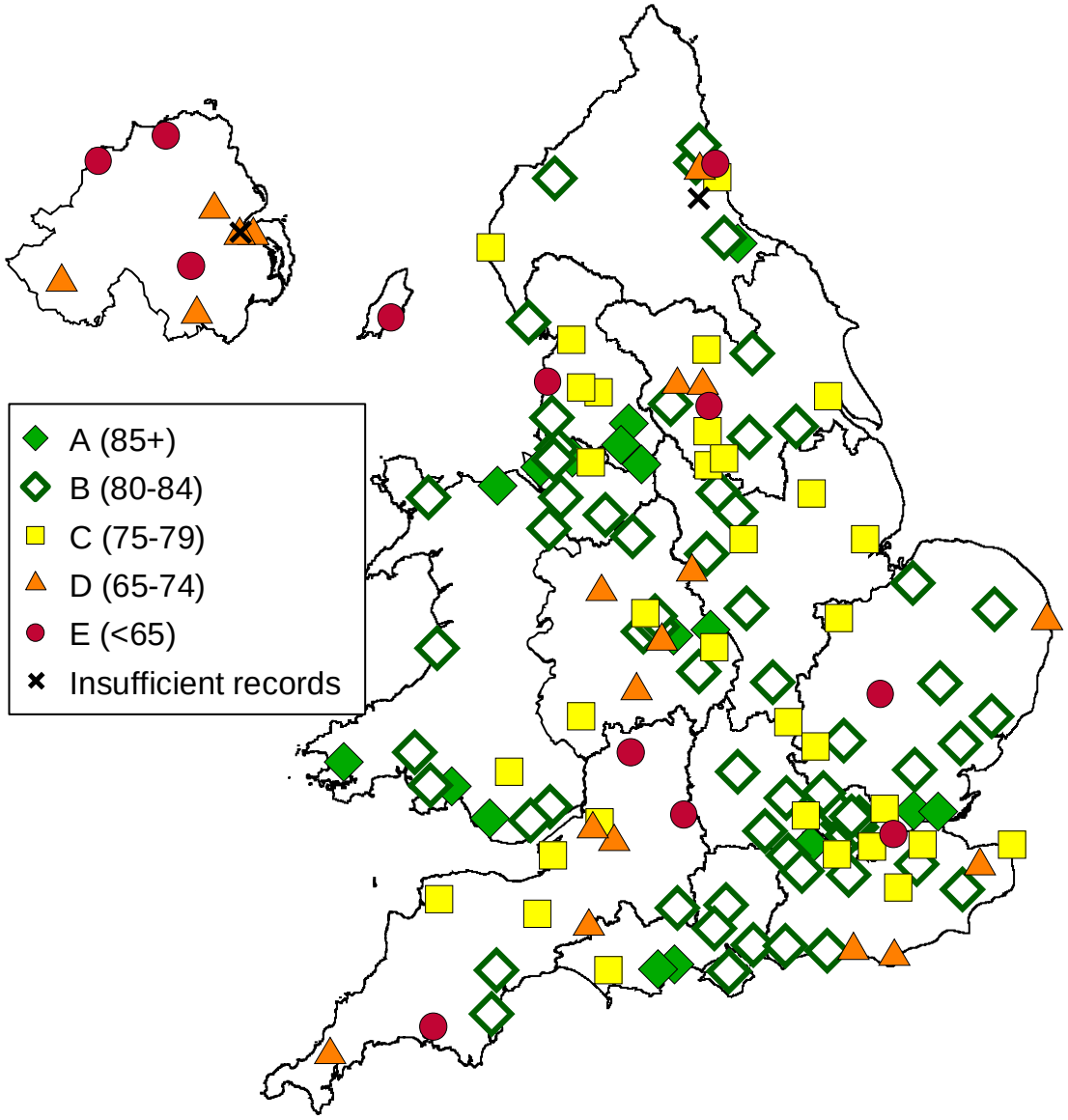
**Distribution of Domain 8 level across all routinely admitting teams (144 teams)**




| D8 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 11 teams (7%) | 13 teams (9%) | 14 teams (10%) | 17 teams (12%) |
| B | 45 teams (30%) | 51 teams (35%) | 55 teams (37%) | 62 teams (43%) |
| C | 45 teams (30%) | 42 teams (29%) | 36 teams (24%) | 33 teams (23%) |
| D | 35 teams (23%) | 25 teams (17%) | 25 teams (17%) | 20 teams (14%) |
| E | 16 teams (11%) | 16 teams (11%) | 17 teams (12%) | 12 teams (8%) |

The map below shows the team centred performance of all *routinely admitting* teams for Domain 8. Each symbol represents a team, colour coded by the overall score achieved.

## Multidisciplinary Team Work: Domain 8




Source: SSNAP Aug-Nov 2016 (Team Centred)

## Domain 9: Standards by Discharge

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

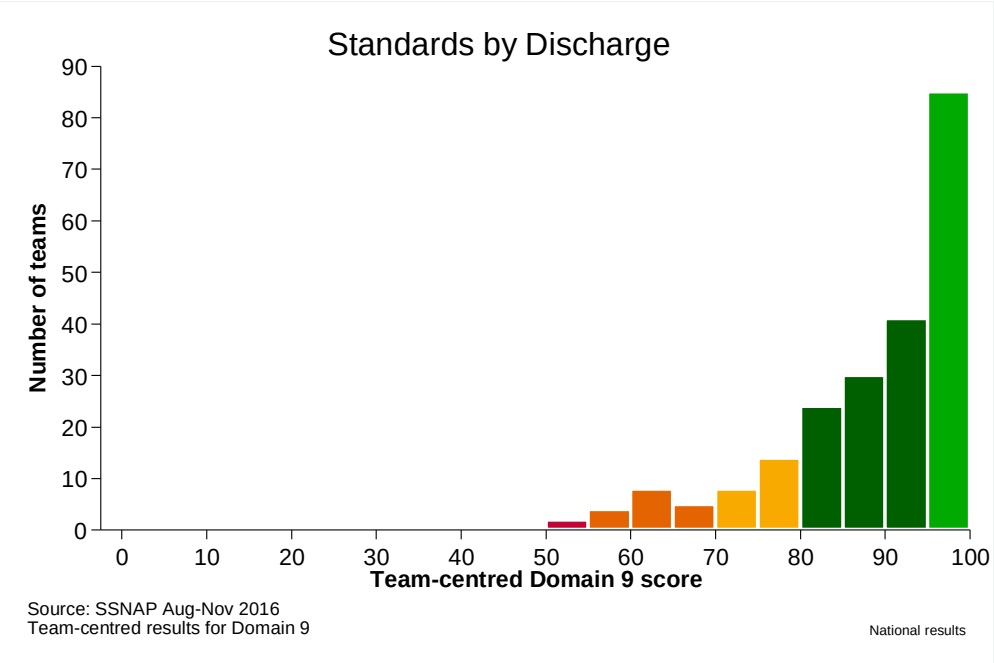
**2.12.1F** Services for people with stroke should include specialist clinical neuropsychology/clinical psychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition.

**4.7.1F** Patients with stroke who are unable to maintain adequate nutrition and fluids orally should be:

- referred to a dietitian for specialist nutritional assessment, advice and monitoring;
- be considered for nasogastric tube feeding within 24 hours of admission;
- assessed for a nasal bridle if the nasogastric tube needs frequent replacement, using locally agreed protocols;
- Assessed for gastrostomy if they are unable to tolerate a nasogastric tube with nasal bridle.

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Standards by Discharge** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge* | 80.4% | 78.5% | 82.1% | 83.3% |
| Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start | 89.6% | 89.7% | 90.7% | 92.0% |
| Percentage of applicable patients who have mood and cognition screening by discharge | 90.1% | 89.2% | 90.7% | 91.9% |

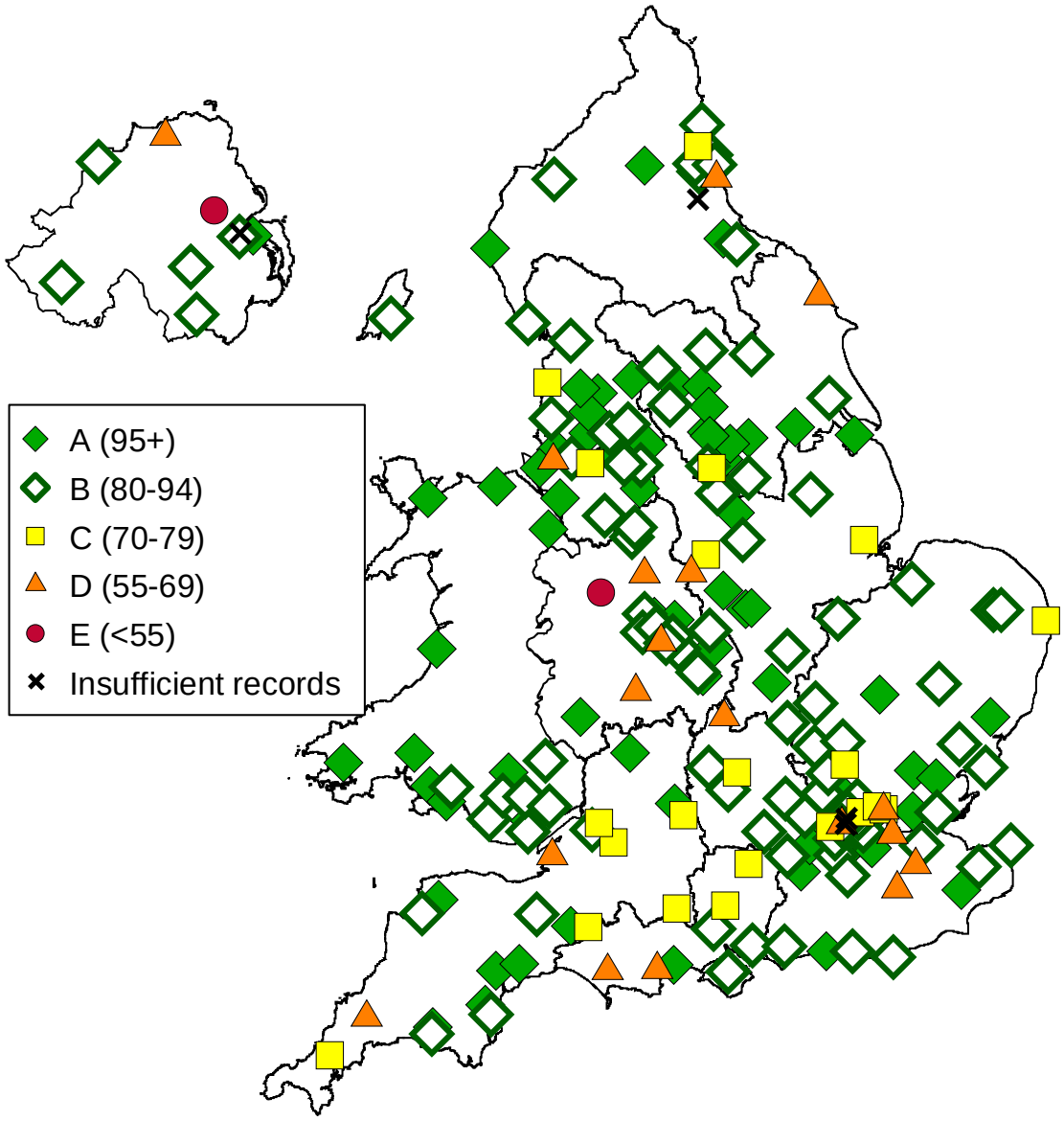
.**Distribution of Domain 9 level across inpatient teams (220 teams)**




| D9 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 63 teams (29%) | 63 teams (30%) | 75 teams (33%) | 85 teams (39%) |
| B | 89 teams (42%) | 80 teams (38%) | 102 teams (45%) | 94 teams (43%) |
| C | 36 teams (17%) | 32 teams (15%) | 21 teams (9%) | 21 teams (10%) |
| D | 18 teams (8%) | 30 teams (14%) | 24 teams (11%) | 18 teams (8%) |
| E | 8 teams (4%) | 7 teams (3%) | 5 teams (2%) | 2 teams (1%) |

The map below shows the team centred performance of all *inpatient teams* for Domain 9. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.

## Standards by Discharge: Domain 9




Source: SSNAP Aug-Nov 2016 (Team Centred)

## Domain 10: Discharge Processes

### What should be done?

*RCP National Clinical Guideline for Stroke, 5th Edition*

**2.7.1A** Hospital in-patients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge

*NICE Quality Standards*

Statement 4: Adults who have had a stroke are offered early supported discharge if the core multidisciplinary stroke team assess that it is suitable for them.

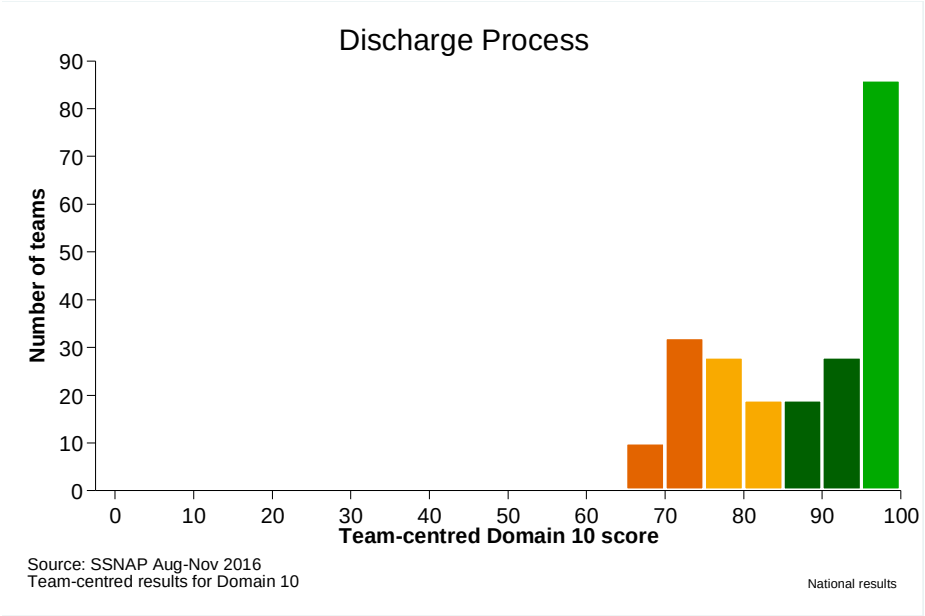
[2016]

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Discharge Processes** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of applicable patients receiving a joint health and social care plan on discharge | 89.3% | 89.9% | 90.5% | 90.6% |
| Percentage of patients treated by a stroke skilled Early Supported Discharge team* | 33.7% | 34.3% | 33.7% | 34.5% |
| Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation | 97.6% | 97.0% | 97.4% | 97.5% |
| Percentage of those patients who are discharged alive who are given a named person to contact after discharge | 92.0% | 92.4% | 93.3% | 96.6% |

* According to literature, approximately 34% of stroke patients are considered eligible for ESD [1]

[1] http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000443.pub3/pdf/standard

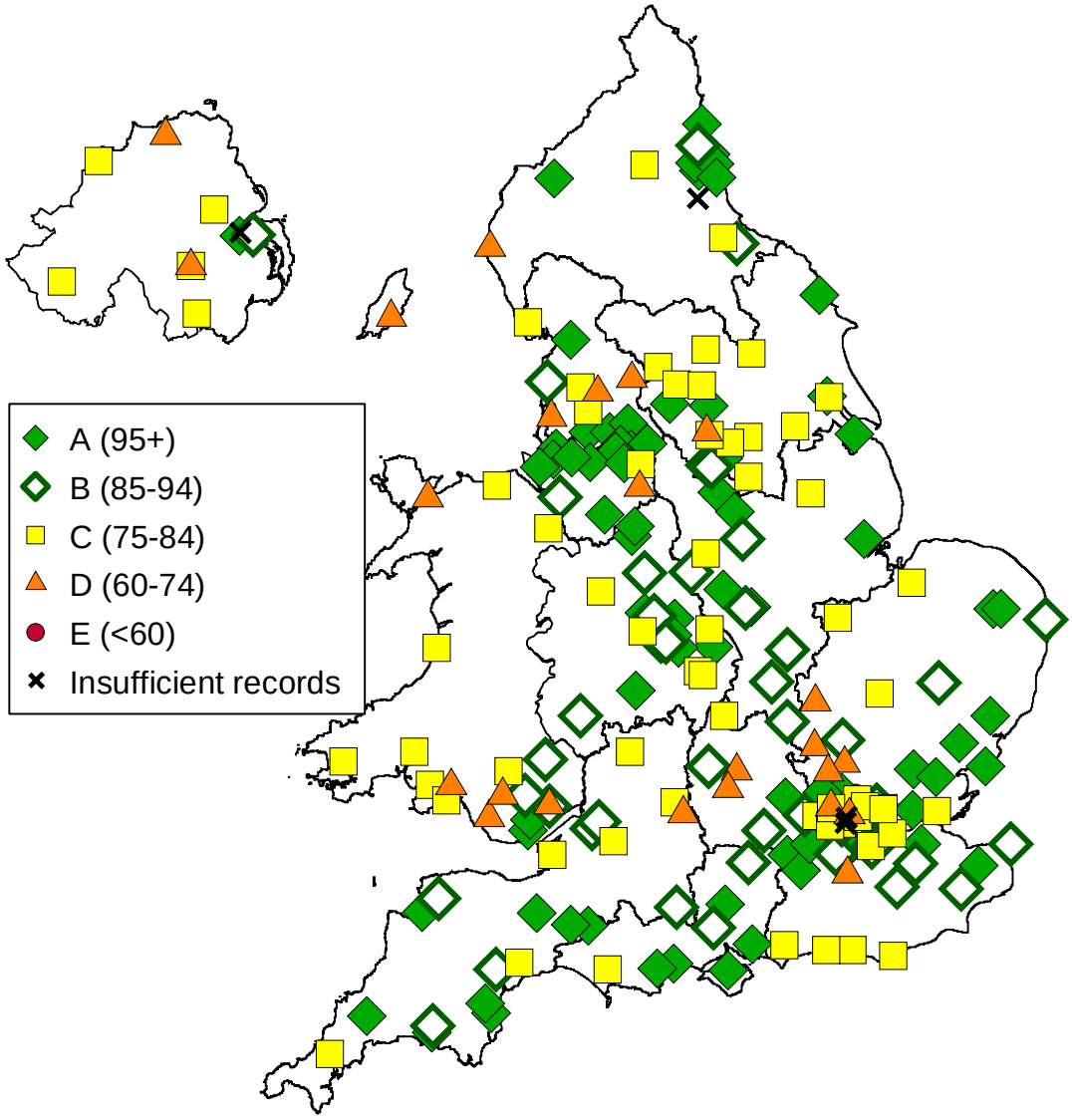
**Distribution of Domain 10 level across all inpatient teams (220 teams)**




| D10 Level | Number of teams achieving each level | | | |
|---|---|---|---|---|
| | Three month reporting | | Four month reporting | |
| | Oct-Dec 2015 | Jan-Mar 2016 | Apr-Jul 2016 | Aug-Nov 2016 |
| A | 71 teams (33%) | 71 teams (34%) | 75 teams (33%) | 86 teams (39%) |
| B | 59 teams (28%) | 53 teams (25%) | 56 teams (25%) | 46 teams (21%) |
| C | 51 teams (24%) | 58 teams (27%) | 54 teams (24%) | 64 teams (29%) |
| D | 25 teams (12%) | 23 teams (11%) | 37 teams (16%) | 24 teams (11%) |
| E | 8 teams (4%) | 6 teams (3%) | 3 teams (1%) | 0 teams (0%) |

The map below shows the team centred performance of all *inpatient teams* for Domain 10. Each symbol represents a team, colour coded by the overall score achieved. Teams with insufficient or too few records submitted are highlighted with an X symbol.

# Discharge Processes: Domain 10




Source: SSNAP Aug-Nov 2016 (Team Centred)

# Section 2: Casemix

Casemix describes the characteristics of the group (or cohort) of stroke patients treated by a team. It includes demographics and type of stroke. The figures for casemix are used in other reports to adjust for patient outcomes including mortality. It is therefore extremely important that the casemix data entered is of the highest quality and validated by the lead clinical contact. The casemix figures in this section relate to those patients admitted between August-November 2016. The casemix of the patients discharged during the same time period are very similar and have not been included in this public report.

Over the past 4 periods, the percentage of patients newly arriving in hospital and has remained relatively stable at between 94 and 95%. The current percentage for this reporting period is 94.4%. The percentage of patients already in hospital at time of stroke (Q1.10) fluctuated between 5 and 6% over the past 4 reporting periods.

## 2.1 Patient Numbers

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Number of stroke patients (Q1.9) included in report** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Number of stroke patients | 20,989 | 20,991 | 28,003 | 27,327 | *F1.1* |
| *Patients newly arriving in hospital* | *94.0%* | *94.4%* | *94.4%* | *94.4%* | |
| *Patients already in hospital at time of stroke (Q1.10)* | *6.0%* | *5.6%* | *5.6%* | *5.6%* | *F11.3* |

## 2.2 Gender

The distribution of gender ranges between 50.6% and 51.6% over the past four periods for males and between 48.4% and 49.4% for females.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Gender (Q1.6)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Male patients | 50.6% | 50.6% | 51.6% | 51.0% | *F3.5* |
| Female patients | 49.4% | 49.4% | 48.4% | 49.0% | *F3.3* |

## 2.3 Age

The median age for the past four reporting periods has remained stable at 77.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Median age on clock start (Q1.5)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Age (years) | 77 | 77 | 77 | 77 | *F4.1* |
| Male Patients | 74 | 74 | 73 | 73 | *F4.10* |
| Female Patients | 81 | 80 | 80 | 80 | *F4.7* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **% of patients aged >80 years on clock start (Q1.5)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Patients aged over 80 years | 40.2% | 39.7% | 38.5% | 38.6% | *F4.6* |
| Males aged over 80 years | 30.0% | 30.3% | 29.3% | 28.6% | *F4.18* |
| Females aged over 80 years | 50.6% | 49.3% | 48.4% | 49.1% | *F4.15* |

**Comment** The patients being entered onto SSNAP appear to be very similar in terms of age to previous audits that we have conducted (Sentinel and SINAP).

## 2.4 Co-morbidities

SSNAP collects details of co-morbidities, these were recorded for all cases. The percentages relating to comorbidities for the past four reporting period are stable.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Number of co-morbidities (Q2.1)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| 0 | 25.5% | 26.6% | 26.5% | 26.6% | *F5.3* |
| 1 | 36.2% | 35.5% | 35.6% | 35.7% | *F5.5* |
| 2 | 25.8% | 26.2% | 26.2% | 26.0% | *F5.7* |
| 3 | 10.3% | 9.7% | 9.6% | 9.8% | *F5.9* |
| 4 | 2.0% | 1.8% | 1.8% | 1.7% | *F5.11* |
| 5 | 0.2% | 0.2% | 0.2% | 0.2% | *F5.13* |

SSNAP collects information on the type of co-morbidity of patients that are admitted with stroke. Data for the last four reporting periods suggest that there is very little change in this area.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Type of co-morbidity (Q2.1)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Congestive Heart Failure | 5.7% | 5.4% | 5.5% | 5.5% | *F5.16* |
| Hypertension | 54.6% | 53.7% | 53.1% | 53.1 | *F5.19* |
| Diabetes | 20.5% | 20.4% | 20.8% | 20.8 | *F5.22* |
| Stroke/TIA | 26.8% | 26.0% | 26.5% | 26.3% | *F5.25* |
| Atrial Fibrillation | 20.0% | 19.5% | 19.3% | 19.4% | *F6.3* |

# Atrial Fibrillation

Between Aug – Nov 2016 19.4% of patients has a prior diagnosis of AF before admission. Of those patients in AF before stroke 53.8% of patients were on anticoagulant medication, 10.7% of patients were not on anticoagulants for a "no but" reason. A "no but" reason would mean the patient was not put on anticoagulants for good reason, for instance to reduce the risk of bleeding complications related to anticoagulant medicines. 35.5% of patients were not on anticoagulants

## Atrial Fibrillation on admission

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If patient has Atrial Fibrillation, was the patient on antiplatelet medication prior to admission? (Q2.1.6)** | **Oct-Dec 2015 N=4200** | **Jan-Mar 2016 N=4103** | **Apr-Jul 2016 N=5401** | **Aug-Nov 2016 N=5313** | *Ref* |
| Yes | 29.0% | 27.2% | 25.5% | 22.5% | *F6.6* |
| No | 57.1% | 58.3% | 60.5% | 64.9% | *F6.8* |
| No but | 13.9% | 14.4% | 14.0% | 12.6% | *F6.10* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If patient had Atrial Fibrillation, was the patient on anticoagulant medication prior to admission? (Q2.1.7)** | **Oct-Dec 2015 N=4200** | **Jan-Mar 2016 N=4103** | **Apr-Jul 2016 N=5401** | **Aug-Nov 2016 N=5313** | *Ref* |
| Yes | 48.9% | 50.1% | 51.4% | 53.8% | *F6.13* |
| No | 39.0% | 38.5% | 36.0% | 35.5% | *F6.15* |
| No but | 12.1% | 11.5% | 12.6% | 10.7% | *F6.17* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If patient had Atrial Fibrillation, what combination of anticoagulant and antiplatelet medication was the patient on prior to admission?** | **Oct-Dec 2015 N=4200** | **Jan-Mar 2016 N=4103** | **Apr-Jul 2016 N=5401** | **Aug-Nov 2016 N=5313** | *Ref* |
| Anticoagulant AND antiplatelet medication | 4.0% | 4.1% | 3.9% | 3.3% | *F6.20* |
| Anticoagulant medication only | 44.9% | 46.0% | 47.5% | 50.5% | *F6.22* |
| Antiplatelet medication only | 25.1% | 23.2% | 21.7% | 19.1% | *F6.24* |
| Neither medication | 26.0% | 26.8% | 27.0% | 27.1% | *F6.26* |

**Comment:** These data are similar to the last National Sentinel Stroke Audit and reveal that there are still major issues in primary and secondary care about ensuring that patients have effective stroke prevention. Approximately one fifth of patients are in atrial fibrillation (AF) on admission. Over 50% of patients in AF on admission are taking anticoagulants with over 20% taking only antiplatelet drugs which are considered ineffective for patients in AF. Over a quarter of patients have had a prior stroke or TIA.

## Atrial Fibrillation on discharge

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive, patient has Atrial Fibrillation (AF) (Q7.10)** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N=22834 | *Ref* |
| Patient in Atrial Fibrillation | 22.2% | 21.7% | 21.6% | 21.3% | *J32.3* |
| Patient not in Atrial Fibrillation | 77.8% | 78.3% | 78.4% | 78.7% | |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If patient has AF, given anticoagulation (Q7.10.1)** | **Oct-Dec 2015** N=3857 | **Jan-Mar 2016** N=3725 | **Apr-Jul 2016** N=5123 | **Aug-Nov 2016** N=4858 | *Ref* |
| Yes | 83.5% | 83.1% | 83.4% | 83.3% | *J32.6* |
| No | 2.1% | 2.6% | 2.2% | 2.1% | *J32.8* |
| No but | 14.5% | 14.3% | 14.4% | 14.6% | *J32.10* |
| | | | | | |
| Applicable for receiving anticoagulation | 16.2% | 15.8% | 15.9% | 15.6% | *J32.13* |
| Compliant | 97.6% | 97.0% | 97.4% | 97.5% | *J32.16* |

## Atrial Fibrillation at six months

SSNAP provides an opportunity to measure the number of patients identified as being in AF six months post admission. From April 2014 a “not known” option was added to the dataset for the following questions, however the percentage of patients for whom “not known” was answered is less than 8%.

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Atrial Fibrillation at 6 months:** % (n) | **Jul-Dec 2015** N=8117 | **Oct 2015 – Mar 2016** N=8640 | **Apr-Jul 2016** N=6140 | **Aug-Nov 2016** N=6555 | *Ref* |
| Persistent, permanent or paroxysmal Atrial Fibrillation (AF) at the time of six month follow-up assessment | 23.6% (1917) | 23.5% (2030) | 23.6% (1448) | 23.2% (1518) | *M9.1.1, M9.1.2* |
| Taking anti-coagulant | 81.5% (1563) | 82.1% (1667) | 80.7% (1168) | 81.2% (1233) | *M9.10 M9.12* |

| | Six month reporting period | | Four month reporting period | | |
|---|---|---|---|---|---|
| **If patient is in Atrial Fibrillation at time of six month follow-up assessment** % (n) | **Jul-Dec 2015** N=1917 | **Oct 2015 – Mar 2016** N=2030 | **Apr-Jul 2016** N=1448 | **Aug-Nov 2016** N=1518 | *Ref* |
| Was also in AF when first admitted to hospital | 50.9%(975) | 52.2% (1060) | 50.1% (726) | 52.2% (792) | *M9.4, M9.6* |
| Was also in AF when discharged from inpatient care | 66.6% (1276) | 66.8% (1356) | 66.6% (965) | 66.1% (1004) | *M9.7, M9.9* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Current Medication*** % (n) | **Jul-Dec 2015** N=8117 | **Oct 2015 – Mar 2016** N=8640 | **Apr-Jul 2016** N=6140 | **Aug-Nov 2016** N=6551 | *Ref* |
| Taking antiplatelet | 60.7% (4927) | 61.2% (5289) | 60.8% (3736) | 61.3% (4014) | *M12.2, M12.3* |
| Taking anticoagulant | 28.6% (2325) | 28.3% (2442) | 27.8% (1708) | 27.6% (1809) | *M13.2, M13.3* |
| Taking lipid lowering | 76.8% (6233) | 77.4% (6684) | 77.5% (4758) | 77.9% (5100) | *M15.2, M15.3* |
| Taking antihypertensive | 69.8% (5662) | 70.2% (6062) | 71.4% (4385) | 69.7% (4566) | *M16.2, M16.3* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Medication** % (n) | **Jul-Dec 2015** N=1588 | **Oct 2015 – Mar 2016** N=1662 | **Apr-Jul 2016** N=1149 | **Aug-Nov 2016** N=1183 | *Ref* |
| If patient was discharged on anti-coagulant, still taking at six month follow-up assessment | 79.8% (1268) | 81.1% (1348) | 81.2% (933) | 82.7% (978) | *M14.1, M14.3* |

## 2.5 Stroke Type

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Stroke Type (Q2.5)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Infarction | 87.0% | 86.8% | 87.4% | 87.1% | *F7.3* |
| Intracerebral Haemorrhage | 12.4% | 12.8% | 12.1% | 12.5% | *F7.5* |
| Unknown (not scanned) | 0.6% | 0.4% | 0.5% | 0.4% | *F7.7* |

**Comment:** The distribution of haemorrhage and infarction is as expected from UK stroke epidemiology supporting the impression that there has not been significant case selection bias in terms of cases submitted to the audit.

## 2.6 Modified Rankin Scale scores before stroke

This is fully recorded for all patients in this cohort.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Modified Rankin Scale score before stroke (Q2.2)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| 0 (no symptoms) | 53.6% | 54.6% | 54.9% | 55.0% | *F8.3* |
| 1 (no significant disability) | 15.8% | 15.1% | 14.9% | 14.7% | *F8.5* |
| 2 (slight disability) | 10.5% | 10.7% | 10.1% | 10.3% | *F8.7* |
| 3 (moderate disability) | 11.8% | 11.8% | 12.2% | 12.0% | *F8.9* |
| 4 (moderately severe disability) | 6.4% | 6.1% | 6.2% | 6.2% | *F8.11* |
| 5 (severe disability) | 1.9% | 1.7% | 1.7% | 1.8% | *F8.13* |
| ***Groups*** | | | | | |
| 1 or 2 | 26.3% | 25.8% | 25.0% | 25.0% | *H1.12* |
| 3, 4 or 5 | 20.0% | 19.6% | 20.1% | 20.0% | *H1.13* |

**Comment:** These data reinforce the message that stroke often occurs in frail patents. Nearly half of the cohort had restriction of activity before their stroke (Rankin score greater than 0) with nearly one fifth having very significant pre-stroke problems (Rankin Score greater than 2). These data will be used in the future to evaluate stroke outcomes at six months to assess how effective treating the stroke has been.

## 2.7 Completion rate of NIHSS items

High quality data are needed to assess the severity of stroke at admission. The best way of doing this is by using the National Institutes of Health Stroke Scale (NIHSS). It is a 15 item scale with one item that is mandatory on SSNAP (level of consciousness (LOC)). NIHSS completion is included in the audit compliance score for individual teams with the expectation that completion rates will continue to improve.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Number of NIHSS components completed (Q2.3)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| 1 (only the compulsory LOC) | 8.2% | 6.7% | 5.1% | 4.2% | *F9.12* |
| 2-14 | 5.8% | 5.1% | 4.9% | 3.9% | *F9.14* |
| 15 (all components) | 86.0% | 88.2% | 90.0% | 91.9% | *F9.16* |

**Comment:** It is encouraging to see a consistent increase in the rate of NIHSS completion each reporting period. Completing an NIHSS for all stroke patients is fundamental in quantifying the level of impairment caused by a stroke and we would expect the level of completion to continue to increase in future reporting periods.

## 2.8 Summary of total NIHSS score

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| ***If NIHSS fully completed, severity groups:*** | **Oct-Dec 2015** N=18059 | **Jan-Mar 2016** N=18517 | **Apr-Jul 2016** N=25197 | **Aug-Nov 2016** N=25106 | *Ref F9.17* |
| 0 | 6.9% | 6.8% | 7.0% | 7.0% | *F9.19* |
| 1-4= minor stroke | 42.3% | 42.1% | 42.6% | 42.1% | *F9.21* |
| 5-15= moderate stroke | 35.0% | 35.4% | 34.8% | 35.0% | *F9.23* |
| 16-20= moderate/severe stroke | 7.2% | 7.5% | 6.9% | 7.4% | *F9.25* |
| 21-42= severe stroke | 8.6% | 8.2% | 8.7% | 8.5% | *F9.27* |

Median and mean NIHSS scores are publicly available in the full results portfolio, which is available at the link below.

https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx

**Comment:** A score of 0 does not mean that the patient did not have a stroke. There are deficits that are unrecorded by the score and some patients will have presented after the first 24 hours following stroke and have made a complete recovery. The distribution of the NIHSS scores is in line with what we expected again reassuring us that a representative sample of stroke patients is being submitted to SSNAP.

## 2.9 Palliative Care within 72h

All data items collected regarding palliative care can be found within the Full Results Portfolio within the casemix tab. https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Palliative Care Decisions** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Has it been decided in the first 72 hours that the patient is for palliative care? (Q3.1) | 5.3% | 5.2% | 5.5% | 5.5% | *F10.3* |

**Comment:** About 5% of patients have such severe strokes that a decision is made within the first 72 hours to palliate.

## 2.10 Onset of symptoms

The provision of standards of care within a specific timeframe depends on whether or not the day and time of onset can be obtained. The audit recognises that it may not be possible to identify a precise time for all patients, in which case the 'best estimate' is used.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Date of symptom onset (Q1.11.1)** | **Jul-Sep 2015** | **Oct-Dec 2015** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Precise | 68.1% | 67.2% | 66.5% | 66.1% | *H2.3* |
| Best estimate | 18.7% | 19.7% | 21.1% | 21.6% | *H2.5* |
| Stroke during sleep | 13.1% | 13.1% | 12.4% | 12.3% | *H2.7* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Time of symptom onset (Q1.11.2)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Known | 68.5% | 67.8% | 68.6% | 68.4% | *H2.17* |
| *Precise* | 32.3% | 32.1% | 32.7% | 32.7% | *H2.10* |
| *Best estimate* | 36.3% | 35.7% | 36.0% | 35.8% | *H2.12* |
| Not known | 31.5% | 32.2% | 31.4% | 31.6% | *H2.14* |

Time of onset is an important measure of data quality as it reflects the care taken to ascertain the time of onset as accurately as possible. From a clinical perspective a known time of onset will determine whether patients are appropriate for thrombolysis and intra-arterial treatment.

**Comment:** It is notable that a low percentage of patients reported as having stroke during sleep. The data highlights how important it is that specialist services are available 24 hours a day and seven days a week.

## 2.11 Ethnicity

| **Ethnicity (Q1.8)** | **April 2015-March 2016** | |
|---|---|---|
| Known | 79069 | 93.9% |
| *White* | 74408 | 88.4% |
| *Mixed / multiple ethnicity group* | 374 | 0.4% |
| *Asian / Asian British* | 2381 | 2.8% |
| *Black / African / Caribbean / Black British* | 1048 | 1.2% |
| *Other ethnic group* | 858 | 1.0% |
| Not known | 5115 | 6.1% |

Due to low numbers in some categories, the ethnicity data is reported on an annual cohort. The high proportion of not known responses indicates difficulties in collecting this data. Furthermore the low completion rate makes the results difficult to interpret.

# Section 3: Processes of care in the first 72 hours

## 3.1 Timings from onset

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Timings from onset (using both precise and best estimate times) (Q1.11.1 and 1.11.2)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| | Median (IQR) | Median (IQR) | Median (IQR) | Median (IQR) | |
| Time from onset to arrival † | 2h 45m (1h 25m – 8h 05m) | 2h 49m (1h 28m – 8h 31m) | 2h 49m (1h 26m – 8h 52m) | 2h 54m (1h 30m –08h 52m) | *H3.1 H3.2 H3.3* |
| Time from onset to stroke unit admission* | 7h 10m (4h 12m – 19h 31m) | 7h 53m (4h 23m – 20h 33m) | 7h 20m (4h 09m – 20h 13m) | 7h 33m (4h 18m – 20h 04m) | *H3.4 H3.5 H3.6* |
| Time from onset to scan* | 3h 58m (1h 58m – 11h 40m) | 4h 01m (2h 00m – 12h 05m) | 3h 56m (1h 57m – 11h 57m) | 4h 02m (2h 00m – 11h 56m | *H3.7 H3.8 H3.9* |
| Time from onset to thrombolysis* | 2h 23m (1h 50m – 3h 06m) | 2h 25m (1h 53m – 3h 07m) | 2h 23m (1h 48m – 3h 06m) | 2h 25m (1h 50m – 3h 09m | *H3.10 H3.11 H3.12* |

†excluding in hospital stroke onset
*including in hospital stroke onset

**Comment**: There are clearly major improvements to be made in terms of reducing the time from symptom onset to arrival in the hospital. This will require further campaigns such as the FAST campaign to improve the understanding of the public and also work with the ambulance services to reduce the time from call to hospital arrival.

## 3.2 Arrival by ambulance

The percentages in the table below are for patients who arrived at hospital by ambulance. Patients already in hospital at the time of stroke are excluded.

For the past 4 reporting periods, the percentage of patients reported as arriving to hospital by ambulance has remained stable varying from 81.6% to 82.4%. In this latest reporting period 81.6% of patients arrived at hospital by ambulance.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Patient arrived by ambulance (Q1.12)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 82.4% | 82.2% | 81.8% | 81.6% | *H4.3* |

**Comment**: As in previous audits, most patients arrive at hospital by ambulance, highlighting the importance of ensuring that paramedics are seen as an integral part of the stroke team and are included in training education and quality improvement. We aspire to link ambulance data to SSNAP so that we can report an accurate account of the whole acute care pathway.

### 3.3 Timings from Clock Start

Clock start is defined as the time of arrival for newly arrived patients, and the symptom onset time (precise and best estimate) for patients who have a stroke while in hospital.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Timings from clock start (hours & minutes)** | **Oct-Dec 2015** Median (IQR) | **Jan-Mar 2016** Median (IQR) | **Apr-Jul 2016** Median (IQR) | **Aug-Nov 2016** Median (IQR) | *Ref* |
| Time from clock start to first arrival on a stroke unit | 3h 35m (2h 06m – 6h 35m) | 3h 51m (2h 14m – 8h 00m) | 3h 35m (2h 03m – 6h 43m) | 3h 38m (2h 07m – 6h 48m) | *H7.4, H7.5, H7.6* |
| Time from clock start to scan | 1h 04m (26m – 2h 42m) | 1h 04m (26m – 2h 50m) | 59m (24m – 2h 34m) | 59m (23m – 2h 33m) | *H6.4, H6.5, H6.6* |
| Time from clock start to thrombolysis | 55m (38m – 1h 19m) | 54m (37m – 1h 19m) | 52m (36m – 1h 16m) | 51m (36m – 1h 15m) | *H16.42, H16.43, H16.44* |

### 3.4 Period of Arrival

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Arrival during (Q1.13)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Patient arrived in 'Normal hours' (Monday to Friday 8am – 6pm, excluding bank holidays) | 46.1% | 45.2% | 45.1% | 47.3% | *H5.3* |
| Patient arrived 'Out of hours' | 47.9% | 49.3% | 49.3% | 47.1% | *H5.5* |
| The onset of stroke was when the patient was already in hospital | 6.0% | 5.6% | 5.6% | 5.6% | *H5.7* |

### 3.5 Brain Scanning (Domain 1)

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Brain Imaging (Q2.4)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Scanned | 99.4% | 99.6% | 99.5% | 99.6% | *H6.3* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Brain scan timings** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| | Median (IQR) | Median (IQR) | Median (IQR) | Median (IQR) | |
| Time from clock start to scan | 1h 04m (26m – 2h 42m) | 1h 04m (26m – 2h 50) | 0h 59m (24m – 2h 34) | 0h 59m (23m – 2h 33m) | *H6.4, H6.5, H6.6* |
| Time from onset to scan* | 3h 58m (1h 58m – 11h 40m) | 4h 01m (2h 00m – 12h 05m) | 3h 56m (1h 57m – 11h 57m) | 4h 02m (2h 00m – 11h 56m) | *H3.7, H3.8, H3.9* |

*This standard is based on patients who had a scan and for whom a precise or best estimate onset time was known.

Approximately half of patients were scanned within 1 hour of clock start. Please note, the new RCP National Clinical Guideline for Stroke (fifth edition, 2016) recommends that all patients are scanned within 1 hour. It is appreciated that this change will take time to implement. The National Clinical Guideline for Stroke 2012 recommended that all patients are scanned within 12 hours of clock start. In this sample, this standard was achieved for more than 90% of all patients.

**Comment:** Improved access to scanning has been one of the main successes in stroke care over recent years, with over 90% of patients in the cohort for this report being scanned within 12 hours. Many services appear to be adopting the logical policy of scanning patients immediately on arrival at hospital. However SSNAP data has shown that there is a lower chance of patients being scanned at weekends than during the week and there are still relatively few patients scanned at night time.

### 3.6 Stroke Unit Admission (Domain 2)

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Went to stroke unit (at first admitting team) (Q1.15)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 96.3% | 96.0% | 96.1% | 95.9% | *H7.3* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Stroke unit timings** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |

| | Median (IQR) | Median (IQR) | Median (IQR) | Median (IQR) | |
|---|---|---|---|---|---|
| Time from clock start to first arrival on a stroke unit | 3h 35m (2h 06m – 6h 35m) | 3h 51m (2h 14m – 8h 00m) | 3h 35m (2h 03m – 6h 43m) | 3h 38m (2h 07m – 6h 48m) | *H7.4, H7.5, H7.6* |
| Time from symptom onset to arrival at stroke unit * | 7h 10m (4h 12m – 19h 31m) | 7h 53m (4h 23m - 20h 33m) | 7h 20m (4h 09m - 20h 13m) | 7h 33m (4h 18m – 20h 04m) | *H3.4, H3.5, H3.6* |

*This standard is based on patients who went to a stroke unit and for whom a precise or best estimate onset time was known.

### 3.7 First ward of admission

It is acknowledged that for a small proportion of patients direct admission to a stroke unit is not appropriate and the audit captures and differentiates between those who go to an acceptable other location (e.g. intensive care) compared to a 'non acceptable' location (e.g. generic admissions unit).

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **First ward of admission (at first admitting team) (Q1.14)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Stroke Unit | 78.4% | 77.4% | 78.4% | 78.9% | *H7.11* |
| Medical Assessment Unit / Acute Admissions Unit / Clinical Decisions Unit (unacceptable) | 14.5% | 15.6% | 14.7% | 14.3% | *H7.9* |
| Intensive Therapy Unit / Coronary Care Unit / High Dependency Unit (acceptable) | 2.4% | 2.0% | 2.1% | 2.2% | *H7.13* |
| Other (unacceptable) | 4.7% | 5.0% | 4.8% | 4.6% | *H7.15* |

**Comment:** Almost all of this group of patients were treated at some time during their stay on a stroke unit although it is still of great concern that such a large percentage of patients are admitted initially to a general ward such as a medical admission unit. Direct admission to a stroke unit remains the most important intervention we have for acute stroke and so it is concerning that a significant number of patients are failed in this way. Correcting this part of the pathway should be a top priority for all hospitals operating such systems. In some cases this will be understandable if the patient has their stroke post-surgery or while on an intensive care unit, but we know that in-hospital stroke patients do tend to be identified and managed more slowly.

### 3.8 Thrombolysis (Domain 3)

Thrombolysis is a clot busting drug which can be a very effective way of treating ischaemic strokes (caused by blood clot). The eligibility criteria for thrombolysis are based on age, type of stroke and time lapse since stroke onset. Based on these criteria, it is expected that between 15 and 20% of patients would be eligible for thrombolysis.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Was the patient given thrombolysis (Q2.6)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 11.0% | 11.4% | 11.9% | 11.5% | *H16.3* |
| No | 1.0% | 1.0% | 0.9% | 1.0% | *H16.5* |
| *Thrombolysis not available at hospital* | *0.6%* | *0.7%* | *0.5%* | *0.6%* | *H16.14* |
| *Outside thrombolysis service hours* | *0.2%* | *0.1%* | *0.1%* | *0.2%* | *H16.16* |
| *Unable to scan quickly enough* | *0.1%* | *0%* | *0%* | *0%* | *H16.18* |
| *None* | *0.2%* | *0.2%* | *0.3%* | *0.2%* | *H16.20* |
| No but* | 88.0% | 87.7% | 87.2% | 87.5% | *H16.7* |

*Since a patient can have more than one "no but" reason, the breakdown is given in the following table.

**Comment:** It is encouraging to see that a higher level of thrombolysis is being sustained compared to other high income countries.

'No but' is answered when there was a medical reason stated for not giving thrombolysis according to the hospital. The most common l reasons are outlined below.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **'No but' reasons for not thrombolysing** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Patient arrived outside the time window for thrombolysis | 31.8% | 32.9% | 33.2% | 32.5% | *H16.25* |
| Wake up time unknown | 36.8% | 37.5% | 37.1% | 36.8% | *H16.39* |
| Stroke too mild/severe | 14.3% | 13.9% | 13.8% | 13.8% | *H16.37* |
| Haemorrhagic stroke | 14.8% | 15.2% | 14.3% | 14.7% | *H16.23* |

Other reasons for not giving thrombolysis were that the patient's condition was improving, the patient had other co-morbidities and 'other medical reasons'. Other less common 'No but' reasons were the patient's age, medication, and patient refusal.

Further details of less common "No but" reasons, can be found within the results portfolio.

www.strokeaudit.org/results/national

### 3.8.1 Thrombolysis timings

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Thrombolysis timings** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| | Median (IQR) | Median (IQR) | Median (IQR) | Median (IQR) | |

| | | | | | |
|---|---|---|---|---|---|
| Time from clock start to thrombolysis | 55m (38m – 1h 19m) | 54m (37m – 1h 19m) | 52m (36m – 1h 16m) | 51m (36m-1h 15m) | *H16.42, H16.43, H16.44* |
| Time from onset to thrombolysis | 2h 23m (1h 50m – 3h 06m) | 2h 25m (1h 53m – 3h 07m) | 2h 23m (1h 48m – 3h 06m) | 2h 25m (1h 50m – 3h 09m) | *H3.10, H3.11, H3.12* |
| If thrombolysed, time from onset to clock start | 1h 20m | 1h 21m | 1h 21m | 1h 23m | *H16.45* |
| If thrombolysed, time from clock start to scan | 21m | 20m | 20m | 19m | *H16.46* |
| If thrombolysed, time from scan to thrombolysis | 30m | 30m | 29m | 29m | *H16.47* |

**Comment**: These data show there are still improvements to be made in door to needle time for patients receiving thrombolysis. There are big variations between units demonstrating that it is possible to set services up to operate more efficiently.

### 3.8.2 Thrombolysis based on eligibility

There are several reasons why thrombolysis might not be clinically appropriate for certain patients. This section presents results for eligible patients only. Eligibility is defined by the National Clinical Guideline for Stroke 2016 and includes:

Patients with a final diagnosis of stroke (Q1.9 recorded as 'Stroke'), and one of:

- newly arrived patients aged under 80 with an onset to arrival time of less than 3.5 hours
- newly arrived patients aged 80 or over with an onset to arrival time of less than 2 hours
- patients already in hospital at time of stroke

***except patients*** with at least one medical reason for not giving thrombolysis that is **consistent** with information provided in other sections of the audit.

| | **Three month reporting** | | **Four month reporting** | | |
|---|---|---|---|---|---|
| **Minimum threshold for thrombolysis** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients eligible for thrombolysis (according to the RCP guideline minimum threshold) | 11.4% | 11.8% | 12.1% | 11.6% | *H16.50* |
| Percentage of eligible patients (according to above threshold) who were given thrombolysis | 85.6% | 85.7% | 87.7% | 88.1% | *H16.55* |

See the 'Technical Information' section of the 'Full Results Portfolio' on the SSNAP reporting portal for more details about how eligibility is calculated.

### 3.8.3 Complications following thrombolysis

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Thrombolysis complications (Q2.8) if patient received thrombolysis** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Patient had complications (Patients with complications/total number thrombolysed) | 9.5% (220/2309) | 9.2% (220/2391) | 8.6% (285/3331) | 7.7% (243/3137) | *H17.3, H17.1, H17.2* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Type of complication (as reported) (Q2.8.1)*** | **Oct-Dec 2015** N=2309 | **Jan-Mar 2016** N=2389 | **Apr-Jul 2016** N=3331 | **Aug-Nov 2016** N=3137 | *Ref* |
| Symptomatic intracranial haemorrhage (SIH) | 4.3% | 4.4% | 4.5% | 3.8% | *H17.6* |
| Angio oedema (AO) | 0.7% | 0.5% | 0.5% | 0.8% | *H17.8* |
| Extracranial bleed (EB) | 0.6% | 0.4% | 0.6% | 0.5% | *H17.10* |
| Other | 4.2% | 4.0% | 3.3% | 2.8% | *H17.12* |

*some patients had more than one type of complication

**Comment:** The symptomatic intracranial haemorrhage rate in patients treated with thrombolysis is in line with data from randomised controlled trials.

### 3.8.4 NIHSS 24 hours after thrombolysis

| | Three month reporting Four month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **NIHSS 24h after thrombolysis, if patient received thrombolysis (Q2.9)** | **Oct-Dec 2015** N=2309 | **Jan-Mar 2016** N=2389 | **Apr-Jul 2016** N=3331 | **Aug-Nov 2016** N=3137 | *Ref* |
| Known | 88.4% | 89.6% | 90.8% | 94.1% | *H18.3* |

| | | | | | |
|---|---|---|---|---|---|
| Not known | 11.6% | 10.4% | 9.2% | 5.9% | |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If NIHSS 24h after thrombolysis is known, severity groups:** | **Oct-Dec 2015** N=2042 | **Jan-Mar 2016** N=2140 | **Apr-Jul 2016** N=3070 | **Aug-Nov 2016** N=2951 | *Ref* |
| 0 | 14.2% | 14.4% | 15.2% | 15.1% | *H18.6* |
| 1-4 (minor stroke) | 33.5% | 32.7% | 34.3% | 33.8% | *H18.8* |
| 5-15 (moderate stroke) | 33.1% | 34.4% | 31.9% | 33.5% | *H18.10* |
| 16-20 (moderate/severe stroke) | 8.4% | 9.3% | 8.9% | 9.1% | *H18.12* |
| 21-42 (severe stroke) | 10.8% | 9.1 % | 9.6% | 8.4% | *H18.14* |

Cases that do not report NIHSS 24h after thrombolysis cannot be used in analyses into clinical outcomes after thrombolysis. SSNAP therefore requires high completion rates of NIHSS scores 24 hours after thrombolysis. Teams with less than 90% completion rate of NIHSS score after 24 hours are excluded from the SSNAP Collaboration. The SSNAP collaboration is an acknowledgement for use in peer reviewed papers, more details of which can be found in the link below.

https://www.strokeaudit.org/Research/SSNAP-Collaboration.aspx

**Comment:** A higher percentage of stroke admissions are thrombolysed than nearly every other country. The majority of patients not being thrombolysed, when there were no medical contraindications, were the result of services not being available on site or at the hour the patient arrived. Reorganisation of services is urgently needed in those areas that are still not providing specialist 24 hour hyperacute stroke care.

### 3.8.5 Emerging treatment: Thrombectomy

Thrombectomy is an emerging treatment in ischaemic stroke. It involves insertion of a guidewire catheter tube into an artery in the groin, and feeding this up into the blocked artery in the brain. The clot is then removed using a mechanical device with the aim of restoring blood and oxygen flow to the brain. If technically successful and done in time thrombectomy can greatly improve the outcome of the brain injury due to stroke in selected patients.

The evidence base for using thrombectomy in treating ischaemic stroke has expanded enormously over the past 18 months but the implications for implementation in routine clinical practice are still emerging. For any service providing thrombectomy, ensuring that treatment is provided safely and effectively is of the highest clinical importance. For this reason SSNAP added questions on intra-arterial therapy to the mandatory core dataset on 1 October 2015. Between August and November 2016, it was reported that 155 patients out of 23,798 ischaemic stroke patients received intra-arterial intervention and data on thrombectomy was submitted by 30 teams. The median number of thrombectomies per team was 3 (IQR 1-6) with one team carrying out 30 and another team carrying out 16-18. According to the 2016 Acute Organisational Audit 107 out of 158 sites that treat patients in the first 72 hours (including two neurosurgical centres), are able to provide patients with intra-arterial thrombectomy either on site (28/158) or by referral (51/158).

Though it is not possible to make meaningful conclusions on thrombectomy provision based on such low numbers at this early stage of data collection, median thrombectomy timings are provided in the table below to give the reader some insight into proposed future reporting. As thrombectomy provision becomes more widely available to patients across the country, it is expected that the number of cases submitted to SSNAP will increase making the data more robust. It will then be possible to provide more detailed results. Until the uptake of intra-arterial intervention increases and this is reflected in SSNAP data, national level results only will be reported on. Teams performing thrombectomies can however access their thrombectomy results through bespoke thrombectomy tools, available within the team level results section of the webtool.

| **Median (IQR) (in minutes)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
|---|---|---|---|---|---|
| Number of patients receiving thrombectomy | 51 | 73 | 164 | 155 | *G.19.1* |
| Onset to puncture | 235 mins (190-310) | 213 mins (172-290) | 231 mins (175-326) | 243 mins (176-312) | *G19.4 G19.5 G19.6* |
| Onset to completion | 310 mins (237-375) | 285 mins (225-350) | 314 mins (228-391) | 310.5 mins (248.5-374) | *G19.7 G19.8 G19.9* |
| Clock start to puncture | 145 mins (92-208) | 124 mins (84 – 171) | 120 mins (77-183) | 130 mins (90-204) | *G19.10 G19.11 G19.12* |
| Puncture to deployment* | 26 mins (15-35) | 20 mins (12 – 29) | 20 mins (10-34) | 21.5 mins (11-34) | *G19.13 G19.14 G19.15* |
| Puncture to end of procedure* | 60 mins (44-90) | 60 mins (40 -84) | 58 mins (35-85) | 53 mins (34-81.5) | *G19.16 G19.17 G19.18* |

**For patients where the device was not deployed these patients have been excluded from this timing*

## 3.9 Specialist assessments (Domain 4)

Following admission, there are a number of assessments that are considered mandatory elements of high quality stroke care. Some assessments (e.g. being seen by a nurse or stroke consultant) are applicable for all stroke patients. There are other instances where certain assessments do not apply for valid reasons. In these cases, teams can answer 'No but' and the record is excluded from the analysis of that particular standard. For example some patients may not need a formal swallow assessment as they had already passed their initial swallow screen. The 'compliant' percentage in the tables below indicates the proportion of *applicable* patients receiving the assessment in question.

### 3.9.1 Swallowing screening and assessments

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Swallow screening within 4h (Q2.10)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable to have swallow screening within 4h* | 89.4% | 89.8% | 90.3% | 90.7% | *H14.17* |
| Percentage of applicable patients who had swallow screening in 4 hours | 72.0% | 71.2% | 74.4% | 74.0% | *H14.20* |
| Median (IQR) time from clock start to swallow screening within 4h (hours & minutes) | 1h 25m (45m – 2h 28m) | 1h 23m (44m – 2h 28m) | 1h 21m (42m – 2h 25m) | 1h 21m (43m – 2h 25m) | *H14.12, H14.13, H14.14* |

*Applicable patients are those for whom Q2.10.1 is not answered "Patient refused" or "Patient medically unwell until time of screening".

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment within 72 hours (Q3.8)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for a formal swallow assessment within 72 hours* | 39.6% | 40.0% | 39.0% | 39.4% | *H15.21* |
| Percentage of applicable patients who had formal swallow assessment within 72 hours | 83.8% | 84.5% | 87.5% | 87.2% | *H15.24* |
| Median (IQR) time from clock start to formal swallow assessment | 20h 10m (5h 40m – 32h 51m) | 20h 03m (6h 30m – 30h 52m) | 19h 55m (6h 47m – 31h 02m) | 19h 54m (7h 24m – 30h 39m) | *H15.1, H15.2, H15.3* |

*Applicable patients are those for whom Q 3.8.1 is answered "patient refused", "patient medically unwell" or "Patient passed swallow screening"

**Comment:** Over 70% of applicable patients are screened for the safety of their swallowing within 4 hours of arrival. While this has improved since data collection began, it is disturbing that there are still so many cases not meeting this standard. This screening should be an essential component of the immediate evaluation of the patient. Swallow assessment within 72 hours of admission is achieved for almost 90% of applicable patients which is another area where results have improved.

### 3.9.2 Assessment by nurse

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Assessed by a nurse trained in stroke management (Q3.2)** | **Oct- Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Assessed within 72h | 94.4% | 94.7% | 95.1% | 95.2% | *H8.6* |
| *Within 12h* | *83.3%* | *83.0%* | *84.9%* | *84.6%* | *H8.9* |
| *12-24h* | *5.5%* | *6.0%* | *5.0%* | *5.4%* | *H8.11* |
| *24-72h* | *5.6%* | *5.7%* | *5.3%* | *5.1%* | *H8.13* |
| Median (IQR) time from clock start to assessment by stroke nurse | 1h 26m (10m – 4h 20m) | 1h 30m (08m – 4h 50m) | 1h 15m (06m – 4h 12m) | 1h 16m (06m – 4h 13m) | *H8.14, H8.15, H8.16* |

### 3.9.3 Assessment by stroke specialist consultant

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Assessed by a stroke specialist consultant physician (Q3.3)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Assessed within 72h | 93.4% | 93.8% | 94.4% | 94.6% | *H9.6* |
| *Within 12h* | 46.1% | 46.8% | 48.1% | 49.0% | *H9.9* |
| *12-24h* | 32.6% | 32.3% | 32.4% | 32.9% | *H9.11* |
| *24-72h* | 14.7% | 14.7% | 13.8% | 12.7% | *H9.13* |
| Median (IQR) time for assessment by stroke consultant physician | 12h 17m (1h 58m – 20h 42m) | 12h 03m (1h 58m – 20h 43m) | 11h 29m (1h 48m – 20h 10m) | 11h 09m (1h 45m – 19h 45m) | *H9.14 H9.15 H9.16* |
| Assessed within 14h | - | - | 53.0% | 54.1% | *H9.19* |

**Comment:** Approximately a fifth of stroke admissions are not seen by a specialist stroke physician within 24 hours of admission.

## 3.10 Therapy Assessments in first 72 hours (Part of Domain 8)

For physiotherapy, occupational therapy and speech and language therapy assessments, applicable patients are those that remain after patients who refused, were medically unwell or had no relevant deficit are excluded. According to the findings of the 2016 Acute Organisational Audit 31% of sites provided at least two types of therapy 7 days a week.

The 'compliant' percentage in the tables below indicates the proportion of *applicable* patients receiving the assessment in question.

**NB** The audit did not ask about applicability in relation to therapy assessments within 24 hours. Adherence is therefore calculated out of all patients but it is not aimed at 100% optimal level/value.

Please refer to Section 4.1 'assessments by discharge' and Section 5 'therapy intensity' for further information about each of the therapy disciplines.

### 3.10.1 Occupational Therapy Assessments in first 72 hours

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Assessed by an Occupational Therapist within 72h of Clock Start (Q3.5)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable to be assessed by an OT within 72h* | 86.2% | 86.6% | 86.7% | 87.1% | *H10.21* |
| Percentage of applicable patients assessed by an OT within 72 hours | 90.3% | 90.7% | 91.2% | 91.7% | *H10.24* |

*Applicable patients are those for whom Q3.5.1 is not answered as "Patient refused", "Patient medically unwell" or "Patient had no relevant deficit"

### 3.10.2 Physiotherapy Assessments in first 72 hours

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Assessed by a Physiotherapist within 72h of Clock Start (Q3.6)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Applicable to be assessed by a PT within 72h* | 88.9% | 89.0% | 89.5% | 89.4% | *H11.21* |
| Percentage of applicable patients assessed by an PT within 72 hours | 94.1% | 94.2% | 94.5% | 95.1% | *H11.24* |

*Applicable patients are those for whom Q3.6.1 is not answered as "Patient refused", "Patient medically unwell" or "Patient had no relevant deficit"

### 3.10.3 Speech and Language Therapy in first 72 hours

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Communication assessed by a Speech and Language therapist within 72h of Clock Start (Q3.7)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Applicable* to be assessed by a SALT within 72h | 47.0% | 47.1% | 48.5% | 49.9% | *H12.21* |
| Percentage of applicable patients assessed by a SALT within 72 hours | 85.1% | 86.4% | 88.3% | 89.0% | *H12.24* |

*Applicable patients are those for whom Q3.7.1 is not answered as "Patient refused", "Patient medically unwell" or "Patient had no relevant deficit"

**Comment:** Assessment by SALT, OT or PT within 72 hours of admission is not a particularly stringent target and should be achievable in the vast majority of cases. It is likely that services with rapid access to therapists are working more efficiently and are more likely to get their patients home more quickly, as well as initiating treatment earlier with the probability of a better outcome than when treatment is delayed.

# Section 4: Discharge results

## 4.1 Assessments by discharge

For physiotherapy, occupational therapy and speech and language therapy assessments, applicable patients are those that remain after patients who refused, were medically unwell or had no relevant deficit are excluded.

The 'compliant' percentage in the tables below indicates the percentage of *applicable* patients receiving the assessment in question.

For more information on assessments in the first 72 hours please see section 3.10.

### *4.1.1 Swallow assessment by discharge*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment by discharge (Q6.4)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for formal swallow assessment by discharge* | 41.4% | 42.3% | 41.7% | 41.6% | *J23.3* |
| Percentage of applicable patients who received formal swallow assessment by discharge | 91.1% | 91.4% | 92.9% | 93.0% | *J23.6* |
| Median time (IQR) from Clock Start to formal swallow assessment | 22h 52m (7h 28m – 48h 14m) | 22h 21m (8h 39m – 46h 53m) | 22h 11m (8h 59m – 46h 12m) | 22h 15m (10h 03m – 45h 45m) | *J23.7, J23.8, J23.9* |

*Includes patients who were assessed within 72h and those assessed between 72h and discharge.

**Comment:** It appears that hospitals are performing well in terms of achieving the standards for swallowing assessment. It is encouraging to see significant improvement in the number of patients receiving a swallow assessment by discharge since data collection began. I am however concerned looking at the data that there may be errors in completion of this item. It refers to when a speech and language therapist (or another professional trained in dysphagia assessment) sees a patient who has been identified on screening as possibly having problems with the safety of their swallow.

### *4.1.2 Physiotherapy assessment by discharge*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Physiotherapy assessment by discharge* (Q6.2)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for formal physiotherapy assessment by discharge* | 90.5% | 90.8% | 91.2% | 90.9% | *J21.3* |
| Percentage of applicable patients who received formal physiotherapy assessment by discharge | 98.9% | 98.8% | 98.9% | 99.1% | *J21.6* |
| Median time (IQR) from Clock Start to formal physiotherapy assessment | 22h 02m (16h 18m – 36h 14m) | 21h 56m (16h 15m – 36h 45m) | 21h 51m (15h 55m – 35h 33m) | 21h 31m (15h 40m – 31h 22m) | *J21.7 J21.8 J21.9* |

*Includes patients who were assessed within 72h and those assessed between 72h and discharge.

**Comment:** Almost all patients with motor deficits are assessed by a physiotherapist during their hospital stay. The median time from arrival (or stroke onset in hospital) was around 21.5 hours.

### *4.1.3 Occupational therapy assessment by discharge*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Occupational therapy assessment by discharge* (Q6.1)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for formal occupational therapy assessment by discharge* | 89.0% | 89.3% | 89.6% | 89.7% | *J20.3* |
| Percentage of applicable patients who received formal occupational therapy assessment by discharge | 98.3% | 98.3% | 98.3% | 98.5% | *J20.6* |
| Median time (IQR) from Clock Start (hrs & mins) to formal occupational therapy assessment | 23h 26m (17h 30m - 45h 35m) | 23h 05m (17h 17m - 44h 29m) | 23h 11m (17h 03m - 43h 59m) | 22h 48m (16h 39m - 42h 56m) | *J20.7, J20.8, J20.9* |

*Includes patients who were assessed within 72h and those assessed between 72h and discharge.

## 4.2 Speech and language therapy communication assessment by discharge

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Speech and language therapy communication assessment by discharge* (Q6.3)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for formal speech and language therapy communication assessment by discharge* | 49.0% | 48.9% | 50.3% | 51.9% | *J22.3* |
| Percentage of applicable patients who received formal speech and language communication therapy assessment by discharge | 95.8% | 95.7% | 96.3% | 96.6% | *J22.6* |
| Median time (IQR) from Clock Start (hrs & mins) to formal speech and language therapy communication assessment | 26h 46m (19h 16m – 54h 21) | 26h 01m (18h 45m – 51h 50m) | 25h 17m (17h 53m – 49h 45m) | 24h 42m (17h 48m – 48h 39m) | *J22.7* *J22.8* *J22.9* |

*Includes patients who were assessed within 72h and those assessed between 72h and discharge.

**Comment:** Though the vast majority applicable patients are seen by speech therapists during their stay, this percentage is not as high as for physiotherapy and occupational therapy. The median time between arrival or onset of stroke in hospital and assessment is less than 25 hours. This is longer than for the other two principal therapies and probably reflects the fact that very few services provide weekend speech and language therapy.

## 4.3 Multidisciplinary Working (part of Domain 8)

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Rehabilitation goals agreed (Q4.7)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for rehab goals within 5 days* | 81.5% | 81.6% | 82.2% | 82.8% | *J13.12* |
| Percentage of applicable patients who have rehab goals set within 5 days | 90.1% | 90.2% | 90.0% | 91.9% | *J13.15* |

*Patients are applicable unless they have no deficits, refuse rehabilitation goals, or are on palliative care and have no rehabilitation potential

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Bundle of care** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| If applicable, assessed by stroke nurse within 24h, at least one therapist within 24h, all applicable therapists within 72h and rehab goals agreed within 4 days | 57.4% | 57.8% | 58.7% | 61.8% | *J14.3* |

## 4.4 Standards by Discharge (Domain 9)

### *4.4.1 Nutritional screening, risk of malnutrition and dietitian*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Nutritional screening (Q6.6)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of ALL patients screened | 96.4% | 96.0% | 96.4% | 96.8% | *J16.3* |
| If screened for nutrition: | | | | | |
| Identified as being at high risk of malnutrition | 19.5% | 20.2% | 20.3% | 19.6% | *J16.6* |
| If identified as being at high risk of malnutrition following nutritional screening: | | | | | |
| Seen by a dietitian | 89.9% | 89.9% | 92.2% | 92.4% | *J16.9* |

**Comment:** Over 7% of patients identified as being at high risk of malnutrition on screening do not get to see a dietitian.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Combination of nutritional screening, risk of malnutrition, and seen by dietitian:** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for nutritional screening/being seen by a dietitian * | 15.7% | 16.6% | 16. 6% | 15.5% | *J16.12.1* |
| Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge** | 80.4% | 78.5% | 82.1% | 83.3% | *J16.15.1* |

*Patients are applicable if screened for nutrition AND identified as high risk, or not screened for nutrition.

** Patients who are indicated as being for palliative care (either within 72 hours or by discharge) are excluded from this measurement

### 4.4.2 Urinary continence plan

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Urinary continence plan by discharge from inpatient care (Q6.5)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of ALL patients for whom urinary continence plan drawn up | 39.7% | 40.3% | 40.2% | 40.4% | *J15.3* |
| Median (IQR) time from clock start to continence plan drawn up (in days) | 0 days (0-1) | 0 days (0-1) | 0 days (0-1) | 0 days (0-1) | *J15.12 J15.13 J15.14* |
| Percentage of patients applicable for urinary continence plan by discharge* | 43.7% | 43.9% | 43.3% | 43.2% | *J15.17* |
| Percentage of applicable patients for whom urinary continence plan drawn up by discharge | 91.0% | 91.7% | 92.8% | 93.5% | *J15.20* |

*Applicable patients are those for whom Q6.5.1 has not been answered "Patient refused" or "Patient continent"

**Comment:** Over 90% of patients with incontinence are having an assessment performed while an in-patient. It is encouraging to see sustained improvements in results each reporting period but given the profound impact of incontinence on a person's life, the fact that around 6% of patients are not being adequately assessed is unacceptable. Becoming incontinent as an adult is embarrassing and demoralising. It should be treated with the utmost sensitivity and skill. To ignore it and not even bother to establish the cause and treatment is unacceptable practice.

### 4.4.3 Mood and Cognition screening

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Mood screening (Q6.7)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for mood screening by discharge* | 86.0% | 85.9% | 85.2% | 85.2% | *J17.14* |
| Percentage of applicable patients who received mood screening by discharge | 87.3% | 86.0% | 88.4% | 89.9% | *J17.17* |

*Patients that are not applicable are those who refused either or both screens, patients who were medically unwell for entire admission and patients who were discharged from inpatient care within 7 days of clock start without receiving both screens are excluded from this indicator.

**Comment:** There remains a significant issue in terms of screening patients for mood disturbance. Over 50% of patients are likely to have a significant depression or anxiety state at some time after their stroke. This is frequently seen early after the stroke and it is vital that the diagnosis is made early and patients helped to deal with the problem. While there have been continued improvements in mood screening many patients who should be screened are not.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Cognition screening (Q6.7)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Percentage of patients applicable for cognition screening by discharge* | 83.4% | 82.9% | 82.5% | 82.9% | *J18.14* |
| Percentage of applicable patients who received cognition screening by discharge | 91.9% | 91.3% | 92.3% | 93.5% | *J18.17* |

*Applicable patients are those for whom Q6.7.1 or Q6.8.1 has not been answered "Patient refused" or "Patient medically unwell for entire admission" and whose total length of stay is 7 days or longer.

**Comment:** There are similar issues with screening for cognitive impairment where about 6% of patients are not being evaluated in the way that they should.

**Comment:** The data shows that there remain issues about the quality of care being provided after the first 72 hours. There is rarely an excuse not to achieve all of these aspects of care. They are not optional. Though it is important to recognise that post 72 hour results have significantly improved since data collection began, efforts should be made to improve these aspects of care further going forward.

## 4.5 Patient Condition up to discharge

### 4.5.1 Worst Level of consciousness in first 7 days

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Patient's worst level of consciousness (LOC) in the first 7 days (Q5.1)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| 0: Alert keenly responsive | 79.6% | 79.4% | 79.5% | 79.9% | *J24.3* |
| 1: Not alert but arousable by minor stimulation | 8.3% | 8.6% | 8.8% | 8.3% | *J24.5* |
| 2: Not alert but require repeated stimulation to attend | 4.7% | 4.7% | 4.7% | 4.7% | *J24.7* |
| 3: Respond only with reflex motor or autonomic effects /totally unresponsive | 7.4% | 7.4% | 6.9% | 7.1% | *J24.9* |

### 4.5.2 Urinary tract infection in first 7 days

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Did the patient develop a urinary tract infection in the first 7 days? (Q5.2)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 4.5% | 4.8% | 4.6% | 4.7% | *J25.3* |
| No | 94.9% | 94.2% | 94.6% | 94.6% | *J25.5* |
| Not known | 0.6% | 1.0% | 0.8% | 0.6% | *J25.7* |

### 4.5.3 Pneumonia in first 7 days

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Did the patient receive antibiotics for a newly acquired pneumonia in the first 7 days? (Q5.3)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 8.1% | 8.8% | 8.7% | 8.7% | *J26.3* |
| No | 91.3% | 90.2% | 90.6% | 90.7% | *J26.5* |
| Not known | 0.6% | 1.0% | 0.8% | 0.6% | *J26.7* |

The following paper authored by Craig J. Smith and Benjamin D. Bray and published in the Journal of the American Heart Association, uses SSNAP data to derive a clinical risk score for predicting stroke-associated pneumonia.
https://www.strokeaudit.org/SupportFiles/Documents/Research/J-Am-Heart-Assoc-2015-Smith.aspx

### 4.5.4 Modified Rankin Scale score at discharge

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Modified Rankin Scale (mRS) score at discharge (Q7.4)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| 0 (no symptoms) | 12.0% | 12.1% | 12.5% | 12.2% | *J28.3* |
| 1 (no significant disability) | 18.8% | 18.3% | 18.6% | 18.2% | *J28.5* |
| 2 (slight disability) | 15.8% | 15.7% | 15.6% | 16.3% | *J28.7* |
| 3 (moderate disability) | 17.0% | 17.4% | 17.4% | 17.3% | *J28.9* |
| 4 (moderately severe disability) | 14.8% | 14.2% | 14.7% | 14.6% | *J28.11* |
| 5 (severe disability) | 6.9% | 7.0% | 7.1% | 7.0% | *J28.13* |
| 6 (Dead) | 14.8% | 15.2% | 14.2% | 14.3% | *J28.15* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Modified Rankin Scale (mRS) score Median (IQR)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| mRS score before stroke | 0 (0-2) | 0 (0-2) | 0 (0-2) | 0 (0-2) | *J28.16, J28.17, J28.18* |
| mRS score at discharge | 3 (1-4) | 3 (1-4) | 3 (1-4) | 3 (1-4) | *J28.19, J28.20, J28.21* |
| Change in mRS score | 1 (0-3) | 1 (0-3) | 1 (0-3) | 1 (0-3) | *J28.22, J28.23, J28.24* |

### 4.5.5 Palliative care

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Patients for palliative care after 72 hrs* (Q6.9)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 11.7% | 12.0% | 11.8% | 12.1% | *J29.3* |

*Palliative care decision between 72h and discharge from inpatient care.

**Comment:** One of the areas of care that we need to improve is care of the patients when they are unlikely to survive. The evidence suggests that patients prefer to die at home. We appear to be achieving this for only a small minority of patients.

### 4.5.6 Intermittent Pneumatic Compression (IPC)

Intermittent Pneumatic Compression (IPC) reduces the risk of a person admitted to hospital with a stroke developing a deep vein thrombosis (DVT). The CLOTS 3 trial results showed a 3.6% decrease in absolute risk reduction in the incidence of DVT and that IPC improves the six month survival rate of stroke patients.

In August 2013 NHS England and NHS Improving Quality (NHS IQ) put forward a bid to supply approximately six months' worth of IPC sleeves to all stroke units in an effort to realise the benefits in every day practice. To ascertain the level of implementation of IPC sleeves following the findings of the trial, the questions related to IPC were added to the revised SSNAP dataset and are mandatory for patients admitted on or after 1 April2014.

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| Patients who have intermittent pneumatic compression applied at any point | **Oct-Dec 2015** N=20408 | **Jan-Mar 2016** N=20223 | **Apr-Jul 2016** N=27605 | **Aug-Nov 2016** N=26658 | *Ref* |
| Yes | 17.7% | 18.7% | 19.0% | 20.6% | *J35.3* |
| No | 78.1% | 78.2% | 78.9% | 77.7% | *J35.5* |
| Not Known | 4.2% | 3.1% | 2.1% | 1.7% | *J35.7* |
| If yes: | N=3611 | N=3776 | N=5238 | N=5491 | *J35.2* |
| Median length of time IPC is applied for | 7 days IQR (2-16) | 6 days IQR (2-15) | 6 days IQR (2-15) | 6 days IQR (2-15) | *J35.8 J35.9, J35.10* |
| Mean length of time IPC is applied for | 14 days | 13 days | 13 days | 12 days | *J35.11* |

**Comment:** Since 2012 there is new RCT evidence to support intermittent pneumatic compression device use in selected stroke patients. We will look to monitor the implementation of this at a patient level in SSNAP.

### 4.5.7 Mortality Data on SSNAP

Based on data collected on SSNAP from April 2015 - March 2016, it is reported that 13.6% of stroke patients admitted to hospitals in England and Wales died (either in hospital or after being discharged from inpatient care) within 30 days of clock start. Annual mortality results including those for 2013/14 and 2014/15 and 2015/2016 at provider level are publicly available on the SSNAP webtool. Provider level mortality results are adjusted for case mix including stroke severity and presented as a standardised mortality ratio.

https://www.strokeaudit.org/results/Clinical/National-Results

## 4.6 Length of Stay

Participation of post-acute teams has continued to increase, and therefore an increased number of records have been fully completed and locked to discharge which will more accurately reflect length of stay across the entire pathway.

(See section 3.6 for additional stroke unit key indicators).

### *4.6.1 Length of stay in an inpatient setting*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Length of stay (in days)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Length of stay from Clock Start to final inpatient discharge including death (in days) | Median = 7.2 IQR (2.8-22.3) Mean = 18.4 | Median = 7.3 IQR (2.8-23.1) Mean = 18.6 | Median = 7.3 IQR (2.8-24.1) Mean = 19.0 | Median = 7.2 IQR (2.8-23.6) Mean = 19.2 | *J8.1, J8.2, J8.3, J8.4* |

**Comment:** The median length of stay in this cohort for all patients (including deaths in hospital) is 7.2 days which is shorter than we would have expected.

### *4.6.2 Length of stay on Stroke Unit*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Length of stay on stroke unit (in days)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Length of stay on an SU across inpatient pathway - based on component parts of provider level SU length of stay (in days) | Median = 6.3<br>IQR (2.1-20.4)<br>Mean = 16.9 | Median = 6.3<br>IQR (2.1-20.9)<br>Mean = 16.9 | Median = 6.4<br>IQR (2.1-21.9)<br>Mean = 17.4 | Median = 6.2<br>IQR (2.1-21.6)<br>Mean = 17.7 | *J8.5, J8.6, J8.7, J8.8* |

(excludes patients who go straight to ITU/CCU/HDU at any provider during their inpatient stay)

### *4.6.3 90% of stay on Stroke Unit (Part of Domain 2)*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Is over 90% of a patient's stay in hospital spent on a stroke unit?** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 84.4% | 82.4% | 84.0% | 84.8% | *J8.11* |

(excludes patients who go straight to ITU/CCU/HDU at any provider during their inpatient stay)

**Comment:** While we are managing to treat most patients at some stage on a stroke unit, approximately 15% are not spending at least 90% of their stay on the unit.

### *4.6.4 Delays in discharging patients who no longer require inpatient rehabilitation*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Date patient considered by the multidisciplinary team to no longer require inpatient rehabilitation (Q7.3.1)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Number of days from patient no longer requiring inpatient rehabilitation to stroke unit discharge (Mean) | 0.6 days | 0.6 days | 0.8 days | 0.9 days | *K20.7* |
| Number of days from patient no longer requiring inpatient rehabilitation to hospital discharge (Mean) | 1.0 days | 1.0 days | 1.1 days | 1.1 days | *K20.8* |

**Comment:** It is important that where there are delays in arranging discharge, for whatever reason, these are documented and data submitted to SSNAP.

## 4.7 Discharge Processes (Domain 10)

### *4.7.1 Discharge destination*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Discharge destination (Q7.1)** | **Oct-Dec 2015** N=20409 | **Jan-Mar 2016** N=20223 | **Apr-Jul 2016** N=27606 | **Aug-Nov 2016** N=26659 | *Ref* |
| Discharged alive from inpatient care | 85.2% | 84.8% | 85.8% | 85.7% | *J9.14* |
| *Discharged to a care home* | *9.8%* | *10.0%* | *9.5%* | *9.3%* | *J9.5* |
| *Discharged home* | *37.2%* | *36.0%* | *36.5%* | *35.4%* | *J9.7* |
| *Discharged somewhere else* | *2.4%* | *2.2%* | *1.9%* | *2.1%* | *J9.9* |
| *Transferred to an ESD/community team* | *29.4%* | *30.3%* | *31.1%* | *32.3%* | *J9.10.2* |
| *Transferred to a non-participating inpatient team* | *4.0%* | *4.0%* | *4.0%* | *3.6%* | *J9.11.2* |
| *Transferred to a non-participating ESD/community team* | *2.3%* | *2.3%* | *2.8%* | *3.0%* | *J9.11.4* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged home (Q7.6)** | **Oct-Dec 2015** N=7597 | **Jan-Mar 2016** N=7283 | **Apr-Jul 2016** N=10071 | **Aug-Nov 2016** N=9431 | *Ref* |
| Living Alone | 26.2% | 25.3% | 25.2% | 25.2% | *J9.21* |
| Not living alone | 71.3% | 72.4% | 72.3% | 73.1% | *J9.23* |
| Not known | 2.5% | 2.2% | 2.5% | 1.7% | *J9.25* |

### *4.7.2 Care home discharge*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged to a care home (Q7.5)** | **Oct-Dec 2015** N=1998 | **Jan-Mar 2016** N=2021 | **Apr-Jul 2016** N=2615 | **Aug-Nov 2016** N=2466 | *Ref* |
| Previously a resident | 36.4% | 33.3% | 35.4% | 34.8% | *J9.28* |
| Not previously a resident | 63.6% | 66.7% | 64.6% | 65.2% | *J9.30* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive from inpatient care:** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N=22834 | *Ref* |
| Newly institutionalised (discharged to a care home where not previously a resident) | 7.3% | 7.9% | 7.1% | 7.0% | *J9.33* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If newly institutionalised:** | **Oct-Dec 2015** N=1271 | **Jan-Mar 2016** N=1348 | **Apr-Jul 2016** N=1689 | **Aug-Nov 2016** N=1689 | *Ref* |
| Temporary | 20.1% | 21.9% | 19.7% | 20.9% | *J9.36* |
| Permanent | 79.9% | 78.1% | 80.3% | 79.1% | *J9.38* |

**Comment:** About 85% of patients leave hospital alive after a stroke, with about a third of those returning home. Close to 10% are discharged to a care home, with 65% of these being sent to a home for the first time. Approximately 80% of these were expected to become permanent residents. The new institutionalisation rate is an important measure of outcome, which at 7% is lower than we have previously seen in the Sentinel audits where there were rates of about 10-15%.

### *4.7.3 Early Supported Discharge and Multidisciplinary Community Rehabilitation Teams*

According to published literature, approximately 34% of stroke patients are considered eligible for ESD.[2]

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive from previous team did the patient go on to receive therapy with an Early Supported Discharge team? (Q7.7)** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N=22834 | *Ref* |
| Yes, stroke/neurology specific | 33.7% | 34.3% | 33.7% | 34.5% | *J10.3* |
| Yes, non-specialist | 1.0% | 1.0% | 0.8% | 0.8% | *J10.5* |
| No | 65.3% | 64.7% | 65.5% | 64.7% | *J10.7* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive from previous team did the patient go on to receive therapy with a multidisciplinary community rehabilitation team? (Q7.8)** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N=22834 | *Ref* |
| Yes, stroke/neurology specific | 22.0% | 21.9% | 22.1% | 20.7% | *J11.3* |
| Yes, non-specialist | 6.0% | 5.4% | 5.5% | 5.6% | *J11.5* |
| No | 72.0% | 72.7% | 72.4% | 73.6% | *J11.7* |

[2] http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000443.pub3/pdf/standard

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive, was it with either ESD or CRT?** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N= 22834 | *Ref* |
| Discharged with a stroke/neurology specific service* | 49.1% | 49.3% | 49.3% | 49.3% | *J12.3* |

*Also includes patients who are discharged with both ESD and CRT if at least one is stroke/neurology specific.

**Comment:** Approximately 34% of patients alive at discharge are discharged using a stroke or neurology specific early supported discharge team which is a marked improvement compared to the 2010 National Sentinel Stroke Audit results. Whilst about half of patients are discharged with plans for on-going rehabilitation from a specialist team, including ESD or community neurorehabilitation, only about 38% of patients who were discharged alive from inpatient care had their record transferred on the SSNAP data collection tool to an ESD or community rehabilitation team for continued data entry. It is encouraging that this figure is increasing as more post-acute teams register and participate in SSNAP but further improvements are needed if we are to get an accurate picture of the whole of the patient pathway.

### *4.7.4 Activities of Daily Living*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive, required help with activities of daily living (ADL)? (Q7.9)** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N=22834 | *Ref* |
| Yes | 41.5% | 40.6% | 40.0% | 40.4% | *J30.3* |
| No | 58.5% | 59.4% | 60.0% | 59.6% | |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If patient required help with ADL, what help did they receive (Q7.9.1)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Paid carers | 68.1% | 68.0% | 68.9% | 68.2% | *J30.6* |
| Informal carers | 18.4% | 19.0% | 17.8% | 17.9% | *J30.8* |
| Paid and informal carers | 12.1% | 11.6% | 12.1% | 12.9% | *J30.10* |
| Paid care services unavailable | 0.2% | 0.1% | 0.1% | 0.1% | *J30.12* |
| Patient refused | 1.3% | 1.3% | 1.1% | 0.9% | *J30.14* |
| Applicable for receiving help for ADL (not refused) | 98.7% | 98.7% | 98.9% | 99.1% | *J30.17* |
| Compliant (any type of paid services) | 81.2% | 80.6% | 81.9% | 81.8% | *J30.20* |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If patient required help with ADL, number of social service visits per week (Q7.9.2)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| 0 visits | 31.6% | 32.8% | 32.9% | 34.4% | *J31.18* |
| At least one visit per week | 30.2% | 29.8% | 31.6% | 33.0% | *J31.20* |
| *1-6 visits* | *1.4%* | *1.0%* | *1.1%* | *0.9%* | *J31.5* |
| *7-13 visits* | *5.2%* | *5.2%* | *5.3%* | *5.7%* | *J31.7* |
| *14-20 visits* | *6.1%* | *6.2%* | *6.0%* | *6.4%* | *J31.9* |
| *21-27 visits* | *5.4%* | *4.9%* | *5.0%* | *5.6%* | *J31.11* |
| *28+ visits* | *12.1%* | *12.5%* | *14.3%* | *14.4%* | *J31.13* |
| Not known | 38.2% | 37.4% | 35.5% | 32.6% | *J31.15* |

**Comment:** Approximately 40% of patients are discharged needing help with activities of daily living. Nearly a fifth receive this solely from unpaid carers and about two thirds from only paid carers. The remainder receive help from both paid and unpaid carers. 19% of patients requiring help with ADL receive three or more visits a day from social services.

### *4.7.5 Atrial Fibrillation at Discharge*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive, is patient in Atrial Fibrillation (AF) (Q7.10)** | **Oct-Dec 2015** N=17395 | **Jan-Mar 2016** N=17140 | **Apr-Jul 2016** N=23697 | **Aug-Nov 2016** N=22834 | *Ref* |
| Patient in Atrial Fibrillation | 22.2% | 21.7% | 21.6% | 21.3% | *J32.3* |
| Patient not in Atrial Fibrillation | 77.8% | 78.3% | 78.4% | 78.7% | |

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If in AF, patient given anticoagulation (Q7.10.1)** | **Oct-Dec 2015** N=3857 | **Jan-Mar 2016** N=3725 | **Apr-Jul 2016** N=5123 | **Aug-Nov 2016** N=4858 | *Ref* |
| Yes | 83.5% | 83.1% | 83.4% | 83.3% | *J32.6* |
| No | 2.1% | 2.6% | 2.2% | 2.1% | *J32.8* |
| No but | 14.5% | 14.3% | 14.4% | 14.6% | *J32.10* |
| | | | | | |
| Applicable for receiving anticoagulation | 16.2% | 15.8% | 15.9% | 15.6% | *J32.13* |
| Compliant | 97.6% | 97.0% | 97.4% | 97.5% | *J32.16* |

### *4.7.6 Joint Care Planning*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive, did the patient receive a joint health and social care plan at discharge (Q7.11)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 47.1% | 46.4% | 48.0% | 49.4% | *J33.3* |
| No | 5.6% | 5.2% | 5.0% | 5.2% | *J33.5* |
| Not applicable | 47.3% | 48.4% | 47.0% | 45.4% | *J33.7* |
| | | | | | |
| Applicable for receiving a joint care plan | 44.9% | 43.7% | 45.5% | 46.8% | *J33.10* |
| Compliant | 89.3% | 89.9% | 90.5% | 90.6% | *J33.13* |

### *4.7.7 Named contact at discharge*

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **If discharged alive, was there a named person for the patient and/or carer to contact after discharge? (Q7.12)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Yes | 92.0% | 92.4% | 93.3% | 96.6% | *J34.3* |
| No | 8.0% | 7.6% | 6.7% | 3.4% | |

**Comment:** Approximately 90% of the patients with ongoing health and social care needs are discharged with joint health and social care plans. This represents an increase of over 25 percentage points since data collection began in 2013. Over 90% of patients are given a named contact on discharge. This is another area which has shown consistent improvements each reporting period. However, further improvements are needed as the failure to provide joined up services after discharge is one of the principle areas of concern raised by patients. We are also doing better in terms of anticoagulating or making plans to anticoagulate patients in atrial fibrillation.

# Section 5: Therapy intensity

2016 NICE QS Statement 2

Patients with stroke are offered a minimum of 45 minutes per day of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it

The aim of the therapy measures reported on by SSNAP is to get an overall picture of the intensity of each therapy being provided to patients i.e. to look at national changes over time, for teams to benchmark themselves against national level results and to look at differences between teams in terms of percentage of patients being considered to require each therapy and the average time patients get across their entire length of stay as an inpatient. SSNAP allows teams to reflect when a patient no longer requires one type of therapy but still requires another. This way the intensity of each therapy provided can be compared against what was required.

*Note: SSNAP collects data on whether a patient was considered to require therapy at any point in the admission and does not reflect whether the patient required or was able to tolerate therapy on each day.*

We have calculated a proxy measure for the **NICE quality standard** by combining the percentage of patients considered to require therapy, the percentage of days on which each therapy was received, and the average number of therapy minutes received per day.

**Patients:** The benchmark for levels of patients requiring therapy is 80% for occupational therapy, 85% for physiotherapy and 50% for speech and language therapy. This has been derived using data collected in previous rounds of stroke audit and has proved to be consistent at national level.

**Minutes:** In line with the NICE quality standard, the benchmark is 45 minutes of therapy provided per day 5 days a week. If a patient receives therapy 7 days a week the benchmark is equivalent therefore to 32 minutes per day.

**Days:** In line with the NICE quality standard, an adjustment is made to the total number of days on which therapy was received to approximate the number of *working* days by multiplying by 5 out of 7 (approximately 70%).

To improve performance in the therapy domains, teams may need to improve one or more of the 3 elements. Taking national level results for occupational therapy as an example,

- 83.6% of patients nationally were considered to require therapy
- a median of 40.7 minutes of therapy was provided per day (based on 7 day week)
- therapy was delivered on 64.9% of inpatient days.

These figures show that the percentage of patients considered applicable is in line with the expected level of 80% and the number of therapy minutes *across 7 days* exceeds what would be recommended across this time period (target for 7 days = 32 minutes) if the NICE quality standard was extrapolated. However, the percentage of days on which therapy is provided is below the NICE quality standard of approximately 70%.

With limited resources to achieve equilibrium between patients, days and minutes, the goal is to maximise the use of resources to benefit the highest number of patients throughout their stay. Therapy teams can chose to deliver this therapy as either one 45 minute session a day or through several shorter sessions throughout the day.

In addition to this, SSNAP produces a therapy pack, a comprehensive guide to therapy data and reporting in SSNAP. The guide is published each reporting period and contains useful information on the submission of data, FAQs and an explanation of how data are presented.

The guide is available to logged in users at:
https://www.strokeaudit.org/Support/Resources/Therapy-Resources.aspx

## 5.1 Occupational Therapy (Domain 5)

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Occupational Therapy** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients reported as requiring occupational therapy | 83.6% | 83.6% | 83.5% | 83.6% |
| Median number of minutes per day on which occupational therapy is received | 41.3 mins | 40.0 mins | 40.0 mins | 40.7 mins |
| Median % of days as an inpatient on which occupational therapy is received | 63.5% | 61.7% | 62.3% | 64.9% |
| Proxy for 2016 NICE Quality Standard Statement 2: % of the minutes of occupational therapy required (according to 2016 NICE QS-S2) which were delivered | 85.1% | 80.2% | 80.9% | 85.9% |

## 5.2 Physiotherapy (Domain 6)

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Physiotherapy** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients reported as requiring physiotherapy | 85.4% | 85.0% | 85.3% | 85.1% |
| Median number of minutes per day on which physiotherapy is received | 34.5 mins | 33.8 mins | 34.5 mins | 35 mins |
| Median % of days as an inpatient on which physiotherapy is received | 71.6% | 69.7% | 70.7% | 73.7% |
| Proxy for 2016 NICE Quality Standard Statement 2: % of the minutes of physiotherapy required (according to 2016 NICE | 77.2% | 73.2% | 76.3% | 80.3% |

| | | | | |
|---|---|---|---|---|
| QS-S2) which were delivered | | | | |

### 5.3 Speech and Language Therapy (Domain 7)

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key Indicators: Speech and Language Therapy** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Percentage of patients reported as requiring speech and language therapy | 49.4% | 48.8% | 50.0% | 50.7% |
| Median number of minutes per day on which speech and language therapy is received | 32.5 mins | 31.5 mins | 32.0 mins | 31.5 mins |
| Median % of days as an inpatient on which speech and language therapy is received | 44.7% | 45.0% | 45.3% | 48.1% |
| Proxy for 2016 NICE Quality Standard Statement 2: % of the minutes of speech and language therapy required (according to 2016 NICE QS-S2) which were delivered | 44.7% | 43.0% | 45.1% | 47.8% |

**Comment:** There has been progress made over the last couple of years in terms of the intensity of therapy provided by all of the disciplines, although there is still room for further improvement. The median number of minutes of therapy on the days that patients receive it is 41 minutes for OT, 35 minutes for PT and 32 minutes for SALT. However, there are days when patients should be undergoing therapy and yet they receive none. When these are added in to the equation then the median number of minutes will be lower.

### 5.4 Psychology

| | Three month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Psychology (Q4.4 – 4.6)** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| Applicable for psychology | 5.6% | 5.7% | 5.6% | 5.3% | *J7.3* |
| Median % of the days in hospital on which psychology is received | 9.1% | 9.3% | 9.5% | 9.9% | *J7.4* |
| Median number (IQR) of minutes per day on which therapy is received | 38.8 mins (30 - 51.7 mins) | 40.0 mins (30 – 51.7 mins) | 40.0 mins (30 – 54 mins) | 40.0 mins (30 – 53.8 mins) | *J7.5, J7.6, J7.7* |

**Comment:** The finding that only about 6% of patients need psychology is not consistent with published literature on the prevalence of cognitive and mood difficulties, or the self-reported, long term, unmet needs of stroke survivors. It is important to clarify that teams should answer that the patient is applicable if the patient has any psychological difficulty even if the service does not have access to a psychologist or other mental health professional.

# Section 6: Early supported discharge and community rehabilitation preliminary results

## 6.1 Introduction

Although national stroke audits have routinely collected data for acute stroke care and services since 1998, up until recently, there has been limited opportunity to audit and benchmark post-acute stroke services in the same way. With the arrival of SSNAP in early 2013, and the expansion of stroke clinical audit up to 6 months post-stroke, this changed and there are now 123 domiciliary services submitting data and receiving reports on the care they provide their stroke patients.

### 6.1.1 Domiciliary teams and SSNAP

There is no single model of stroke care organisation or commissioning and consequently pathways of stroke care beyond the acute setting are complex. The 2015 post-acute audit reported on the availability and structure of stroke services in community settings, we can now estimate that there are 160 teams providing ESD and approximately 200 community rehabilitation services in England and Wales. More information on this pioneering audit can be found here:
http://www.strokeaudit.org/results/PostAcute.aspx

There are currently 320 teams working in the community registered on SSNAP, a total of 197 domiciliary teams have submitted at least one record to this report and 123 of these teams submitted enough records to receive named team results. We congratulate these teams for leading the way in SSNAP data collection. A full list of the domiciliary teams which submitted sufficient data to receive results can be found in the results portfolio.

https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx

It is clear that certain areas of the country are performing significantly better than others in terms of submitting domiciliary data to the audit. It is therefore important that all post-acute inpatient teams and community teams are encouraged to register for SSNAP and fully complete the information collected at this stage on all records transferred to them to give an accurate picture of the whole of the patient pathway.

### 6.1.2 Early supported discharge and community rehabilitation

A key element of the National Stroke Strategy is the implementation of early supported discharge (ESD). ESD is a system in which rehabilitation is provided to stroke patients at home instead of at hospital by a multi-disciplinary team at the same intensity as inpatient care. ESD should be stroke

specific and delivered by teams with specialist stroke skills. According to literature, approximately 34% of stroke patients are considered eligible for ESD [3].

ESD can result in better outcomes for patients including reduction of long-term mortality and institutionalisation rates, increased independence six months after a stroke and increased capacity to undertake activities of daily living and greater patient satisfaction (Langhorne et al 2005). Benefits have also been identified for acute hospital providers with reduced lengths of stays for stroke patients.

Community stroke rehabilitation services cater for those stroke survivors who are able to return home following inpatient rehabilitation or ESD. Access to a specialist stroke multi-disciplinary community rehabilitation team should be available to all those for whom it is clinically appropriate.

The needs of patients being treated by these teams will differ case by case. For example, some will need only one therapy while others will need several. Domiciliary stroke services should be designed around the needs of the stroke survivor and their family and be appropriate for all ages. For example, patients with aphasia and other communication-related impairments will have specific needs while working age adults will have different recovery goals such as returning to work or parenting.

From research literature, it is known that there is a wide variation in the availability of rehabilitation and community services. Some areas have ESD, responsive community stroke rehabilitation teams and vocational rehabilitation services which demonstrate good outcomes and value for money. Other areas have no dedicated community stroke service and are without access to even generic rehabilitation teams. This inequality of access to services results in variation in patient experience and outcomes. The Care Quality Commission (CQC, 2011) reported across a number of aspects of ESD and community rehabilitation services and concluded: 'the overall picture is one of inconsistency, waits between transfer home and commencing community rehabilitation and lack of specialist access.'

### 6.1.3 Interpreting the SSNAP results

SSNAP publicly reports results for domiciliary teams at national and provider level. SSNAP now reports domiciliary results over a four month reporting period, in the same way that results for inpatient teams are reported. In the past, SSNAP combined 2 quarters worth of domiciliary data due to the slower rate of recruitment of these teams but now SSNAP has been collecting data for years it is expected that all domiciliary teams should be participating and entering all their data to SSNAP.

National figures have been calculated based on the combined data input by ESD teams, CRT teams and a small number of teams which provide both of these functions. In the text that follows the term used will be 'domiciliary team' as there is insufficient data to report on the different types of team separately. However, it should be noted that ESD and CRT teams have distinct functions and, in the future, results for each type of team will be presented separately to better reflect this.

The mechanics of collecting information at this stage of the pathway require the inpatient team to collect data on SSNAP about the processes of care as an inpatient and to send the data electronically to the next team to continue the electronic data capture. The domiciliary team has to be registered to have permission to complete the electronic record. Between August - November 2016:

[3] http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000443.pub3/pdf/standard

11,260 patients were reported in SSNAP as being discharged with a stroke specific domiciliary service (ESD or CRT team). This is approximately 45% of all patients discharged alive from inpatient care.

- However, only 8,617 patient records were electronically transferred to domiciliary teams for further information to be collected on SSNAP.
- In this time period, 6564 electronic records were **fully** completed by the domiciliary team for 6395 patients.

It is planned to report on case ascertainment for domiciliary teams using data from the post-acute organisational audit in the future.

Provider level results for teams submitting at least 20 records are publicly available. Please see Tab L of the 'Full Results Portfolio' on the SSNAP Reporting Portal for these results.
http://www.strokeaudit.org/results/National-Results.aspx

## 6.2 Results for Domiciliary Teams

Domiciliary teams August – November 2016.

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Rehabilitation Goals** | **Jul-Dec 2015** N=9076 | **Oct 2015-Mar 2016** N=9655 | **Apr-Jul 2016** N=6684 | **Aug- Nov 2016** N=6564 | *Ref* |
| Reported on SSNAP as applicable for rehabilitation goals while being treated by a domiciliary team | 89.9% | 89.8% | 90.8% | 91.5% | *L2.3* |
| If applicable, rehabilitation goals set by domiciliary team | 94.4% | 94.2% | 94.2% | 95.4% | *L2.6* |
| Median number of days under the care of a domiciliary team until rehabilitation goals are set | 0 (0 -3) | 0 (0-2) | 0 (0-1) | 0 (0-1) | *L2.7, L2.8, L2.9* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Modified Rankin Scale (mRS) score** Median (IQR) | **Jul-Dec 2015** | **Oct 2015-Mar 2016** | **Apr-Jul 2016** | **Aug- Nov 2016** | *Ref* |
| mRS score at discharge from domiciliary teams | 2 (1-3) | 2 (1-3) | 2 (1-3) | 2 (1-3) | *L3.1, L3.2, L3.3* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Duration of treatment (in days)** | **Jul-Dec 2015** | **Oct 2015-Mar 2016** | **Apr-Jul 2016** | **Aug- Nov 2016** | *Ref* |
| Duration of treatment with a domiciliary team (in days) | Median 36.0<br>IQR (16.0 – 54.9)<br>Mean 46.4 | Median 36.0<br>IQR (16.9 – 54.9)<br>Mean 47.1 | Median 37.1<br>IQR (18.0 – 56.8)<br>Mean 48.6 | Median 36.8<br>IQR (16.9 – 56.3)<br>Mean 48.5 | *L4.1, L4.2, L4.3, L4.4* |
| Number of days between discharge from inpatient care to first direct contact with domiciliary team | Median = 1<br>IQR (0-2) | Median = 1<br>IQR (0-3) | Median = 1<br>IQR (0-3) | Median = 1<br>IQR (0-3) | *L4.5, L4.6, L4.7* |

### 6.2.1 Therapy results

This section presents results about the intensity of rehabilitation provided by domiciliary teams in the community. As described earlier in this report, intensity of therapy is collected separately for each part of the patient's pathway.

The tables in this section present results for the 6,564 patient records for which data on therapy whilst under domiciliary care is available.

The results cover 4 aspects:

- the percentage of patients reported as being **applicable** for each therapy during their domiciliary rehabilitation
- the percentage of **days** on which therapy was provided
- the median number of **daily therapy minutes** received on **each day** therapy was provided
- the median number of **daily therapy minutes** received across the **entire treatment period** under domiciliary team (i.e. regardless of whether or not therapy was provided every day).

Note: SSNAP collects data on whether a patient was considered to require therapy at any point whilst under the care of a domiciliary team and does not reflect whether the patient required or was able to tolerate therapy on each day.

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Occupational Therapy** whilst being treated by a domiciliary team | **Oct-Dec 2015** N=9076 | **Oct 2015-Mar 2016** N=9655 | **Apr-Jul 2016** N=6684 | **Aug-Nov 2016** N=6564 | *Ref* |
| Percentage of **patients** reported as **applicable** for OT at any point during treatment | 80.1% | 80.7% | 79.5% | 80.2% | *L6.3* |
| Median percentage of **days** on which OT is received by the patient | 21.5% | 21.5% | 20.9% | 21.3% | *L6.4* |
| Number of OT **minutes** received per day (on days when OT is provided) Median (IQR) | 50 mins (41.4–60 mins) | 50 mins (40.9-60 mins) | 48.8 mins (40-60 mins) | 50 mins (40-60 mins) | *L6.5, L6.6, L6.7* |
| Number of OT **minutes** received per day (across entire treatment period) Median (IQR) | 10.3 mins (5.1-19.3 mins) | 10 mins (4.8-19.2 mins) | 9.8 mins (4.9-18.6 mins) | 10 mins (4.8-18.9 mins) | *L6.12, L6.13, L6.14* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Physiotherapy** whilst being treated by a domiciliary team | **Oct-Dec 2015** N=9076 | **Oct 2015-March 2016** N=9655 | **Apr-Jul 2016** N=6684 | **Aug-Nov 2016** N=6564 | *Ref* |
| Percentage of **patients** reported as **applicable** for PT at any point during treatment | 72.6% | 72.4% | 71.2% | 72.4% | *L7.3* |
| Median percentage of **days** on which PT is received by the patient | 27.1% | 27.4% | 26.4% | 27.0% | *L7.4* |
| Number of PT **minutes** received per day (on days when PT is provided) Median (IQR) | 46.3 mins (40-58 mins) | 46.1 mins (39.4-57.5 mins) | 45.7 mins (39.2-56.3 mins) | 45.6 mins (38.3-57.2 mins) | *L7.5, L7.6, L7.7* |
| Number of PT **minutes** received per day (across entire treatment period) Median (IQR) | 12.3 mins (6.1-22.5 mins) | 12.1 mins (6-21.7 mins) | 11.7 mins (5.7-20.6 mins) | 11.7 mins (5.9-21.5mins) | *L7.12, L7.13, L7.14* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Speech and language therapy** whilst being treated by a domiciliary team | **Jul-Dec 2015** N=9076 | **Oct 2015-March 2016** N=9665 | **Apr-Jul 2016** N=6684 | **Aug-Nov 2016** N=6564 | *Ref* |
| Percentage of **patients** reported as **applicable** for SALT at any point during treatment | 33.2% | 32.1% | 33.1% | 33.4% | *L8.3* |
| Median percentage of **days** on which SALT is received by the patient | 17.1% | 17.2% | 15.4% | 16.1% | *L8.4* |
| Number of SALT **minutes** received per day (on days when SALT is provided) Median (IQR) | 46.7 mins (40-60 mins) | 48.3 mins (40-60 mins) | 47.0 mins (40-60 mins) | 47.5 mins (40-60 mins) | *L8.5, L8.6, L8.7* |
| Number of SALT **minutes** received per day (across entire treatment period) Median (IQR) | 7.8 mins (3.4-15.5 mins) | 8 mins (3.4-16.2 mins) | 7.1 mins (3.0-14.3 mins) | 7.2 mins (3.1-14.7 mins) | *L8.12, L8.13, L8.14* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Psychology** | **Jul-Dec 2015** N=9076 | **Oct 2015-March 2016** N=9665 | **Apr-Jul 2016** N=6684 | **Aug-Nov 2016** N=6564 | *Ref* |
| Percentage of **patients** reported as **applicable** for psychology at any point during treatment | 8.3% | 8.2% | 7.8% | 8.0% | *L10.3* |
| Median Percentage of **days** on which psychology is received by the patient | 5.7% | 5.7% | 5.5% | 6.1% | *L10.4* |
| Number of psychology **minutes** received per day (on days when psychology is provided) [Median (IQR)] | 60 mins (45-60 mins) | 60 mins (45-60 mins) | 60 mins (43.7-60 mins) | 56 mins (45-60 mins) | *L10.5, L10.6, L10.7* |
| Number of psychology **minutes** received per day (across entire treatment period) [Mean] | 4.2 mins | 4.4 mins | 5.2 mins | 4.9 mins | *L10.8* |

**Comment:** The figure reported for patients applicable for psychology from an ESD/CRT team is unlikely to be an accurate reflection of the care needs for patients post-stroke. It is expected that at least 50% of stroke patients will suffer from depression or cognitive impairments in the weeks following their stroke and will therefore require psychological support. We urge all teams to indicate when a patient is applicable for psychology, even if the team is not in a position to provide this service to their patients.

## Section 7: Six month follow up assessments

Collection of six month outcome data is key to assessing the outcomes of stroke care. It notably forms part of the CCG Outcomes Indicator Set that was reported in December 2014 ,December 2015 and December 2016 in England.

205 teams have submitted data for at least one patient who received a six month assessment. 102 teams have provided a six month assessment for at least 20 patients and the breakdown is shown in table below. These include acute hospitals, domiciliary teams, and voluntary organisations e.g. the Stroke Association. As this is a relatively small number, the results may not be representative of six month follow-up provision nationally. A full list of six month assessment provider teams which submitted at least 20 records to SSNAP can be found in the results portfolio. Named team results for teams providing six month follow ups are publicly available. Please see the 'Full Results Portfolio' on the SSNAP Results Portal for individual team results: www.strokeaudit.org/results/nationa l

| | Six month reporting period | | Four month reporting period | |
|---|---|---|---|---|
| **Region** | **Number of teams providing at least 20 six month assessments July-December 2015** | **Number of teams providing at least 20 six month assessments October 2015-March 2016** | **Number of teams providing at least 20 six month assessments April-July 2016** | **Number of teams providing at least 20 six month assessments Aug-Nov 2016** |
| London | 14 | 12 | 9 | 5 |
| East of England | 11 | 9 | 9 | 10 |
| East Midlands | 1 | 3 | 3 | 2 |
| West Midlands | 7 | 8 | 9 | 8 |
| North West Coast (formerly Cheshire and Mersey) | 10 | 11 | 9 | 12 |
| Greater Manchester and Eastern Cheshire (formerly Manchester, Lancashire & South Cumbria ) | 9 | 10 | 8 | 7 |
| North of England | 14 | 13 | 11 | 12 |
| Yorkshire and The Humber | 11 | 14 | 12 | 14 |
| South East | 5 | 6 | 4 | 3 |
| South West | 7 | 9 | 9 | 6 |
| Thames Valley | 5 | 5 | 4 | 4 |
| Wessex | 4 | 4 | 3 | 5 |
| Wales | 11 | 11 | 10 | 9 |
| Northern Ireland | 2 | 3 | 4 | 5 |
| Islands | 1 | 1 | 0 | 0 |
| **Total** | **112** | **119** | **104** | **102** |

## 7.1 Interpreting the Results

The results which follow are based on six month assessments which were due in this reporting period. The record completion analysis below concerns whether the question about six month assessment has been answered at all, and the analyses covering the percentage of patients applicable to receive this assessment and the percentage of those who actually received it are based on all patients who were alive at the relevant time point.

### *Breakdown of six month assessment analysis*

**Record completion**

Information on record completion for the six month assessment question is provided to give an indication of how widely this section of the audit is being answered, rather than indicating the numbers of patients who had a six month assessment completed. If this question is not answered, it is interpreted as an assessment did not take place.

- 24,726 patient records should have had an answer recorded on the webtool
    - Of these, 11,474 patient records (46.4%) did have an answer.

**Comment:** It is extremely important that data regarding a patient's six month follow up is recorded on SSNAP. This is regardless of whether or not the assessment was provided. These data have the potential to reveal variations in access to six month assessments across the country. In cases where six month assessments are being provided but are not recorded on SSNAP, valuable information about patient outcomes post stroke is being missed.

Applicability for six month assessment

Patients are considered to be applicable to receive a six month assessment unless they are known to have died before six months after admission, or if they have a 'no but' reason recorded for the six month assessment question. Therefore any patients alive six months after admission who do not have an answer recorded in the audit are deemed applicable.

- 20,940 patients were considered to be applicable to receive a six month assessment (excludes died in care, died within six months of admission* and 'no but')
  *either as recorded on SSNAP or from the national register of deaths, the Office for National Statistics

Note: SSNAP records are linked with mortality information from the Office for National Statistics (ONS). Usually, SSNAP data are securely sent for linkage following each reporting deadline, enabling SSNAP to track mortality other than as reported on SSNAP (i.e. after patients have left care). We use this in determining eligibility for receiving a six month assessment and for other purposes, such as providing casemix adjusted mortality rates for providers. (Following lengthy delays, SSNAP was able to perform linkage with ONS to obtain information for patients that died up to mid-2016. Casemix-adjusted mortality results were publicly reported earlier in the year. These patients have therefore been able to be excluded from the denominator for 6 month assessments).

Patients assessed at six months

Out of 20,940 patients considered to be applicable to receive a six month assessment:

- 6,555 patients (31.3%) received a six month assessment
- The inpatient teams which had the highest percentage of patients going on to receive a six month assessment are:
    - Ipswich Hospital, Arrowe Park Hospital, Cumberland Infirmary, West Cumberland Hospital, Prince Philip Hospital, Hexham General Hospital, Staffordshire Rehabilitation Team, Chesterfield Royal, Airedale General Hospital, Kendray Hospital, Ysbyty Cwm Rhondda.
- N.B. This does not necessarily indicate that these were the teams who carried out the six month assessments, only that their patients went on to have them.

**Comment:** While the vast majority of patients alive at this time after stroke are applicable to receive a six month review this is currently happening in a minority of cases. Clinical teams and commissioners need to work closely together to see this improve to get the most value from the audit for service improvement.

## 7.2 Preliminary Results

| | **Six month reporting period** | | **Four month reporting period** | | |
|---|---|---|---|---|---|
| **Six month review timings:** | **Jul-Dec 2015** | **Oct 2015-March 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** | *Ref* |
| | **Median (IQR)** | **Median (IQR)** | **Median (IQR)** | **Median (IQR)** | |
| Time from admission to hospital (or stroke in hospital) to six month review assessment | 6.4 (5.8-7.2) *months* | 6.5 (5.8-7.4) *months* | 6.5 (5.9-7.5) *months* | 6.5 (5.9-7.5) *months* | *M5.1, M5.2, M5.3* |
| Time from discharge from all care (In patient and domiciliary) to six month assessment | 5.6 (4.4-6.3) *months* | 5.6 (4.4-6.4) *months* | 5.6 (4.4-6.4) *months* | 5.6 (4.4-6.4) *months* | *M5.4, M5.5, M5.6* |

SSNAP is collecting the mode of administration of the review as it provides context.

| | **Six month reporting period** | | **Four month reporting period** | | |
|---|---|---|---|---|---|
| **Method of assessment /review (Q8.1.2)** % (n) | **Jul-Dec 2015** N=8141 | **Oct 2015-March 2016** N=8664 | **Apr-Jul 2016** N=6150 | **Aug-Nov 2016** N=6555 | *Ref* |
| In person | 81.6% (6639) | 82.6% (7155) | 81.9% (5034) | 83.1% (5445) | *M6.2, M6.3* |
| By telephone | 17.5% (1426) | 16.7% (1445) | 17.6% (1085) | 3% (1085) | *M6.6, M6.7* |
| By post | 0.8% (67) | 0.7% (64) | 0.4% (27) | 0.3% (22) | *M6.8, M6.9* |
| Online | 0.1% (9) | 0.0% (0) | 0.1% (4) | <0.1% (3) | *M6.4, M6.5* |

SSNAP offers six categories to identify the person who contacted the patient for a review. Unfortunately, this question was not well recorded throughout this reporting period and "*other*" was recorded for 2,065 cases (31.5%).

| | **Six month reporting period** | | **Four month reporting period** | | |
|---|---|---|---|---|---|
| **Discipline providing the six month follow up? (Q8.1.3)** %(n) | **Jul-Dec 2015** N=8141 | **Oct 2015-Mar 2016** N= 8664 | **Apr-Jul 2016** N=6150 | **Aug-Nov 2016** N=6555 | *Ref* |
| Stroke coordinator | 37.6% (3065) | 34.1% (2958) | 32.2% (1982) | 33.7% (2209) | *M6.13, M6.14* |
| Secondary care clinician | 7.7% (624) | 7.3% (636) | 7.6% (470) | 7.4% (483) | *M6.21, M6.22* |
| Therapist | 9.6% (784) | 10.5% (909) | 11.9% (731) | 13.1% (858) | *M6.15, M6.16* |
| Voluntary services employee | 6.3% (511) | 6.2% (533) | 6.4% (394) | 6.5% (425) | *M6.19, M6.20* |
| District/community nurse | 6.9% (564) | 7.9% (685) | 8.5% (525) | 7.7% (507) | *M6.17 M6.18* |
| GP | 0.1% (7) | 0.1% (8) | 0.1% (7) | 0.1% (8) | *M6.11, M6.12* |
| Other | 31.8% (2586) | 33.9% (2935) | 33.2% (2041) | 31.5% (2065) | *M6.23 M6.24* |

| | **Six month reporting period** | | **Four month reporting period** | | |
|---|---|---|---|---|---|
| **Was the patient screened for mood, behaviour or cognition (Q8.2)** %(n) | **Jul-Dec 2015** N=8141 | **Oct 2015-Mar 2016** N=8664 | **Apr-Jul 2016** N=6150 | **Aug-Nov 2016** N=6555 | *Ref* |
| Yes | 68.3% (5573) | 70.9% (6140) | 74.1% (4558) | 74.2% (4861) | *M7.2 M7.3* |
| No | 23.4% (1905) | 22.0% (1902) | 19.5% (1198) | 19.4% (1273) | *M7.4 M7.5* |
| 'No but'* | 8.1% (663) | 7.2% (622) | 6.4% (394) | 6.4% (421) | *M7.6 M7.7* |

*'No but' is an appropriate response if a problem has already been detected and there is an action plan in place

| | Six month reporting period | | Four month reporting period | | |
|---|---|---|---|---|---|
| **Patient identified as needing support (if screened)** % (n) | **Jul-Dec 2015** N=5573 | **Oct 2015-Mar 2016** N=6140 | **Apr-Jul 2016** N=4558 | **Aug-Nov 2016** N=4861 | *Ref* |
| Yes | 19.6% (1094) | 20.3% (1247) | 20.9% (953) | 19.1% (928) | *M7.8 M7.10* |
| *Of those identified as needing support, support given* | *N=1094* | *N=1247* | *N=953* | *N=928* | *M7.8* |
| Yes | 61.8% (648) | 64.6% (806) | 61.3% (584) | 60.8% (564) | *M7.12, M7.13* |
| No | 24.0% (252) | 24.3% (303) | 25.9% (247) | 28.0% (260) | *M7.14, M7.15* |
| No but | 14.1% (148) | 11.1% (138) | 12.8% (122) | 11.2% (104) | *M7.16, M7.17* |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Patient location at the time of the review** % (n) | **Jul-Dec 2015** N=8141 | **Oct 2015-Mar 2016** N=8664 | **Apr-Jul 2016** N=6150 | **Aug-Nov 2016** N=6555 | *Ref* |
| Home | 89.8% (7312) | 89.3% (7735) | 89.3% (5489) | 89.5% (5867) | *M8.2, M8.3* |
| Care Home | 9.3% (756) | 9.6% (829) | 9.5% (583) | 9.4% (618) | *M8.4, M8.5* |
| Other | 0.9% (73) | 1.2% (100) | 1.3% (78) | 1.1% (70) | *M8.6, M8.7* |

**Changes in Rankin Score between time periods**

Information about the function of stroke patients six months after admission to hospital is also collected. During this period it is available for 6,463 out of 20,940 patients applicable for a review during this reporting period and cannot be interpreted as representative until the data have been collected for a longer time period. The data on this cohort shows that patients who are receiving a review include all severity levels.

**Comment:** Though the percentage of patients with follow up data recorded on SSNAP is improving each reporting period, it may not be entirely representative of the national picture. As recruitment of six month providers continues to increase, data will become more meaningful and robust. The results below reinforce how invaluable these data could be.

| Modified Rankin Score at 3 time points for the 6463 patients for whom data was available* | Pre stroke | | At discharge from all care | | At six months | |
|---|---|---|---|---|---|---|
| | N | % | N | % | n | % |
| 0 (no symptoms) | 4109 | 63.6 | 989 | 15.3 | 1128 | 17.5 |
| 1 (no significant disability) | 1032 | 16.0 | 1772 | 27.4 | 1779 | 27.5 |
| 2 (slight disability) | 556 | 8.6 | 1478 | 22.9 | 1279 | 19.8 |
| 3 (moderate disability) | 508 | 7.9 | 1163 | 18.0 | 1319 | 20.4 |
| 4 (moderately severe disability) | 214 | 3.3 | 841 | 13.0 | 708 | 11.0 |
| 5 (severe disability) | 44 | 0.7 | 220 | 3.4 | 250 | 3.9 |

| Change in mRS from before stroke to six months after stroke | Number of patients | Percentage of patients |
|---|---|---|
| -5 | 0 | 0 |
| -4 | 4 | 0.1 |
| -3 | 40 | 0.6 |
| -2 | 97 | 1.5 |
| -1 | 306 | 4.7 |
| 0 | 1678 | 26.0 |
| 1 | 1981 | 30.7 |
| 2 | 1215 | 18.8 |
| 3 | 780 | 12.1 |
| 4 | 293 | 4.5 |
| 5 | 69 | 1.1 |
| **Total** | **6463** | **100** |

| | Six month reporting | | Four month reporting | | |
|---|---|---|---|---|---|
| **Since initial stroke patient suffered** % (n) | **Jul-Dec 2015** N=8141 | **Oct 2015-Mar 2016** N=8664 | **Apr-Jul 2016** N=6150 | **Aug-Nov 2016** N=6555 | *Ref* |
| Another stroke | 2.9% (235) | 3.0% (261) | 2.7% (167) | 2.8% (182) | *M17.2 M17.3* |
| Myocardial infarction | 0.5% (42) | 0.6% (48) | 0.7% (42) | 0.5% (35) | *M18.2 M18.3* |
| Other hospitalisation illness | 12.8% (1038) | 13.3% (1156) | 14.4% (887) | 13.7% (901) | *M19.2 M19.3* |

## Section 8: SSNAP Performance Tables (by named team)

This section aims to provide a summary of performance for named teams based on **10 domains** of care. Both patient-centred domain scores (whereby scores are attributed to every team which treated the patient at any point in their care) and team-centred domain scores (whereby scores are attributed to the team considered to be most appropriate to assign the responsibility for the measure to) are calculated. Each domain is given a performance level (level A to E) and a **key indicator score** is calculated based on the average of the 10 domain levels for both patient-centred and team centred domains.

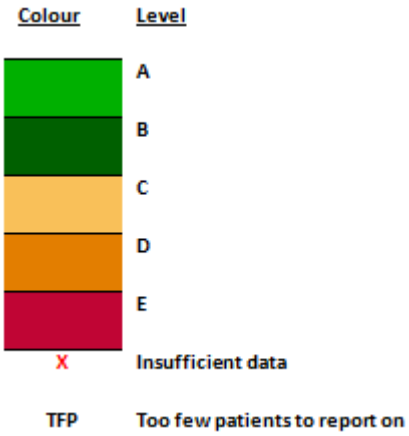
The **overall performance** section of the table consists of:

- A **Combined Key Indicator (KI) Score** derived from the average of the patient- and team-centred total KI score.
- **Case ascertainment** and **audit compliance** levels
- **SSNAP level** which is the combined total key indicator score adjusted for case ascertainment and audit compliance.

The results in this table should be read in combination with the SSNAP 'Summary Report' which includes named team results for the 44 key indicators which comprise the 10 domains: www.strokeaudit.org/results/National-Results

To be included in the SSNAP scoring, teams had to achieve a minimum case ascertainment requirement. Teams which did not meet this requirement (i.e. with insufficient records to be included in the named team results) are shown by an **X**. Some teams did not receive results due to them treating small number of patients during the time period. These teams are shown by 'TFP' (too few patients to report on).

Across the SSNAP domain results a consistent colour code is used to represent each team's performance for specific domains and overall.




**Changes over time**

Teams are being encouraged to review their results (which are provided every 4 months) and plan to implement change. In some aspects it may be possible to make change rapidly, in other areas of care this may take longer. We are providing information on how the current results compare with the previous reporting period for an indication of where changes may be starting to be made. These need to be interpreted with caution at this stage as a number of factors may be influential at this time. Changes between the August-November 2016 results and the previous reporting period are

illustrated within the table by arrows. Upward pointing arrows indicate that the team has achieved a higher level this reporting period than in the previous reporting period; downward pointing arrows that the team has achieved a lower level this reporting period than previously. The number of arrows represents the extent of the change.

For example, an *increase of 2 levels* from D to B would be shown by the symbol 


**Six month follow up results**

SSNAP report upon the numbers and percentage of patients going on to receive a six month assessment; these results are patient-centred (attributed to all teams who treated the patient). Therefore, the named-team results do not necessarily indicate that these were the teams who carried out the six month assessments, just that their patients went on to have them. Please refer to results in the 'Full Results Portfolio' for details about the clinical information related to these reviews reported on SSNAP, for example, whether patients are taking appropriate medication at six months.

**Interpreting the results**

The colour-coded tables are structured as follows:

1. Patient-centred results
    - A. Routinely admitting teams
        - i. Geographical Region
            - Hospital (ordered alphabetically)
    - B. Non-routinely admitting teams *(as above)*
    - C. Non-acute teams (as above)
2. Team-centred results
   *Same structure as above*

The column headings in the performance tables have been abbreviated for reasons of space. Please use the following key as a guide when using the results.

| Abbreviated heading | Full Description |
|---|---|
| SSNAP Level | SSNAP Level |
| CA | Case ascertainment |
| AC | Audit compliance |
| Combined KI level | Combined Total Key Indicator Level |
| D1 Scan | Domain 1: Scanning |
| D2 SU | Domain 2: Stroke unit |
| D3 Throm | Domain 3: Thrombolysis |
| D4 Spec asst | Domain 4: Specialist assessments Domain |
| D5 OT | 5: Occupational therapy |
| D6 PT | Domain 6: Physiotherapy |
| D7 SALT | Domain 7: Speech and language therapy |
| D8 MDT | Domain 8: Multi-disciplinary team working |
| D9 Std disch | Domain 9: Standards by discharge |
| D10 Disch proc | Domain 10: Discharge processes |
| PC KI level | Patient-centred Total Key Indicator Level |
| TC KI level | Team-centred Total Key Indicator Level |

41 teams in England have achieved the top overall performance level this reporting period. Considering the extremely high standards SSNAP has set, an 'A' score is a fantastic achievement for these teams. Though nowhere else in the world has set such stringent standards, it does show that this top score is achievable. It is expected that the number of teams achieving top scores will increase as further improvements to stroke services are made nationally in future reporting periods.

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **London - London SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | Queens Hospital Romford HASU | 218 | 208 | D↓ | D↓ | C↓ | B↓ | B↓ | C↑ | C↓ | C↓ | A | A↑ | A | C | D↓↓ | C | B | 220 | 97% | 37 | 17% |
| Barts Health NHS Trust | Royal London Hospital HASU | 285 | 272 | B | A | B↓ | A↑ | A | C | B | B | A↑↑ | A↑ | B | A↑ | B | B | A↑ | 202 | 93% | 14 | 7% |
| Imperial College Healthcare NHS Trust | Charing Cross Hospital HASU | 280 | 233 | C↓ | C↓↓ | A | B | A | B | B↓ | B | B↓ | B | C | A↑ | D | B | B | 274 | 98% | 17 | 6% |
| King's College Hospital NHS Foundation Trust | King's College Hospital HASU | 260 | 255 | A | A | B | A | A | D↓ | B | B | A | A↑ | B↓ | B | A | A | A | 186 | 94% | 34 | 18% |
| King's College Hospital NHS Foundation Trust | Princess Royal University Hospital HASU | 224 | 222 | C↓ | C↓↓ | B | B↓ | A | D↓ | B | A | A | A | C | D | A | B | B↓ | 200 | 96% | 11 | 6% |
| London North West Healthcare NHS Trust | Northwick Park Hospital HASU | 372 | 347 | A | A | A | A | A | B | A | A | A | B | B↓ | A | A | C | A | 267 | 94% | 77 | 29% |
| St George's Healthcare NHS Trust | St George's Hospital HASU | 431 | 407 | A | A | A↑ | A | A | C | B | B | A | A | B↓ | A↑ | A | A | A | 335 | 94% | 20 | 6% |
| University College London Hospitals NHS Foundation Trust | University College Hospital HASU | 413 | 382 | A | A | A | A | A | D↓ | B | B | A | A | A | D | B | B | B↓ | 300 | 94% | 47 | 16% |
| **Midlands & East - East Midlands SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Derby Hospitals NHS Foundation Trust | Royal Derby Hospital | 264 | 245 | C↑ | A↑ | B↑ | B↑ | C | C | B↑ | B | B | B | C↑↑ | B↑ | B↑↑ | C↓ | B↑ | 165 | 100% | 0 | 0% |
| Northampton General Hospital NHS Trust | Northampton General Hospital | 306 | 289 | A | A | A | A | A↑ | D | C | A | A | A | A↑ | B | B | B | A↑ | 111 | 56% | 72 | 65% |
| Nottingham University Hospitals NHS Trust | Nottingham City Hospital | 366 | 394 | C↑ | A | B | C | D | B | C | C | A | B | E | C | B | B↑↑ | C | 305 | 98% | 28 | 9% |
| Sherwood Forest Hospitals NHS Foundation Trust | Kings Mill Hospital | 162 | 169 | A↑ | A | A | A↑ | C | C↓ | B↑ | B↓ | A | B↓ | C↑ | B↑ | A | A | B | 110 | 100% | 0 | 0% |
| United Lincolnshire Hospitals NHS Trust | Lincoln County Hospital | 195 | 204 | C↓ | A | C↓ | B | A↑ | D↓ | A | C↓ | B | B | B↑ | C↓ | B | C | B | 127 | 100% | 0 | 0% |
| United Lincolnshire Hospitals NHS Trust | Pilgrim Hospital | 176 | 180 | B↓ | A | A↑ | B↓ | A | B | A | A | C↓ | B | D↓ | C↓ | C↓ | A | B↓ | 132 | 100% | 1 | 1% |
| University Hospitals of Leicester NHS Trust | Leicester Royal Infirmary | 373 | 351 | B↑ | A | A↑ | B | C↓ | D↓ | C↓ | B | C | B↑ | D↑ | B↑ | A | A | B | 298 | 100% | 0 | 0% |
| **Midlands & East - East of England SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Basildon and Thurrock University Hospitals NHS Foundation Trust | Basildon University Hospital | 211 | 219 | A | A | A | A | A | C | A↑ | B | A | A | B | A | A↑ | A | A | 60 | 67% | 26 | 43% |
| Cambridge University Hospitals NHS Foundation Trust | Addenbrooke's Hospital | 184 | 178 | D | A | B↑ | D | C | E | C | D↓ | C | A | E | E↓ | A↑ | C | D | 159 | 99% | 3 | 2% |
| Colchester Hospital University NHS Foundation Trust | Colchester General Hospital | 198 | 190 | A | A | A | A | A | C | A↑ | B | A | A | C | A↑ | B | A | A | 87 | 82% | 57 | 66% |
| East and North Hertfordshire NHS Trust | Lister Hospital | 259 | 252 | B↓ | A | A | B↓ | A | C | C | B | A | A | C | B | B | B | B | 189 | 97% | 48 | 25% |
| Ipswich Hospital NHS Trust | Ipswich Hospital | 239 | 178 | A↑ | A | A | A↑ | C | B | A↑ | C | A | A | C | B | A↑ | A | A↑ | 78 | 49% | 78 | 100% |
| James Paget University Hospitals NHS Foundation Trust | James Paget Hospital | 129 | 134 | C | A | B↓ | C | C | C | D↓ | B | A↑ | B | C↑ | D | C | B | C | 128 | 99% | 0 | 0% |
| Luton and Dunstable University Hospital NHS Foundation Trust | Luton and Dunstable Hospital | 262 | 252 | C↑ | A | A↑ | C | A↑ | D | B | B | A | B | E | D↑ | B | D↓ | C | 150 | 98% | 6 | 4% |
| Mid Essex Hospital Services NHS Trust | Broomfield Hospital | 174 | 169 | A | A | A | A | A | B | B | A↑ | A | B | D↓ | B↑ | A↑ | A | A | 137 | 96% | 47 | 34% |
| Norfolk and Norwich University Hospitals NHS Foundation Trust | Norfolk and Norwich University Hospital | 374 | 366 | B | A | A↑ | B | B | C | B | A | B | B | C | B | B | A | B | 227 | 99% | 61 | 27% |
| Peterborough and Stamford Hospitals NHS Foundation Trust | Peterborough City Hospital | 220 | 207 | D | A | A↑ | D | C | E | D | C | C | D | C↑↑ | D | B | C | D | 159 | 100% | 0 | 0% |
| Queen Elizabeth Hospital King's Lynn NHS Foundation Trust | Queen Elizabeth Hospital Kings Lynn | 180 | 177 | A↑ | A | B | A | A↑ | B | A | A | A | A | A | B↓ | B↑↑ | C↑↑ | A | 65 | 61% | 35 | 54% |
| Southend University Hospital NHS Foundation Trust | Southend Hospital | 213 | 219 | B↓ | A | B↓ | A | A | D↓ | B↓ | B | A | A | B↓ | B | B | C↓ | B↓ | 104 | 70% | 83 | 80% |
| West Hertfordshire Hospitals NHS Trust | Watford General Hospital | 192 | 188 | A | A | A | A | A | C | B | A↑ | A | A | B | C | B↓ | B | A | 152 | 93% | 47 | 31% |
| West Suffolk NHS Foundation Trust | West Suffolk Hospital | 170 | 142 | A↑ | A | A | A↑ | A | B↑ | B↑↑ | B | A | A | A↑↑ | B↑ | B↑ | B↓ | A↑ | 106 | 82% | 53 | 50% |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **Midlands & East - West Midlands SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Burton Hospitals NHS Foundation Trust | Queens Hospital Burton upon Trent | 122 | 114 | D | B↓ | C↑ | D↓ | A | D↓ | D | E↓ | C↓↓ | B | C | D | D | B↑ | D↓ | 67 | 94% | 13 | 19% |
| Dudley Group of Hospitals NHS Foundation Trust | Russells Hall Hospital | 193 | 179 | C | A | B | C | C | D↓ | C↓ | B | C↑ | B | C↑ | B | B↑↑ | C↓ | C | 135 | 89% | 36 | 27% |
| George Eliot Hospital NHS Trust | George Eliot Hospital | 69 | 79 | C↑ | A | B↑ | C↑ | A↑ | E | C↑ | B | D↑ | C↑ | C | A↑ | B | C↑ | C↑ | 59 | 92% | 21 | 36% |
| Heart of England NHS Foundation Trust | Birmingham Heartlands Hospital | 293 | 294 | A↑ | A | B↑ | A | A | B↑ | A↑ | B | A | A↑ | C | A↑ | B↑↑ | A | A↑ | 238 | 99% | 2 | 1% |
| Royal Wolverhampton NHS Trust | New Cross Hospital | 175 | 191 | C | A | B↓ | B↑ | A↑ | C | B↑ | C | B | B↑ | E | C | B | A | B↑ | 105 | 95% | 24 | 23% |
| Sandwell and West Birmingham Hospitals NHS Trust | Sandwell District Hospital | 168 | 168 | C | A | C | B | A | C | C↓ | B | E↓↓ | B | C | B↑ | B↑↑ | A↑ | B | 169 | 100% | 28 | 17% |
| Shrewsbury and Telford Hospital NHS Trust | Princess Royal Hospital Telford | 312 | 300 | D | A | C | D | D | D↓ | C↓ | D | A↑ | D | E | D | E | C↑ | D | 291 | 99% | 9 | 3% |
| South Warwickshire NHS Foundation Trust | Warwick Hospital | 100 | 97 | C | A | A | C | D | D↑ | D↓ | D | A↑ | B↓ | B↑ | B | A↑ | C↑ | C | 83 | 100% | 0 | 0% |
| University Hospitals Birmingham NHS Foundation Trust | Queen Elizabeth Hospital Edgbaston | 198 | 153 | C↑ | A | A | C↑ | B↑ | C | C | B↑ | C | C | C | D↑ | C | B | C↑ | 126 | 77% | 60 | 48% |
| University Hospitals Coventry and Warwickshire NHS Trust | University Hospital Coventry | 267 | 266 | C | A | A | C | B↓ | E | B | D | A↑↑ | B↑ | D | C | A↑ | A | B↑ | 191 | 99% | 24 | 13% |
| University Hospitals of North Midlands NHS Trust | Royal Stoke University Hospital | 450 | 458 | B | A | A | B | A | D | B | B | A | A | E↓↓ | B↓ | C↓ | A | B↓ | 261 | 83% | 127 | 49% |
| Walsall Healthcare NHS Trust | Manor Hospital | 127 | 107 | C↓ | A | A | C↓ | B↓ | E↓↓ | D | B | C | C↓ | B | B | A↑ | B | C↓ | 62 | 95% | 25 | 40% |
| Worcestershire Acute Hospitals NHS Trust | Worcestershire Royal Hospital | 268 | 204 | D↑ | B↑ | D↓ | D | B↑ | E | E↓ | E | A | B | D↑ | D | D↑ | A↑ | D | 129 | 65% | 12 | 9% |
| Wye Valley NHS Trust | Hereford County Hospital | 166 | 156 | C↑ | A | A | C↑ | C↓ | E↓ | C↑ | D | B↓ | B | E | C↑ | A↑ | B↑ | C↑ | 142 | 99% | 0 | 0% |
| **North of England - Greater Manchester and Eastern Cheshire SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Pennine Acute Hospitals NHS Trust | Fairfield General Hospital | 348 | 355 | A | A | A | A | A | B | B↓ | A | A | A↑ | B | A | B | A | A | 240 | 99% | 65 | 27% |
| Salford Royal NHS Foundation Trust | Salford Royal Hospital | 712 | 689 | A | A | A | A | A | B | B↑ | A | A | A↑ | C | A | A | A | A | 532 | 92% | 140 | 26% |
| Stockport NHS Foundation Trust | Stepping Hill Hospital | 365 | 372 | A↑ | A | A↑ | A | A | B | A↑ | A | C↓ | C | C↓ | A | B | C | B↓ | 254 | 89% | 94 | 37% |
| **North of England - North West Coast SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Aintree University Hospitals NHS Foundation Trust | University Hospital Aintree | 138 | 155 | C | A | A | C | B | E | C↑ | B | C | D | E↓ | C↑ | A | A | C | 153 | 99% | 40 | 26% |
| Blackpool Teaching Hospitals NHS Foundation Trust | Blackpool Victoria Hospital | 154 | 158 | D↑ | A | A | D↑ | C↑ | D | D | D | E | E | E | E | C↑ | B | D↑ | 104 | 92% | 39 | 38% |
| Countess of Chester Hospital NHS Foundation Trust | Countess of Chester Hospital | 127 | 126 | B | A | A | B | A | C | B | B↓ | A↑ | B↑ | D↑ | B↓ | A↑ | B↓ | B | 56 | 86% | 34 | 61% |
| East Lancashire Hospitals NHS Trust | Royal Blackburn Hospital | 213 | 199 | D | A | A | D | D↓ | D | D | E↓ | D | D | C↑↑ | C | A↑ | D↓ | D | 174 | 97% | 73 | 42% |
| Lancashire Teaching Hospitals NHS Foundation Trust | Royal Preston Hospital | 218 | 200 | D | A | A | D | C | E↓ | D | E↓ | D | D | C↑↑ | D↓ | A↑ | C | D | 124 | 95% | 4 | 3% |
| Mid Cheshire Hospitals NHS Foundation Trust | Leighton Hospital | 236 | 234 | C | A | A↑ | C | A↑↑ | E | E↓ | C↑ | A | A | B | A↑ | B | A | B | 58 | 79% | 47 | 81% |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | Royal Liverpool University Hospital | 204 | 204 | C | A | B | B | B↑ | D | C↓ | B | A | A | E | B | D↓ | A | B | 184 | 97% | 22 | 12% |
| Southport and Ormskirk Hospital NHS Trust | Southport and Formby District General | 114 | 115 | D | A | B↓ | C↑ | B | E | D↑ | C↑ | B↓ | B | D↑ | B↓ | B | D | C↑ | 83 | 93% | 16 | 19% |
| St Helens and Knowsley Teaching Hospitals NHS Trust | Whiston Hospital | 246 | 227 | A | A | A | A | B↓ | B | B↑ | A↑ | B↓ | C↓ | B↑↑ | A | B | A | A | 202 | 86% | 106 | 52% |
| University Hospitals of Morecambe Bay NHS Foundation Trust | Furness General Hospital | 83 | 84 | D | A | C↑ | C↑ | B↓ | C↑ | D | B | A↑ | C | E | B | B↑↑ | C | C | 58 | 100% | 13 | 22% |
| University Hospitals of Morecambe Bay NHS Foundation Trust | Royal Lancaster Infirmary | 108 | 113 | D | A | B | D | A↑↑ | E | E | D | C | D↓↓ | E | D | B | A | D | 83 | 100% | 0 | 0% |
| Warrington and Halton Hospitals NHS Foundation Trust | Warrington Hospital | 123 | 125 | C | A | A | C | C↓ | C↑ | D↓ | D | A | A↑ | E | B | C↓ | A | C | 66 | 71% | 49 | 74% |
| Wirral University Teaching Hospital NHS Foundation Trust | Arrowe Park Hospital | 221 | 216 | A | A | A | A | A | C↓ | B | B↓ | A | B | C | A | A↑↑ | A | A | 120 | 84% | 114 | 95% |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **North of England - North of England SCN** | | | | | | | | | | | | | | | | | | | | | | |
| City Hospitals Sunderland NHS Foundation Trust | Sunderland Royal Hospital | 135 | 112 | D↑ | A↑↑↑ | B | D | B | C | C↑ | B | E | D | E | D | D | A↑↑↑ | D | 134 | 100% | 13 | 10% |
| County Durham and Darlington NHS Foundation Trust | University Hospital of North Durham | X | X | X | E↓↓ | X | X | X | X | X | X | X | X | X | X | X | X | X | 230 | 100% | 0 | 0% |
| Gateshead Health NHS Foundation Trust | Queen Elizabeth Hospital Gateshead | 111 | 121 | D↓ | B↓ | C | B | B | C | C | C↓ | B↓ | A | D↑ | D | B | A | B | 84 | 93% | 48 | 57% |
| Newcastle upon Tyne Hospitals NHS Foundation Trust | Royal Victoria Infirmary | 215 | 209 | A | A | A | A | A | B | B | B | A↑ | A | A↑↑ | B↑ | B↓ | A↑ | A | 138 | 86% | 80 | 58% |
| North Cumbria University Hospitals NHS Trust | Cumberland Infirmary | 126 | 128 | C | A | B | B↑ | B | D | D | C↑ | A | B↓ | C↑↑ | B↑ | B | A | B↑ | 64 | 66% | 59 | 92% |
| North Cumbria University Hospitals NHS Trust | West Cumberland Hospital | 74 | 74 | B | A | A | B | B | C | C↑ | B | A | A | B↓ | C↓ | A | D | B | 50 | 71% | 48 | 96% |
| North Tees and Hartlepool NHS Foundation Trust | University Hospitals of North Tees and Hartlepool | 191 | 192 | C↑ | A | B | C↑ | C↑ | B | B↑ | B↑ | C↑ | D↓ | E | B↑ | A↑ | C | C↑ | 136 | 96% | 96 | 71% |
| Northumbria Healthcare NHS Foundation Trust | Northumbria Specialist Emergency Care Hospital HASU | 343 | 326 | B↓ | A | A | B↓ | C↓ | B | B↓ | B | A | A | C↓ | B | B↑ | A | A | 243 | 93% | 92 | 38% |
| South Tees Hospitals NHS Foundation Trust | James Cook University Hospital | 242 | 240 | A↑ | A | A | A↑ | B↑ | B | B | B | A | B | C | A | B | B | A↑ | 161 | 95% | 121 | 75% |
| South Tyneside NHS Foundation Trust | South Tyneside District Hospital | 89 | 83 | D | A | A | D | D↓ | E | E | E | C | C↑ | E | D↑ | B | A | D | 71 | 90% | 57 | 80% |
| **North of England - Yorkshire and The Humber SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Barnsley Hospital NHS Foundation Trust | Barnsley Hospital | 144 | 146 | D↓↓ | A | A | D↓↓ | D↓ | D | E↓ | D↓↓ | A | A | C | C↓ | A | D↓ | C↓ | 94 | 74% | 66 | 70% |
| Bradford Teaching Hospitals NHS Foundation Trust | Bradford Royal Infirmary | 157 | 159 | D | A | B↑↑ | D | D | C↑ | E | E | B↑ | C | C | D | B↓ | C | D | 113 | 77% | 101 | 89% |
| Calderdale and Huddersfield NHS Foundation Trust | Calderdale Royal Hospital | 233 | 231 | B↑ | A | A↑ | B | C | C↑ | A↑↑ | B↓ | A↑ | B↑ | C↓ | B↑ | B | A | B | 132 | 95% | 65 | 49% |
| Chesterfield Royal Hospital NHS Foundation Trust | Chesterfield Royal | 171 | 178 | C↑ | A | A↑ | C | C | C | D↓ | D | C | C↓ | E | C | B | A | D↓ | 114 | 66% | 114 | 100% |
| Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Doncaster Royal Infirmary | 192 | 206 | B↓ | A | A | B↓ | B | C | C↓ | C | A | A | A | B | A↑ | C↓ | B↓ | 119 | 76% | 8 | 7% |
| Harrogate and District NHS Foundation Trust | Harrogate District Hospital | 85 | 88 | D↓ | A | B | C | D | C↓ | D↑ | D↓↓ | B↓ | B | C↑ | C↓ | B | C | C | 74 | 96% | 0 | 0% |
| Hull and East Yorkshire Hospitals NHS Trust | Hull Royal Infirmary | 249 | 267 | C↓ | A | B | B | B | C↓ | C↓ | B | A | A | E | D | B | B | B | 166 | 90% | 46 | 28% |
| Leeds Teaching Hospitals NHS Trust | Leeds General Infirmary | 317 | 305 | C | A | B↓ | B↑ | B↑ | C↑ | B | B↑ | C | B↑↑ | B | D | A | C | B↑ | 251 | 100% | 96 | 38% |
| Mid Yorkshire Hospitals NHS Trust | Pinderfields Hospital | 252 | 233 | C | A | A | C | B | C↓ | B↑ | C | C↓ | B | E | E↓ | A↑ | A | C | 195 | 88% | 33 | 17% |
| Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Scunthorpe General Hospital | 209 | 215 | A | A | A | A | A | B | C | B↓ | A | A↑ | A↑↑ | B↑ | A | C | A↑ | 144 | 99% | 17 | 12% |
| Rotherham NHS Foundation Trust | Rotherham Hospital | 144 | 139 | B↑ | A | A | B↑ | A | C | D↑ | D | A | A↑ | E | D | A↑ | A↑↑ | B↑ | 58 | 64% | 47 | 81% |
| Sheffield Teaching Hospitals NHS Foundation Trust | Royal Hallamshire Hospital | 293 | 302 | C↑ | A | B | C | B↓ | B | D | C | A↑↑ | B↑ | E | C↑ | B | B↑ | C | 217 | 86% | 114 | 53% |
| York Teaching Hospital NHS Foundation Trust | York Hospital | 323 | 305 | B↑ | A | A | B↑ | B↑ | C↑ | C | B | A | A↑ | C↑ | B | B | C | B↑ | 202 | 69% | 80 | 40% |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **South England - South East SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Ashford and St Peter's Hospitals NHS Foundation Trust | St Peter's Hospital | 139 | 133 | A | B | A | A | A | C | D↓↓ | A | A↑ | A↑ | B | A↑ | A | A | A | 124 | 98% | 1 | 1% |
| Brighton and Sussex University Hospitals NHS Trust | Royal Sussex County Hospital | 189 | 173 | B | A | A | B | A | B | B | A | C | C | C↑ | D | B | C↓ | B | 124 | 98% | 8 | 6% |
| Dartford and Gravesham NHS Trust | Darent Valley Hospital | 109 | 85 | D | B | B | D | B↓ | E | C | E | C | B↑ | E | E | D↓ | C | D | 84 | 100% | 0 | 0% |
| East Kent Hospitals University NHS Foundation Trust | Kent and Canterbury Hospital | 94 | 88 | D | A | C↓ | C↑ | B | D↓ | B↑↑ | B↓ | C | D | E | D | B↑ | A↑ | C↑ | 72 | 95% | 5 | 7% |
| East Kent Hospitals University NHS Foundation Trust | Queen Elizabeth the Queen Mother Hospital | 120 | 114 | C | A | A↑ | C | A | D | E↓↓↓ | A | A↑↑ | B | D↓ | C↑ | B | C | C↓ | 99 | 97% | 1 | 1% |
| East Kent Hospitals University NHS Foundation Trust | William Harvey Hospital | 156 | 152 | B↑ | A | A | B↑ | A↑ | C↑ | B↑↑ | A | C↓↓ | C↓ | D↑ | C | A↑ | B | B↑ | 111 | 97% | 7 | 6% |
| East Sussex Healthcare NHS Trust | Eastbourne District General Hospital | 122 | 152 | C | B↓ | A | C | A | B | C | A↑ | D↓ | C | E | D | B | C↓ | C | 141 | 100% | 12 | 9% |
| Epsom and St Helier University Hospitals NHS Trust | Epsom Hospital | 103 | 92 | C | A↑ | A | C↓ | A | C↑ | E↓↓ | B↑ | B↓ | C↓ | C | B↑ | B | B | B | 47 | 89% | 29 | 62% |
| Frimley Health NHS Foundation Trust | Frimley Park Hospital | 131 | 120 | A↑ | A | A↑ | A | A | C | C↓ | A | A | A | C↑ | B | B | A↑ | A | 127 | 100% | 1 | 1% |
| Maidstone and Tunbridge Wells NHS Trust | Maidstone District General Hospital | 90 | 91 | B | A | B↓ | B | B | C↑ | C↑ | C | A | A | A↑↑ | B↑ | D↓↓ | B | B | 82 | 100% | 0 | 0% |
| Maidstone and Tunbridge Wells NHS Trust | Tunbridge Wells Hospital | 117 | 120 | B↑↑ | A | A↑↑ | B↑ | B | D | C | C↑ | A↑ | A | A↑↑ | C | D | B | B↑ | 78 | 100% | 0 | 0% |
| Medway NHS Foundation Trust | Medway Maritime Hospital | 113 | 120 | D | A | C | D | B↓ | E | D | D | E | D↑ | D↑ | C↑ | B↑ | A | D | 89 | 100% | 16 | 18% |
| Royal Surrey County Hospital NHS Foundation Trust | Royal Surrey County Hospital | 111 | 100 | B | A↑ | A↑ | B↓ | A | D↓ | D↓ | D↓↓ | A | A | B↓ | B↓ | A↑ | B↓ | B↓ | 101 | 100% | 1 | 1% |
| Surrey and Sussex Healthcare NHS Trust | East Surrey Hospital | 164 | 143 | D | C | C | C | A | D | C↑ | C↓ | C | C | B↑ | B | B↓ | D | C | 164 | 99% | 3 | 2% |
| Western Sussex Hospitals NHS Trust | St Richards Hospital | 141 | 135 | B | A | A | B | C↓ | C | A | C↓ | A | B | C↓ | B | B | C↑ | B | 98 | 100% | 0 | 0% |
| Western Sussex Hospitals NHS Trust | Worthing Hospital | 145 | 139 | B↓ | A | A↑ | B↓ | B↓ | C↓ | B | B↓ | B↓ | B | C↓ | C↓ | A | C | B↓ | 127 | 100% | 0 | 0% |
| **South England - South West SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Gloucestershire Hospitals NHS Foundation Trust | Gloucestershire Royal Hospital | 265 | 260 | D | A | B | D | D↓ | D | C | D | D | D↑ | E | E | A↑ | C | D | 127 | 78% | 89 | 70% |
| Great Western Hospitals NHS Foundation Trust | Great Western Hospital Swindon | 137 | 139 | D↑ | B | B↑ | D | A | E | C | D↑ | D↑ | D | E | E | C↓ | D | D | 69 | 83% | 30 | 43% |
| North Bristol NHS Trust | North Bristol Hospitals | 240 | 231 | C | A | A | C | A | C | B↓ | C↓ | C | D | C↑ | D | C↑ | B↓ | C | 168 | 99% | 4 | 2% |
| Northern Devon Healthcare NHS Trust | North Devon District Hospital | 129 | 135 | C↑ | A | B | B↑ | C↑ | C↑↑ | B↑ | E | A | A | D↑ | C | A↑ | A↑ | B↑↑ | 98 | 100% | 3 | 3% |
| Plymouth Hospitals NHS Trust | Derriford Hospital | 268 | 257 | C | A | A↑ | C | B | D | C | B↑ | A | B↓ | D | E | A↑ | A | B↑ | 162 | 100% | 25 | 15% |
| Royal Cornwall Hospitals NHS Trust | Royal Cornwall Hospital | 281 | 235 | D | A | B↓ | C↑ | A | C↑ | C↑ | C↑ | B↑↑ | D | C | D↑ | C↑ | B↓ | C↑ | 186 | 99% | 75 | 40% |
| Royal Devon and Exeter NHS Foundation Trust | Royal Devon and Exeter Hospital | 225 | 228 | B | A | A | B | C↓ | C↑ | B | B | A | B↓ | C | B | A | B | B | 175 | 100% | 0 | 0% |
| Royal United Hospital Bath NHS Trust | Royal United Hospital Bath | 222 | 197 | C↑ | A | B | C | B | D | C | B | A↑ | B | D | D↓ | C | B | C | 156 | 98% | 36 | 23% |
| Salisbury NHS Foundation Trust | Salisbury District Hospital | 118 | 119 | B | A | B | B | A | C | D↓↓ | B | A | A↑ | D↑ | B | C | B | B | 86 | 98% | 10 | 12% |
| Taunton and Somerset NHS Foundation Trust | Musgrove Park Hospital | 207 | 172 | D↓↓ | B↓ | B↓ | C↓ | A | D↓ | C↑ | D↓ | C↓↓ | B↓ | E | C↓ | B | A↑ | C↓ | 138 | 90% | 21 | 15% |
| Torbay and South Devon NHS Foundation Trust | Torbay Hospital | 230 | 223 | B↑↑ | A | A | B↑↑ | B↑ | C↑↑ | C↑ | C↑↑ | A | A↑ | C | B↑ | A↑ | A | B↑ | 148 | 98% | 0 | 0% |
| University Hospitals Bristol NHS Foundation Trust | Bristol Royal Infirmary | 150 | 146 | C | A | A | C | A | D↓ | C↓ | C | B | B↑ | E↓ | D↑ | B↓ | B | C | 126 | 99% | 6 | 5% |
| Weston Area Health NHS Trust | Weston General Hospital | 88 | 85 | D↓↓ | A | A | D↓↓ | C↓ | E↓↓ | C↓ | B | C↓ | B | D | C | B | C | C↓ | 45 | 85% | 16 | 36% |
| Yeovil District Hospital NHS Foundation Trust | Yeovil District Hospital | 136 | 138 | B↑ | A | A | B↑ | A | C | A↑ | D↑ | A | A | E↓ | D | C | A | B | 53 | 90% | 33 | 62% |
| **South England - Thames Valley SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Buckinghamshire Healthcare NHS Trust | Wycombe General Hospital | 184 | 180 | A | A↑ | A | A | A | C↓ | B↓ | A | A | A | B↑ | B | B | B | A | 118 | 84% | 45 | 38% |
| Frimley Health NHS Foundation Trust | Wexham Park Hospital | 121 | 125 | D | A | D | D↓ | D | D↓ | D | E↓ | A↑ | B | C↓ | C | B | B | C | 94 | 100% | 5 | 5% |
| Milton Keynes University Hospital NHS Foundation Trust | Milton Keynes General Hospital | 72 | 71 | C↑ | A↑ | C | B↑ | A | D | B↑↑ | B | A↑↑ | A | D↑ | C | A↑ | B↓ | B↑ | 33 | 92% | 6 | 18% |
| Oxford University Hospitals NHS Foundation Trust | Horton General Hospital | TFP | 22 | TFP | A↑↑ | TFP | TFP | NA | A↑↑ | NA | NA | C | B | C | D↓ | D↓↓ | C | TFP | 36 | 100% | 1 | 3% |
| Oxford University Hospitals NHS Foundation Trust | John Radcliffe Hospital | 196 | 193 | B | A | A | B | A↑ | B↑ | B↓ | C | A | B | C | B↑ | C↓ | B↑ | B | 132 | 99% | 5 | 4% |
| Royal Berkshire NHS Foundation Trust | Royal Berkshire Hospital | 220 | 218 | A↑ | B | A↑ | A | A | C↑ | A | B | A | A | B↑ | B↑ | B | B↓ | A | 135 | 88% | 50 | 37% |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **South England - Wessex SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Dorset County Hospital NHS Foundation Trust | Dorset County Hospital | 127 | 135 | C↑ | A | A↑ | C↑ | D | B↑ | C | D | A | B↑ | B | C↑ | D | C↑ | C↑ | 48 | 76% | 40 | 83% |
| Hampshire Hospitals NHS Foundation Trust | Royal Hampshire County Hospital | 194 | 200 | B | A | A | B | C | C | C | B | B | B | B↑ | B | C | B | B | 176 | 97% | 26 | 15% |
| Isle of Wight NHS Trust | St Mary's Hospital Newport | 108 | 110 | D | A | B | D | A | E | E | C↑ | D↑ | B↑↑ | E | C↑ | B | A↑ | D | 81 | 100% | 41 | 51% |
| Poole Hospital NHS Foundation Trust | Poole Hospital | 188 | 191 | B↑ | A↑ | A | B↑ | C↑ | C | C | D | A | B | C | A | D | A↑ | B↑ | 90 | 88% | 50 | 56% |
| Portsmouth Hospitals NHS Trust | Queen Alexandra Hospital Portsmouth | 344 | 366 | B↑ | A | B↑ | B↑ | C | D | C | B↑ | A | A | C↑ | B↑ | B | A | B | 255 | 100% | 10 | 4% |
| Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust | Royal Bournemouth General Hospital | 264 | 259 | A | A | A | A | C | C | C | B | A | A | A | A | A | A | A | 112 | 91% | 58 | 52% |
| University Hospital Southampton NHS Foundation Trust | Southampton General Hospital | 252 | 269 | B | A | A↑ | B | B | B | B↑ | B | B↓ | B | D↓ | B | B | B↓ | B | 208 | 93% | 87 | 42% |
| **Islands** | | | | | | | | | | | | | | | | | | | | | | |
| Isle of Man Department of Health | Noble's Hospital | 39 | 37 | E | A↑ | D | E | E↓ | D | E↓ | E | C↑↑ | C↑↑ | E | E | B | D | E | 39 | 100% | 7 | 18% |
| **Northern Ireland** | | | | | | | | | | | | | | | | | | | | | | |
| Belfast Health and Social Care Trust | Mater Infirmorum Hospital | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | . | . | . | . |
| Belfast Health and Social Care Trust | Royal Victoria Hospital Belfast | 174 | 151 | C↑ | A | C | C↑ | B | D↑ | B↑ | D↑ | B↑ | A↑ | C↑ | D↑ | C | A | C↑ | 52 | 100% | 0 | 0% |
| Northern Health and Social Care Trust | Antrim Area Hospital | 131 | 120 | E | A | D | D | C↑ | E | C↑ | D↑ | A↑↑ | D | E↓ | D↑ | E↓ | C↓ | D | 116 | 100% | 0 | 0% |
| Northern Health and Social Care Trust | Causeway Hospital | 71 | 75 | E | A | D | E | D↑ | E | E↓ | E | B↑ | C↑ | C↑ | E | D↑ | D↓ | D↑ | 55 | 100% | 0 | 0% |
| South Eastern Health and Social Care Trust | Downe General Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | TFP | . | . | . | . |
| South Eastern Health and Social Care Trust | Ulster Hospital | 178 | 167 | D | A | A | D | D | E | C | E | A↑↑ | B | C↓ | D↑ | A↑↑ | B↑↑ | C↑ | 89 | 87% | 73 | 82% |
| Southern Health and Social Care Trust | Craigavon Area Hospital | 111 | 102 | D↑ | A | A↑ | D↑ | D | E | C↑↑ | E | C↑ | D | D↑ | E | B | D | D↑ | 76 | 89% | 41 | 54% |
| Southern Health and Social Care Trust | Daisy Hill Hospital | 42 | 46 | D | B↓ | A | D | C | E | C | E↓ | C↓ | B↑ | E | E | B | C↑ | D | 36 | 90% | 11 | 31% |
| Western Health and Social Care Trust | Altnagelvin Hospital | 72 | 64 | D↑ | A | B↑ | D | C↑ | E | B | D↑ | C↑ | C↑ | E | E | B | C | D | 49 | 89% | 16 | 33% |
| Western Health and Social Care Trust | South West Acute Hospital | 67 | 58 | C | A | A | C | B↑ | C | B↓ | B | B | B↑ | E | D↑ | B | C | C | 46 | 100% | 28 | 61% |
| **Wales** | | | | | | | | | | | | | | | | | | | | | | |
| Abertawe Bro Morgannwg University Health Board | Morriston Hospital | 229 | 207 | C | A | A↑ | C | C | E | C↑ | C↓ | B↑ | A↑ | C↑ | A | B | D | C | 107 | 78% | 22 | 21% |
| Abertawe Bro Morgannwg University Health Board | Princess Of Wales Hospital | 95 | 86 | C↑ | A | A↑ | C↑ | C | C↑↑ | D↓ | B↑ | C | E | B | B | B | D | C↑ | 67 | 80% | 45 | 67% |
| Aneurin Bevan University Health Board | Royal Gwent Hospital | 237 | 229 | B | A | A | B | A | C↓ | C | A | C | D | C | A | A↑ | C | B | 179 | 100% | 27 | 15% |
| Betsi Cadwaladr University Health Board | Glan Clwyd District General Hospital | 117 | 117 | C↓ | A | A | C↓ | C | C | D↓ | A↑ | E↓ | E↓↓ | B↓ | A | A | C | C↓ | 55 | 73% | 6 | 11% |
| Betsi Cadwaladr University Health Board | Maelor Hospital | 137 | 111 | C | A | A | C | C↓ | E | D↓ | B↓ | D↑ | C | D↓ | A | A | C | C | 96 | 70% | 54 | 56% |
| Betsi Cadwaladr University Health Board | Ysbyty Gwynedd | 102 | 85 | C↓ | A | A | C↓ | C | D | E | A | A | B↓ | E↓↓ | B↓ | A | D | C↓ | 88 | 98% | 36 | 41% |
| Cardiff and Vale University Health Board | University Hospital of Wales | 175 | 162 | B↑ | A | A | B↑ | A | C↑ | C | B↑↑ | C↑ | A↑ | D↑ | B↑↑ | A | A | B↑ | 167 | 100% | 0 | 0% |
| Cwm Taf University Health Board | Prince Charles Hospital | 188 | 171 | C | A | B | C↓ | B↓ | D↑ | D | D | A | B↑ | B↑ | C | A | C↓↓ | C | 83 | 97% | 70 | 84% |
| Hywel Dda Health Board | Bronglais Hospital | 46 | 42 | C↑ | A | A↑ | C↑ | A↑ | B | A | C | E | D | C↑↑ | C↑ | B↓ | D | C↑ | 36 | 95% | 2 | 6% |
| Hywel Dda Health Board | Prince Philip Hospital | 61 | 68 | C | A | A↑ | C | A | C | C↓ | B | D↓ | D | E | B↑ | B↓ | C | C | 36 | 52% | 35 | 97% |
| Hywel Dda Health Board | West Wales General | 97 | 92 | D | A | B | D | A | E | D↓ | D | C | B↑ | E | C↑ | A | C | D | 54 | 92% | 1 | 2% |
| Hywel Dda Health Board | Withybush General Hospital | 67 | 61 | B↑ | A | B | B↑ | A | C↑ | B↑↑ | B↑ | C | B | E↓ | A | A↑ | C↑ | B↑ | 44 | 73% | 29 | 66% |

| Non-Routinely Admitting Acute Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **London - London SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | Queens Hospital Romford SU | 107 | 101 | C | A↑ | D↓↓↓ | B | B↓ | C↑ | C | D↓↓ | A | B | B↓ | C | D↓ | C | C↓ | 147 | 97% | 25 | 17% |
| Barts Health NHS Trust | Newham General Hospital | 43 | 49 | B | A | D | A | B | D↓ | D↓ | B | A | A | A | B | A↑ | A | A | 22 | 52% | 7 | 32% |
| Barts Health NHS Trust | Royal London Hospital SU | 111 | 97 | A | B↓ | A | A | A | C | B | B | A | A | A | B | B | B↓ | A | 64 | 97% | 2 | 3% |
| Barts Health NHS Trust | Whipps Cross University Hospital | 61 | 60 | B | A | A↑ | B↓ | A | E↓ | C↑ | D | B↓ | C↓↓ | A | C | A | C↓ | C↓ | 44 | 90% | 8 | 18% |
| Chelsea and Westminster Hospital NHS Foundation Trust | Chelsea and Westminster Hospital | TFP | X | TFP | E↓↓ | X | TFP | NA | NA | NA | NA | X | X | X | NA | X | X | TFP | 26 | 100% | 1 | 4% |
| Croydon Health Services NHS Trust | Croydon University Hospital | 76 | 71 | C | A | D | B | B | E↓ | D↓↓ | C↑ | A | B | B | C | A | A | B | 63 | 94% | 8 | 13% |
| Epsom and St Helier University Hospitals NHS Trust | St Helier Hospital | 53 | 54 | B↑ | A↑ | D | A | A↑ | C↑ | A↑ | C↑ | A | B | A | B↑ | A | A | A↑ | 30 | 77% | 4 | 13% |
| Guy's and St Thomas' NHS Foundation Trust | St Thomas Hospital | 63 | 66 | A | A | A | A | B↓ | D | B | C↓ | A | A | A | C | A | A | A | 48 | 91% | 9 | 19% |
| Hillingdon Hospitals NHS Foundation Trust | Hillingdon Hospital | 44 | 44 | B | A↑ | D↓ | A | A | A↑ | A↑ | A↑ | A | A↑ | A | A | A↑ | C | A | 48 | 100% | 0 | 0% |
| Homerton University Hospital NHS Foundation Trust | Homerton University Hospital | 46 | 45 | C↑ | A↑↑ | E | A | A | C↓ | D↓↓↓ | C↓ | A | A | A | C | C | B | B↓ | 48 | 100% | 8 | 17% |
| Imperial College Healthcare NHS Trust | Charing Cross Hospital SU | 107 | 86 | B | A | D↓↓ | A | A | B | B↓ | B | A↑ | B | B | B | B | B | A | 108 | 99% | 5 | 5% |
| Imperial College Healthcare NHS Trust | Charing Cross Hospital SU - Nine South Ward | TFP | X | TFP | E↓↓↓↓ | X | TFP | NA | NA | NA | NA | X | X | X | NA | X | X | TFP | 51 | 94% | 5 | 10% |
| King's College Hospital NHS Foundation Trust | King's College Hospital SU | 53 | 49 | A | A | A↑ | A | A | C | A↑↑ | B | A | A | B | B↑ | A | A | A | 31 | 94% | 10 | 32% |
| King's College Hospital NHS Foundation Trust | Princess Royal University Hospital SU | 90 | 83 | B | A | B↑ | A | A | C↓ | B↓ | A | A | A | C↓ | C↑ | A | B↓ | A | 68 | 92% | 8 | 12% |
| Kingston Hospital NHS Foundation Trust | Kingston Hospital | 66 | 55 | B | B↓ | C↑ | A | B | C↑ | D↓↓ | C↑ | A | A | A↑ | B↑ | B | A | B | 56 | 97% | 4 | 7% |
| Lewisham and Greenwich NHS Trust | University Hospital Lewisham | 129 | 134 | B↓ | A | A | B↓ | A | C | C↓ | C↓ | C | B | B | D↓ | B↓ | A | B | 71 | 84% | 15 | 21% |
| London North West Healthcare NHS Trust | Northwick Park Hospital SU | 207 | 185 | A | A | B | A | A | B | A | A | A | A | B↓ | A | A | C | A | 157 | 96% | 54 | 34% |
| North Middlesex University Hospital NHS Trust | North Middlesex Hospital | 74 | 56 | C | C↓↓ | D | A↑ | A | C↑ | B↑ | B↑ | A | A | A | D | B | C↑ | B | 62 | 98% | 4 | 6% |
| Royal Free London NHS Foundation Trust | Barnet General Hospital | 44 | 39 | A | A | A | A | A↑ | C↑ | A↑ | B↑ | A | A | A↑ | D | A↑ | A | A↑ | 30 | 94% | 9 | 30% |
| Royal Free London NHS Foundation Trust | Royal Free Hospital | 73 | 66 | B↓ | B↓ | C↓ | A | A | D↓ | B↑↑ | C↓ | A | A | A | D | B | A | B | 52 | 88% | 11 | 21% |
| St George's Healthcare NHS Trust | St George's Hospital SU | 87 | 67 | B↓ | A | D | A | A | C | D↓↓↓ | B↑ | A | A | A | A↑ | A | A | A | 89 | 97% | 3 | 3% |
| University College London Hospitals NHS Foundation Trust | University College Hospital SU | 67 | 55 | A | A↑ | C↓ | A | A | D↓↓ | B↓ | B | A | A | A | D↑ | A↑ | A | A | 40 | 95% | 5 | 13% |
| West Middlesex University Hospital NHS Trust | West Middlesex University Hospital | 28 | 26 | B | A | D | A | A | B | A↑ | C↓ | A | A | B | B | C↓ | C↓ | A | 36 | 100% | 0 | 0% |
| **Midlands & East - East Midlands SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Kettering General Hospital NHS Foundation Trust | Kettering General Hospital | 52 | 33 | E↓ | D↓ | C↑ | D↓↓ | B↓ | E↓ | E↓↓ | D↓↓↓ | D↓↓↓ | D↓↓↓ | C↓↓ | D↓↓ | B↓ | B↑↑ | D↓↓↓ | 33 | 87% | 10 | 30% |
| **Midlands & East - East of England SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Bedford Hospital NHS Trust | Bedford Hospital | 68 | 69 | C↑ | A | B↑↑ | C↑ | B↑↑ | D↓ | D↓ | B↑ | A↑ | A↑ | D↑ | C↑↑ | B↓ | D↓ | C↑ | 78 | 100% | 0 | 0% |
| Hinchingbrooke Health Care NHS Trust | Hinchingbrooke Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | TFP | 15 | 100% | 0 | 0% |
| **Midlands & East - West Midlands SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Heart of England NHS Foundation Trust | Good Hope General Hospital | 76 | 72 | B↑↑ | A | B↑ | B↑ | B↑ | C↑↑ | B↑ | B↑↑ | B↑ | B | C | B↑ | A↑↑ | A↑ | B↑↑ | 53 | 100% | 2 | 4% |
| Heart of England NHS Foundation Trust | Solihull Hospital | 58 | 66 | B↑↑ | A | A↑↑↑ | B↑↑ | D↓↓ | C | C | C↑ | B↑↑ | B↑ | B↑ | C | B↑↑ | A↑ | B↑↑ | 54 | 100% | 0 | 0% |
| Shrewsbury and Telford Hospital NHS Trust | Royal Shrewsbury Hospital | 22 | 21 | TFP | NA | TFP | TFP | E | E | B↑↑↑ | E | E | E | E | E | E | D↑ | NA | 13 | 100% | 1 | 8% |
| University Hospitals of North Midlands NHS Trust | County Hospital | 35 | 36 | C↓ | A | B | C↓ | C↓↓ | E↓ | B | C↓ | B↓ | B | B↑ | B | D | B↓ | C↓ | 32 | 91% | 2 | 6% |

| Non-Routinely Admitting Acute Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **North of England - Greater Manchester and Eastern Cheshire SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Bolton NHS Foundation Trust | Royal Bolton Hospital | 86 | 84 | B | A | A | B | B | C | C↓ | B↑ | C↓ | B | D | B | B | A | B | 81 | 100% | 3 | 4% |
| Central Manchester University Hospitals NHS Foundation Trust | Manchester Royal Infirmary | 63 | 65 | B↑ | A | A | B↑ | C | E↓ | D↑ | C | A | B | C | B | A↑ | A | B↑ | 38 | 79% | 19 | 50% |
| Central Manchester University Hospitals NHS Foundation Trust | Trafford General Hospital | 51 | 45 | A | A | A | A | A↑↑ | C↓ | B↑ | A | A | A↑ | B | B↓ | A | A | A | 42 | 82% | 13 | 31% |
| East Cheshire NHS Trust | Macclesfield District General Hospital | TFP | 34 | TFP | A | B↑ | TFP | NA | B↑ | NA | NA | B | D↓↓ | C↑ | A↑ | A | D | TFP | 19 | 83% | 10 | 53% |
| Tameside and Glossop Integrated Care NHS Foundation Trust | Tameside General Hospital | 53 | 55 | B↑ | A | A | B↑ | B | D | C | B↑↑ | A↑ | B↑ | C↑↑ | B↑ | A | A | B↑ | 54 | 100% | 0 | 0% |
| University Hospital of South Manchester NHS Foundation Trust | Wythenshawe Hospital | 80 | 82 | B | A | A | B | B↑ | D↑ | B↑ | B↑ | B | B | B | B↑ | B↓ | A | B | 60 | 88% | 10 | 17% |
| Wrightington, Wigan and Leigh NHS Foundation Trust | Royal Albert Edward Infirmary | 126 | 119 | B↓ | A | D↓↓↓ | A | A↑ | C | B↑↑↑ | B | A | B↓ | C | B | A | A | A↑ | 57 | 83% | 35 | 61% |
| **North of England - North of England SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Northumbria Healthcare NHS Foundation Trust | Hexham General Hospital | 34 | 31 | B | A | B↑ | B↓ | C↓↓ | D↓↓ | B↓ | C↓↓ | A | A | D↓ | B | A | C | B↓ | 18 | 72% | 17 | 94% |
| Northumbria Healthcare NHS Foundation Trust | North Tyneside General Hospital | 93 | 86 | A | A | A | A | B | C | B↓ | B | A | A | B↑ | B | B↑ | A | A | 64 | 91% | 21 | 33% |
| Northumbria Healthcare NHS Foundation Trust | Wansbeck General Hospital | 63 | 62 | B↓ | A | A | B↓ | A↑↑ | B | A | B | B↓ | A | C↓ | B | B | A | A | 38 | 95% | 9 | 24% |
| **North of England - Yorkshire and The Humber SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Airedale NHS Foundation Trust | Airedale General Hospital | 81 | 65 | D | A | A | D | C↑ | D | E↓ | E | C | D | B | D | B | C↑ | D | 44 | 81% | 42 | 95% |
| Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Diana Princess of Wales Hospital Grimsby | 44 | 42 | B | A | B↓ | A↑ | C↓ | C | E↓↓ | B↑ | A | A↑ | A↑ | C↑ | A | A | B | 32 | 97% | 6 | 19% |
| Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Goole District Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | TFP | 14 | 100% | 0 | 0% |
| York Teaching Hospital NHS Foundation Trust | Scarborough General Hospital | 65 | 56 | D | B↓ | D | C↑ | B↑ | E | C↑↑ | C | A↑ | A↑ | E | D | D | A | C↑ | 61 | 94% | 24 | 39% |
| **South England - Wessex SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Hampshire Hospitals NHS Foundation Trust | Basingstoke and North Hampshire Hospital | 43 | 45 | C↓ | A↑ | B↓ | C↓ | C | C | C↓ | C↓ | A↑↑ | B↓ | C↓ | C↓ | C | A↑ | B | 33 | 100% | 0 | 0% |
| **Wales** | | | | | | | | | | | | | | | | | | | | | | |
| Abertawe Bro Morgannwg University Health Board | Singleton Hospital | 30 | 29 | D | B↓ | D | C↑ | C | E | D | E↓↓ | D↓ | A | A↑↑ | B | B↓ | C | C | 17 | 53% | 4 | 24% |
| Aneurin Bevan University Health Board | Nevill Hall Hospital | 56 | 49 | D | B | D | C | C↓ | E↓ | B↑↑ | D↓ | C | C | D↑ | C | B | B↓ | D↓ | 35 | 76% | 10 | 29% |
| Aneurin Bevan University Health Board | Ysbyty Ystrad Fawr | 32 | 26 | D | B | D | B | A | B | A | B | C | C | C | B | B | B | B | 32 | 100% | 0 | 0% |
| Cardiff and Vale University Health Board | Llandough Hospital | 78 | 70 | C↑ | B↓ | D | B↑ | A | C | D | B↑↑↑ | C↑ | B | C↑↑ | B↑↑ | A | A | B↑ | 73 | 100% | 0 | 0% |

| Non-Acute Inpatient Teams | | Number of patients | | Overall Performance | | | | Patient Centred Data | | | | | | | | | | | Six Month Assessment | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level | Number Applicable | % Applicable | Number assessed | % Assessed |
| **London - London SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | King George Hospital Inpatient Rehab Team | TFP | 27 | B↑ | A | A↑ | B | NA | A↑ | NA | NA | A | B | B | D↑ | E | B↑ | B↑ | 25 | 100% | 2 | 8% |
| Central and North West London NHS Foundation Trust | St Pancras Hospital | TFP | 24 | D | B | D | B | NA | E | NA | NA | A | A | A | E | A | D | C | 18 | 86% | 2 | 11% |
| **Midlands & East - East Midlands SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Leicestershire Partnership NHS Trust | Coalville Community Hospital | TFP | 33 | D↓ | D↓↓↓ | D↓ | B | NA | A | NA | NA | C | C | C | C | A | A | B | 42 | 100% | 0 | 0% |
| University Hospitals of Leicester NHS Trust | Leicester City Stroke Rehabilitation Unit | TFP | 47 | C↓ | B | D↓↓ | A↑ | NA | A | NA | NA | B↑ | B | C | B↑↑ | A | A | A↑ | 58 | 100% | 0 | 0% |
| **Midlands & East - East of England SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Anglian Community Enterprise CIC | Clacton Hospital | TFP | 21 | C↓ | A | D | A | NA | A | NA | NA | A | B↓ | C↓ | C | B | A | A | 19 | 90% | 10 | 53% |
| Hertfordshire Community NHS Trust | Danesbury Neurological Centre | TFP | 29 | C | A | C | B | NA | A | NA | NA | A | B | A↑↑ | D | B | D | B | 29 | 94% | 5 | 17% |
| Hertfordshire Community NHS Trust | Holywell Rehabilitation Unit - St Albans City Hospital | TFP | 22 | D | D | C | B | NA | A | NA | NA | A | A | B | E | B | D | B | 24 | 100% | 5 | 21% |
| Norfolk Community Health and Care NHS Trust | Norwich Community Hospital - Beech Ward | TFP | 49 | D | A | D↓ | C | NA | A | NA | NA | D | C↑ | C | D | B | A | C | 37 | 100% | 14 | 38% |
| Provide | St Peter's Community Hospital Rehab Unit | TFP | 30 | A | A | B | A | NA | A | NA | NA | A | B↓ | C | C | B | A | A | 37 | 100% | 25 | 68% |
| **Midlands & East - West Midlands SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Birmingham Community Healthcare NHS Foundation Trust | Moseley Hall Stroke Rehabilitation Unit | TFP | 45 | C↑ | B↑ | E↓ | A↑ | NA | A | NA | NA | B | B | A↑ | D↑ | B↓ | B | B | 55 | 100% | 18 | 33% |
| South Warwickshire NHS Foundation Trust | Feldon Stroke Rehabilitation Unit SWFT | TFP | 38 | A↑ | A | B↑ | A | NA | B | NA | NA | A | A | A↑ | A↑ | A | C↑ | A | 43 | 100% | 0 | 0% |
| Staffordshire and Stoke-on-Trent Partnership NHS Trust | Staffordshire Rehabilitation Team | TFP | 48 | B | A | D↓ | A | NA | B↓ | NA | NA | A | A | C↑ | B↓ | B↑ | A | A | 42 | 79% | 38 | 90% |
| **North of England - North West Coast SCN** | | | | | | | | | | | | | | | | | | | | | | |
| East Lancashire Hospitals NHS Trust | Pendle Community Hospital - Marsden Stroke Unit | TFP | 46 | D | C↓ | B↑↑ | C | NA | C↓↓ | NA | NA | C | C | C | E↓ | A↑ | D↓ | D↓ | 48 | 98% | 18 | 38% |
| Lancashire Teaching Hospitals NHS Foundation Trust | Chorley and South Ribble Hospital | TFP | 53 | C | B↓ | D | A | NA | B↓ | NA | NA | A | A | C | D | A | C | B | 37 | 100% | 0 | 0% |
| **North of England - Yorkshire and The Humber SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Bassetlaw District General Hospital | TFP | 32 | C↓ | A | B↑ | C↓↓ | NA | B | NA | NA | A | B↓ | B↓ | D↓↓↓ | B | C↓ | B↓ | 29 | 100% | 0 | 0% |
| Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Montagu Hospital | TFP | 36 | A↑ | A | A | A↑ | NA | A↑ | NA | NA | C | B | A | B↑↑ | A↑ | C | A↑ | 22 | 76% | 3 | 14% |
| Humber NHS Foundation Trust | Rossmore Unit, Hull Integrated Stroke Service | TFP | 20 | C | A | D | B | NA | B | NA | NA | A | A | D | E | B | C | C | 10 | 83% | 7 | 70% |
| Sheffield Teaching Hospitals NHS Foundation Trust | Beech Hill Rehabilitation Unit | TFP | 23 | D | A↑ | E | C | NA | A↑ | NA | NA | C | B | D↓ | C↑ | B | B↑↑ | B↑ | 35 | 92% | 13 | 37% |
| South West Yorkshire Partnership NHS Foundation Trust | Kendray Hospital | TFP | 48 | A | A | A | A | NA | B | NA | NA | A | A↑ | B | C↓↓ | A | C↑ | A | 128 | 78% | 124 | 97% |
| **South England - South West SCN** | | | | | | | | | | | | | | | | | | | | | | |
| CORNWALL PARTNERSHIP NHS FOUNDATION TRUST | Woodfield Stroke Rehabilitation Unit | TFP | 46 | B↑ | A↑ | D↓ | A | NA | A↑ | NA | NA | A↑ | B↑ | A | C↑↑ | C | A | A↑ | 33 | 100% | 13 | 39% |
| Great Western Hospitals NHS Foundation Trust | Forest Ward - Swindon Intermediate Care Centre | TFP | 33 | D | A | E↓ | D | NA | B↓ | NA | NA | D↑ | B↑↑ | C | E | D↓↓↓ | C↑ | D | 11 | 79% | 9 | 82% |
| Northern Devon Healthcare NHS Trust | Bideford Community Hospital | TFP | 27 | B | A | D | A | NA | B↓ | NA | NA | A | A | C↓ | B↑↑ | B↑ | A↑ | A↑ | 15 | 100% | 0 | 0% |
| Northern Devon Healthcare NHS Trust | East Devon Community Stroke Rehab Unit | TFP | 42 | C↓↓ | A | D↓↓↓ | B↓ | NA | A | NA | NA | B↓ | B↓ | C | B | A | C | B↓ | 35 | 100% | 0 | 0% |
| Plymouth Community Healthcare CIC | Mount Gould Hospital | TFP | 28 | A | A | A | A | NA | B | NA | NA | A | A | B | E | B↑ | A | B | 33 | 100% | 3 | 9% |
| Somerset Partnership NHS Foundation Trust | South Petherton Community Hospital | TFP | 40 | C | A | D | B | NA | A | NA | NA | A | B↑ | D↓ | D↓ | B | A↑ | B | 26 | 90% | 18 | 69% |
| Torbay and South Devon NHS Foundation Trust | Newton Abbot Hospital | TFP | 75 | A↑ | A↑ | D | A | NA | A | NA | NA | A | A | A | B↑↑ | A↑ | A | A | 62 | 95% | 0 | 0% |
| **South England - Thames Valley SCN** | | | | | | | | | | | | | | | | | | | | | | |
| Oxford Health NHS Foundation Trust | Abingdon Community Hospital | TFP | 27 | B↑ | A | A↑↑↑ | B | NA | A | NA | NA | A | A↑ | B↑ | D | B | D | B | 19 | 100% | 0 | 0% |
| Oxford Health NHS Foundation Trust | Witney Community Hospital | TFP | 20 | B | B↓ | A↑ | A↑ | NA | A | NA | NA | B↓ | A↑ | B | C | B | B↑ | A↑ | 15 | 100% | 0 | 0% |
| **Northern Ireland** | | | | | | | | | | | | | | | | | | | | | | |
| Southern Health and Social Care Trust | South Tyrone and Lurgan Hospitals | TFP | 27 | D | B↓ | B↓ | C↑ | NA | A↑ | NA | NA | E↓ | B↑ | C↑ | E | B↑ | D↓ | D | 32 | 91% | 20 | 63% |
| **Wales** | | | | | | | | | | | | | | | | | | | | | | |
| Aneurin Bevan University Health Board | St Woolos Hospital | TFP | 45 | D | A | D↓ | C | NA | A | NA | NA | C | C | C↓ | A | A↑ | D | B | 34 | 100% | 0 | 0% |
| Cwm Taf University Health Board | Ysbyty Cwm Rhondda | TFP | 26 | D↓↓ | C↓↓ | C↓ | C↓ | NA | C↓↓ | NA | NA | A | B | C | C↑ | B | D↓ | C↓ | 24 | 100% | 24 | 100% |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **London - London SCN** | | | | | | | | | | | | | | | | | | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | Queens Hospital Romford HASU | 215 | 214 | D↓ | D↓ | C↓ | B↓ | B↓ | C↑ | C↓ | C↓ | A | A | A | C↓ | C↓ | C↓ | B↓ |
| Barts Health NHS Trust | Royal London Hospital HASU | 281 | 285 | B | A | B↓ | A↑ | A | C | B | B | A↑ | B | C | B | B | C | B |
| Imperial College Healthcare NHS Trust | Charing Cross Hospital HASU | 267 | 294 | C↓ | C↓↓ | A | B | A | B | B↓ | B | B↓ | B | C↓ | B | D | C | B |
| King's College Hospital NHS Foundation Trust | King's College Hospital HASU | 255 | 260 | A | A | B | A | A | D↓ | B | B | A | A | A | B | B↓ | A↑ | A |
| King's College Hospital NHS Foundation Trust | Princess Royal University Hospital HASU | 224 | 221 | C↓ | C↓↓ | B | B↓ | A | D↓ | B | A | A | A | C | C↑ | A | C↓ | B↓ |
| London North West Healthcare NHS Trust | Northwick Park Hospital HASU | 371 | 364 | A | A | A | A | A | B | A | A | A | B | B | B | A | D↓ | A |
| St George's Healthcare NHS Trust | St George's Hospital HASU | 426 | 429 | A | A | A↑ | A | A | C | B | B | A | A | A | B | A | A↑ | A |
| University College London Hospitals NHS Foundation Trust | University College Hospital HASU | 413 | 413 | A | A | A | A | A | D↓ | B | B | A | A | A | B | A | B | A |
| **Midlands & East - East Midlands SCN** | | | | | | | | | | | | | | | | | | |
| Derby Hospitals NHS Foundation Trust | Royal Derby Hospital | 261 | 245 | C↑ | A↑ | B↑ | B↑ | C | C | B↑ | B | B | B | D↑ | B↑ | C↑ | C↓ | C |
| Northampton General Hospital NHS Trust | Northampton General Hospital | 304 | 299 | A | A | A | A | A↑ | C↑ | C | A | A | A | A | B | A↑ | B | A |
| Nottingham University Hospitals NHS Trust | Nottingham City Hospital | 364 | 396 | C↑ | A | B | C | D | B | C | C | A | B | E | C | B | B↑↑ | C |
| Sherwood Forest Hospitals NHS Foundation Trust | Kings Mill Hospital | 159 | 168 | A↑ | A | A | A↑ | C | C↓ | B↑ | B↓ | A | A | C↑ | B↑ | A | A | A↑ |
| United Lincolnshire Hospitals NHS Trust | Lincoln County Hospital | 192 | 204 | C↓ | A | C↓ | B | A↑ | D↓ | A | C↓ | B | B | B↑ | C↓ | B | C | B |
| United Lincolnshire Hospitals NHS Trust | Pilgrim Hospital | 173 | 179 | B↓ | A | A↑ | B↓ | A | B | A | A | C↓ | B | E↓↓ | C↓ | C↓ | A | B↓ |
| University Hospitals of Leicester NHS Trust | Leicester Royal Infirmary | 365 | 384 | B↑ | A | A↑ | B | C↓ | D↓ | C↓ | B | B↑ | B↑ | D | B | A | B | B |
| **Midlands & East - East of England SCN** | | | | | | | | | | | | | | | | | | |
| Basildon and Thurrock University Hospitals NHS Foundation Trust | Basildon University Hospital | 208 | 218 | A | A | A | A | A | C | A↑ | B | A | A | B | A↑ | A↑ | A | A |
| Cambridge University Hospitals NHS Foundation Trust | Addenbrooke's Hospital | 179 | 189 | D | A | B↑ | D | C | E | C | D↓ | C | A | E | E↓ | A↑ | C | D |
| Colchester Hospital University NHS Foundation Trust | Colchester General Hospital | 197 | 192 | A | A | A | A | A | C | A↑ | B | A | A | C | B | B | A | A |
| East and North Hertfordshire NHS Trust | Lister Hospital | 249 | 256 | B↓ | A | A | B↓ | B↓ | C↓ | C | B | A | A | C | B | B | B↓ | B↓ |
| Ipswich Hospital NHS Trust | Ipswich Hospital | 178 | 177 | A↑ | A | A | A↑ | C | B | B | C | A | A | C | B | A↑ | A | A↑ |
| James Paget University Hospitals NHS Foundation Trust | James Paget Hospital | 127 | 131 | C | A | B↓ | C | C | C | D↓ | B↑ | A↑ | B | C↑ | D | C | B | C |
| Luton and Dunstable University Hospital NHS Foundation Trust | Luton and Dunstable Hospital | 255 | 260 | C↑ | A | A↑ | C | B | D | B | B | A | B | E | C↑↑ | B | D | C |
| Mid Essex Hospital Services NHS Trust | Broomfield Hospital | 172 | 172 | A | A | A | A | A | B | A | A↑ | A↑ | B | D↓ | B↑ | A | A | A |
| Norfolk and Norwich University Hospitals NHS Foundation Trust | Norfolk and Norwich University Hospital | 371 | 371 | B | A | A↑ | B | B | C | B | A | B | B | C | B | B | A | B |
| Peterborough and Stamford Hospitals NHS Foundation Trust | Peterborough City Hospital | 219 | 212 | D | A | A↑ | D | C | E | D | C | C | D | C↑↑ | C | B | C | D |
| Queen Elizabeth Hospital King's Lynn NHS Foundation Trust | Queen Elizabeth Hospital Kings Lynn | 180 | 177 | A↑ | A | B | A | A↑ | B | A | A | A | A | A | B↓ | B↑↑ | C↑↑ | A |
| Southend University Hospital NHS Foundation Trust | Southend Hospital | 211 | 219 | B↓ | A | B↓ | A | A | C | B↓ | B | A | A | A | A | B | C↓ | A |
| West Hertfordshire Hospitals NHS Trust | Watford General Hospital | 190 | 200 | A | A | A | A | A | C | B | A↑ | A | A | A↑ | B↑ | B↓ | A↑ | A |
| West Suffolk NHS Foundation Trust | West Suffolk Hospital | 142 | 143 | A↑ | A | A | A↑ | A | B↑ | C↑ | B | A | A | A↑↑ | B↑ | B↑ | B↓ | A↑ |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **Midlands & East - West Midlands SCN** | | | | | | | | | | | | | | | | | | |
| Burton Hospitals NHS Foundation Trust | Queens Hospital Burton upon Trent | 122 | 118 | D | B↓ | C↑ | D↓ | A | D↓ | D | E↓ | B↓ | B↓ | C | D | D | B↑ | D↓ |
| Dudley Group of Hospitals NHS Foundation Trust | Russells Hall Hospital | 190 | 181 | C | A | B | C | C | D↓ | C↓ | B | C↑ | B | D | B | B↑↑ | C↓ | C |
| George Eliot Hospital NHS Trust | George Eliot Hospital | 52 | 79 | C↑ | A | B↑ | C↑ | A↑↑ | E | E | B | D↑ | C↑ | C | A | B | C↑ | C↑ |
| Heart of England NHS Foundation Trust | Birmingham Heartlands Hospital | 286 | 294 | A↑ | A | B↑ | A | A | B↑ | A↑ | B | A | A↑ | A | A↑ | B↑ | A | A |
| Royal Wolverhampton NHS Trust | New Cross Hospital | 167 | 185 | C | A | B↓ | B↑ | A↑ | C | B↑ | C | B↑ | B↑ | E | C | B | A | B↑ |
| Sandwell and West Birmingham Hospitals NHS Trust | Sandwell District Hospital | 163 | 168 | C | A | C | B | A | C | C↓ | B | E↓↓ | B | C | B↑ | B↑↑ | A↑ | B |
| Shrewsbury and Telford Hospital NHS Trust | Princess Royal Hospital Telford | 301 | 304 | D | A | C | D | D | D↓ | C↓ | D | A↑↑ | D | E | D | E | C↑ | D |
| South Warwickshire NHS Foundation Trust | Warwick Hospital | 85 | 97 | C | A | A | C | D↑ | D↑ | E | D↑ | B↓ | A | C↓ | B | B | C | C |
| University Hospitals Birmingham NHS Foundation Trust | Queen Elizabeth Hospital Edgbaston | 191 | 158 | C↑ | A | A | C↑ | C | C | C | B↑ | C | C | C↑ | D↑ | D | B↑ | C↑ |
| University Hospitals Coventry and Warwickshire NHS Trust | University Hospital Coventry | 261 | 266 | C | A | A | C | B↓ | E | B | D | A↑↑ | B↑ | E↓↓ | C | A↑ | A | C |
| University Hospitals of North Midlands NHS Trust | Royal Stoke University Hospital | 345 | 460 | B | A | A | B | A | C↑ | B | B | A | A | E↓↓ | B | B | A↑↑↑ | B |
| Walsall Healthcare NHS Trust | Manor Hospital | 126 | 124 | C↓ | A | A | C↓ | A | E↓↓ | D | B | D↓ | D↓ | C↓ | B↑ | A↑ | B | C↓ |
| Worcestershire Acute Hospitals NHS Trust | Worcestershire Royal Hospital | 262 | 259 | D↑ | B↑ | D↓ | D | B↑ | E | E↓ | E | A | B | D↑ | D | D↑ | A↑ | D |
| Wye Valley NHS Trust | Hereford County Hospital | 166 | 159 | C↑ | A | A | C↑ | C↓ | E↓ | C↑ | D | B | B | E | C | A↑ | B↑ | C↑ |
| **North of England - Greater Manchester and Eastern Cheshire SCN** | | | | | | | | | | | | | | | | | | |
| Pennine Acute Hospitals NHS Trust | Fairfield General Hospital | 312 | 357 | A | A | A | A | A | B | A | A | A | A↑ | B | A | B | A | A |
| Salford Royal NHS Foundation Trust | Salford Royal Hospital | 705 | 700 | A | A | A | A | A | B | B↑ | A | A | A↑ | C | A | A | A | A |
| Stockport NHS Foundation Trust | Stepping Hill Hospital | 349 | 360 | A↑ | A | A↑ | A | A | B | A↑ | A | B | B↑ | B | A | B | C | A |
| **North of England - North West Coast SCN** | | | | | | | | | | | | | | | | | | |
| Aintree University Hospitals NHS Foundation Trust | University Hospital Aintree | 136 | 154 | C | A | A | C | B | E | C↑ | B | C | D | D | B↑ | A | A | C |
| Blackpool Teaching Hospitals NHS Foundation Trust | Blackpool Victoria Hospital | 151 | 159 | D↑ | A | A | D↑ | C↑ | D | D | D | E | E | E | E | C↑ | B | D↑ |
| Countess of Chester Hospital NHS Foundation Trust | Countess of Chester Hospital | 125 | 125 | B | A | A | B | A | C | B | B↓ | A↑ | B↑ | E | B↓ | A↑ | B↓ | B |
| East Lancashire Hospitals NHS Trust | Royal Blackburn Hospital | 210 | 210 | D | A | A | D | D↓ | D | D | E↓ | E↓ | D | C↑ | C | A↑ | D↓ | D |
| Lancashire Teaching Hospitals NHS Foundation Trust | Royal Preston Hospital | 215 | 210 | D | A | A | D | C | E↓ | D | E↓ | C↑ | D | C↑ | C | A↑ | C | D |
| Mid Cheshire Hospitals NHS Foundation Trust | Leighton Hospital | 166 | 239 | C | A | A↑ | C | B↑ | E | E↓ | C↑ | D↓ | D↓↓ | C↓ | B | B | A | D↓ |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | Royal Liverpool University Hospital | 203 | 203 | C | A | B | B | B↑ | D | C↓ | B | A | A | E | B | D↓ | A | B |
| Southport and Ormskirk Hospital NHS Trust | Southport and Formby District General | 113 | 115 | D | A | B↓ | C↑ | B | E | D↑ | C | B↓ | B | D↑ | B↓ | B | D | C |
| St Helens and Knowsley Teaching Hospitals NHS Trust | Whiston Hospital | 235 | 226 | A | A | A | A | B↓ | B | B | A | B↓ | C↓ | B↑ | A | B | A | A |
| University Hospitals of Morecambe Bay NHS Foundation Trust | Furness General Hospital | 81 | 82 | D | A | C↑ | C↑ | B↓ | C↑ | D | B | A↑ | C | E | B↑ | B↑↑ | C | C↑ |
| University Hospitals of Morecambe Bay NHS Foundation Trust | Royal Lancaster Infirmary | 108 | 114 | D | A | B | D | A↑ | E | E | D | C | D↓↓ | E | C | B | A | D |
| Warrington and Halton Hospitals NHS Foundation Trust | Warrington Hospital | 114 | 125 | C | A | A | C | C | D | D↓ | D | A | A↑ | E | C↓ | C↓ | A | C |
| Wirral University Teaching Hospital NHS Foundation Trust | Arrowe Park Hospital | 218 | 217 | A | A | A | A | A | C↓ | B | B↓ | A | B | C | A | A↑↑ | A | A |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **North of England - North of England SCN** | | | | | | | | | | | | | | | | | | |
| City Hospitals Sunderland NHS Foundation Trust | Sunderland Royal Hospital | 133 | 114 | D↑ | A↑↑↑ | B | D | B | C | C↑ | B | E | D | E | C↑ | D | A↑↑↑ | D |
| County Durham and Darlington NHS Foundation Trust | University Hospital of North Durham | X | X | X | E↓↓ | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Gateshead Health NHS Foundation Trust | Queen Elizabeth Hospital Gateshead | 104 | 121 | D↓ | B↓ | C | B | B | C | C↑ | C↓ | B↓ | A | D↑ | D | B | A | B |
| Newcastle upon Tyne Hospitals NHS Foundation Trust | Royal Victoria Infirmary | 205 | 216 | A | A | A | A | A↑ | B↑ | B | B | A↑ | A | A↑ | B↑ | B↓ | A↑ | A↑ |
| North Cumbria University Hospitals NHS Trust | Cumberland Infirmary | 126 | 128 | C | A | B | B↑ | B | D | D | C↑ | A | B↓ | C↑↑ | B↑ | B | A | B↑ |
| North Cumbria University Hospitals NHS Trust | West Cumberland Hospital | 72 | 74 | B | A | A | B | B | C | C↑↑ | B | A | A | B↓ | C↓ | A | D | B |
| North Tees and Hartlepool NHS Foundation Trust | University Hospitals of North Tees and Hartlepool | 190 | 194 | C↑ | A | B | C↑ | C↑ | B | B↑ | B↑ | C↑ | D↓ | E | B | A↑ | C | C↑ |
| Northumbria Healthcare NHS Foundation Trust | Northumbria Specialist Emergency Care Hospital HASU | 340 | 341 | B↓ | A | A | B↓ | C↓ | C↓ | B↓ | B | A | A | B↓ | B | C↑ | B | B↓ |
| South Tees Hospitals NHS Foundation Trust | James Cook University Hospital | 239 | 241 | A↑ | A | A | A↑ | B↑ | B | B | B | A | B | C | A↑ | B | B | A↑ |
| South Tyneside NHS Foundation Trust | South Tyneside District Hospital | 89 | 83 | D | A | A | D | D↓ | E | E | E | C↓ | C↑ | E | E | B | A | D |
| **North of England - Yorkshire and The Humber SCN** | | | | | | | | | | | | | | | | | | |
| Barnsley Hospital NHS Foundation Trust | Barnsley Hospital | 132 | 151 | D↓↓ | A | A | D↓↓ | D↓ | E↓ | E↓ | D↓↓ | A | A | C | C↓ | A | D↓ | D↓↓ |
| Bradford Teaching Hospitals NHS Foundation Trust | Bradford Royal Infirmary | 154 | 160 | D | A | B↑↑ | D | D | C↑ | E | E | A↑↑ | C↓ | B↑ | D | A | C↑ | D |
| Calderdale and Huddersfield NHS Foundation Trust | Calderdale Royal Hospital | 229 | 233 | B↑ | A | A↑ | B | C | C↑ | A↑↑ | B↓ | A↑ | B↑ | C↓ | B | B | A | B |
| Chesterfield Royal Hospital NHS Foundation Trust | Chesterfield Royal | 166 | 178 | C↑ | A | A↑ | C | C | C | C | D | C | C↓ | E | B↑ | B | A | C |
| Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Doncaster Royal Infirmary | 183 | 197 | B↓ | A | A | B↓ | B | C | C↓ | C | A | A | A | B | A↑ | C↓ | B↓ |
| Harrogate and District NHS Foundation Trust | Harrogate District Hospital | 81 | 85 | D↓ | A | B | C | D | C↓ | D↑ | D↓↓ | B↓ | B↑ | C↑ | C↓ | B | C | C |
| Hull and East Yorkshire Hospitals NHS Trust | Hull Royal Infirmary | 244 | 256 | C↓ | A | B | B | B | C↓ | C↓ | B | A | A | E | C | A↑ | A↑ | B |
| Leeds Teaching Hospitals NHS Trust | Leeds General Infirmary | 316 | 304 | C | A | B↓ | B↑ | C | C↑ | B | B↑ | C | B↑↑ | B | D | A | C↑ | B↑ |
| Mid Yorkshire Hospitals NHS Trust | Pinderfields Hospital | 249 | 235 | C | A | A | C | B↓ | C↓ | B↑ | C | C↓ | B | E | E↓ | A↑ | A | C↓ |
| Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Scunthorpe General Hospital | 199 | 210 | A | A | A | A | A | B | C | A | A | A | A↑↑ | B↑ | A | C | A |
| Rotherham NHS Foundation Trust | Rotherham Hospital | 139 | 141 | B↑ | A | A | B↑ | A | C | D↑ | D | A | A↑ | E | C↑ | A | A↑↑ | B↑ |
| Sheffield Teaching Hospitals NHS Foundation Trust | Royal Hallamshire Hospital | 282 | 307 | C↑ | A | B | C | B↓ | B | D | C | A↑↑ | B↑ | E | C↑ | B | B↑ | C |
| York Teaching Hospital NHS Foundation Trust | York Hospital | 322 | 310 | B↑ | A | A | B↑ | B↑ | D | C | B | A | B | C↑ | B | B↓ | C↑ | B↑ |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **South England - South East SCN** | | | | | | | | | | | | | | | | | | |
| Ashford and St Peter's Hospitals NHS Foundation Trust | St Peter's Hospital | 136 | 136 | A | B | A | A | A | C | D↓↓ | A | A↑ | A↑ | B | A↑ | A | A | A |
| Brighton and Sussex University Hospitals NHS Trust | Royal Sussex County Hospital | 188 | 193 | B | A | A | B | A | B | B | A | C↑ | C | D↓ | D | B | C↓ | B |
| Dartford and Gravesham NHS Trust | Darent Valley Hospital | 108 | 100 | D | B | B | D | B↓ | E | C | E | C | B↑ | E | E | D↓ | C | D |
| East Kent Hospitals University NHS Foundation Trust | Kent and Canterbury Hospital | 84 | 88 | D | A | C↓ | C↑ | B | D↓ | B↑↑ | B↓ | C | D | E | D↓ | B↑ | A↑ | C |
| East Kent Hospitals University NHS Foundation Trust | Queen Elizabeth the Queen Mother Hospital | 115 | 115 | C | A | A↑ | C | A↑ | D | E↓↓ | A | A↑↑ | B | E↓↓ | C↑ | B | B↑ | C |
| East Kent Hospitals University NHS Foundation Trust | William Harvey Hospital | 152 | 156 | B↑ | A | A | B↑ | A↑ | C↑ | B↑↑ | A | C↓↓ | C↓ | D↑ | B↑ | A↑ | B | B↑ |
| East Sussex Healthcare NHS Trust | Eastbourne District General Hospital | 118 | 147 | C | B↓ | A | C | A | B | C | A↑ | D↓ | C | E | D | B | C | C |
| Epsom and St Helier University Hospitals NHS Trust | Epsom Hospital | 95 | 95 | C | A↑ | A | C↓ | A | C↑ | E↓↓ | B↑ | B↓ | C↓ | C | C | B | B | C↓ |
| Frimley Health NHS Foundation Trust | Frimley Park Hospital | 126 | 130 | A↑ | A | A↑ | A | A | C | C↓ | A | A | A | C↑ | B | B | A↑ | A |
| Maidstone and Tunbridge Wells NHS Trust | Maidstone District General Hospital | 87 | 91 | B | A | B↓ | B | B | C↑ | C↑ | C | A | A | A↑↑ | B↑ | D↓↓ | B | B |
| Maidstone and Tunbridge Wells NHS Trust | Tunbridge Wells Hospital | 114 | 117 | B↑↑ | A | A↑↑ | B↑ | B | D | C↑ | C↑ | A↑ | A | B↑↑ | C | D | B | B↑ |
| Medway NHS Foundation Trust | Medway Maritime Hospital | 112 | 122 | D | A | C | D | B↓ | E | D | D | E | D↑ | D↑ | C | B↑ | A | D |
| Royal Surrey County Hospital NHS Foundation Trust | Royal Surrey County Hospital | 103 | 102 | B | A↑ | A↑ | B↓ | A | D↓ | D↓ | D↓ | A | A | B↓ | B↓ | A↑ | A | B↓ |
| Surrey and Sussex Healthcare NHS Trust | East Surrey Hospital | 163 | 166 | D | C | C | C | A | D↑ | C↑ | C↓ | C↓ | C↓ | B | B | B↓ | D | C↓ |
| Western Sussex Hospitals NHS Trust | St Richards Hospital | 134 | 140 | B | A | A | B | C | C | A | C↓ | A | B | C | B | B | C↑ | B |
| Western Sussex Hospitals NHS Trust | Worthing Hospital | 143 | 145 | B↓ | A | A↑ | B↓ | B↓ | C↓ | B | B↓ | A | B | C↓ | B | A | C | B↓ |
| **South England - South West SCN** | | | | | | | | | | | | | | | | | | |
| Gloucestershire Hospitals NHS Foundation Trust | Gloucestershire Royal Hospital | 261 | 261 | D | A | B | D | D↓ | D | D | D | D | D↑ | E | E | A↑ | C | D |
| Great Western Hospitals NHS Foundation Trust | Great Western Hospital Swindon | 134 | 144 | D↑ | B | B↑ | D | A | E | C | D↑ | C | D | D↑ | E | C↓ | D | D |
| North Bristol NHS Trust | North Bristol Hospitals | 229 | 232 | C | A | A | C | A | C | B | C | C | D | C↑ | C | C↑ | B | C |
| Northern Devon Healthcare NHS Trust | North Devon District Hospital | 128 | 134 | C↑ | A | B | B↑ | C↑ | C↑↑ | B↑ | E | A | A | C↑↑ | C↓ | A | B | B↑ |
| Plymouth Hospitals NHS Trust | Derriford Hospital | 264 | 259 | C | A | A↑ | C | B | D | C | B↑ | C↓↓ | A | E↓ | E | A | B↓ | C↓ |
| Royal Cornwall Hospitals NHS Trust | Royal Cornwall Hospital | 276 | 276 | D | A | B↓ | C↑ | A | C↑ | C↑ | C↑ | C↑↑ | D | C↑ | D↑ | C↑ | C↓ | C↑ |
| Royal Devon and Exeter NHS Foundation Trust | Royal Devon and Exeter Hospital | 222 | 228 | B | A | A | B | C↓ | C↑ | B | B | A | A | B↑ | B | A | B | A↑ |
| Royal United Hospital Bath NHS Trust | Royal United Hospital Bath | 218 | 209 | C↑ | A | B | C | B↑ | D | C | B | B↑ | B | D | D↓ | C | C | C |
| Salisbury NHS Foundation Trust | Salisbury District Hospital | 116 | 118 | B | A | B | B | A | C | D↓↓ | B | A | A↑ | D↑ | B | C | B | B |
| Taunton and Somerset NHS Foundation Trust | Musgrove Park Hospital | 202 | 204 | D↓↓ | B↓ | B↓ | C↓ | A | D↓ | C↑ | D | C↓↓ | A | E | C↓ | B | A↑ | C↓ |
| Torbay and South Devon NHS Foundation Trust | Torbay Hospital | 229 | 228 | B↑↑ | A | A | B↑↑ | B↑ | C↑↑ | C↑ | C↑↑ | A↑ | B↑ | C↑ | B↑ | B | A↑ | B↑↑ |
| University Hospitals Bristol NHS Foundation Trust | Bristol Royal Infirmary | 143 | 145 | C | A | A | C | A | D↓ | C↓ | C | B | B↑ | E↓ | D↑ | B↓ | B | C |
| Weston Area Health NHS Trust | Weston General Hospital | 80 | 85 | D↓↓ | A | A | D↓↓ | C↓ | E↓↓ | C↓ | B | C↓ | B | E↓↓ | C | D↓↓ | C | D↓↓ |
| Yeovil District Hospital NHS Foundation Trust | Yeovil District Hospital | 132 | 133 | B↑ | A | A | B↑ | A↑ | C | A↑ | D↑ | A | A | E↓ | D | C | A | B↑ |
| **South England - Thames Valley SCN** | | | | | | | | | | | | | | | | | | |
| Buckinghamshire Healthcare NHS Trust | Wycombe General Hospital | 176 | 181 | A | A↑ | A | A | A | C↓ | A | A | A | A | B↑ | B | B | A↑↑ | A |
| Frimley Health NHS Foundation Trust | Wexham Park Hospital | 106 | 123 | D | A | D | D↓ | E↓ | D↓ | E | E | A↑ | B | C↓ | C↓ | B | B | D↓ |
| Milton Keynes University Hospital NHS Foundatior Trust | Milton Keynes General Hospital | 54 | 71 | C↑ | A↑ | C | B↑ | A | D | NA | B | C↑ | A | D↑ | C↓ | B | B↓ | B↑ |
| Oxford University Hospitals NHS Foundation Trust | Horton General Hospital | TFP | 22 | TFP | A↑↑ | TFP | TFP | NA | A↑↑ | NA | NA | C | B | C | NA | D↓↓ | C | TFP |
| Oxford University Hospitals NHS Foundation Trust | John Radcliffe Hospital | 193 | 196 | B | A | A | B | A↑ | B↑ | B | C | A | A↑ | C | B↑ | C↓ | D↓ | B |
| Royal Berkshire NHS Foundation Trust | Royal Berkshire Hospital | 218 | 218 | A↑ | B | A↑ | A | A | C↑ | A | B | A | A | B↑ | B | B | B↓ | A |

| Routinely Admitting Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **South England - Wessex SCN** | | | | | | | | | | | | | | | | | | |
| Dorset County Hospital NHS Foundation Trust | Dorset County Hospital | 126 | 132 | C↑ | A | A↑ | C↑ | D | B↑ | C | D | A | B↑ | B | C↑ | D↑ | C↑ | C↑ |
| Hampshire Hospitals NHS Foundation Trust | Royal Hampshire County Hospital | 191 | 199 | B | A | A | B | C | C | C | B | A | A | B↑ | B | C | A↑ | B |
| Isle of Wight NHS Trust | St Mary's Hospital Newport | 105 | 112 | D | A | B | D | A | E | E | C↑ | D↑ | C↑ | E | B↑↑ | B | A | D |
| Poole Hospital NHS Foundation Trust | Poole Hospital | 188 | 192 | B↑ | A↑ | A | B↑ | C↑ | C | C | D | A | B | C | A | D | A↑ | B↑ |
| Portsmouth Hospitals NHS Trust | Queen Alexandra Hospital Portsmouth | 340 | 368 | B↑ | A | B↑ | B↑ | C | D | C↑ | B↑ | A | A | C↑ | B↑ | B | A | B↑ |
| Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust | Royal Bournemouth General Hospital | 262 | 259 | A | A | A | A | C | C | C | B | A | A | A | A | A | A | A |
| University Hospital Southampton NHS Foundation Trust | Southampton General Hospital | 251 | 267 | B | A | A↑ | B | B | B | B↑ | B↓ | A | A↑ | D↓ | B | B | B | B |
| **Islands** | | | | | | | | | | | | | | | | | | |
| Isle of Man Department of Health | Noble's Hospital | 39 | 37 | E | A↑ | D | E | E↓ | D | E↓ | E | C↑↑ | C↑↑ | E | E | B | D | E |
| **Northern Ireland** | | | | | | | | | | | | | | | | | | |
| Belfast Health and Social Care Trust | Mater Infirmorum Hospital | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Belfast Health and Social Care Trust | Royal Victoria Hospital Belfast | 171 | 168 | C↑ | A | C | C↑ | B | D↑ | B↑ | D↑ | C | A↑ | C | D↑ | B↑ | A | C↑ |
| Northern Health and Social Care Trust | Antrim Area Hospital | 128 | 123 | E | A | D | D | C↑ | E | C↑ | D↑ | B↑ | D | E↓ | D | E↓ | C↓ | D |
| Northern Health and Social Care Trust | Causeway Hospital | 71 | 74 | E | A | D | E | D↑ | E | E↓ | E | C | C↑ | C↑ | E | D↑ | D↓ | E |
| South Eastern Health and Social Care Trust | Downe General Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | TFP |
| South Eastern Health and Social Care Trust | Ulster Hospital | 175 | 166 | D | A | A | D | D | E | C | E | B↑ | B | C↓ | D↑ | A↑↑ | B↑↑ | D |
| Southern Health and Social Care Trust | Craigavon Area Hospital | 106 | 107 | D↑ | A | A↑ | D↑ | D | E | D↑ | E | C | D↓ | D | E↓ | B | C↑ | D |
| Southern Health and Social Care Trust | Daisy Hill Hospital | 40 | 46 | D | B↓ | A | D | C | E | C | E↓ | C↓ | B↑↑ | E↓ | D | B | C↑ | D |
| Western Health and Social Care Trust | Altnagelvin Hospital | 70 | 63 | D↑ | A | B↑ | D | C↑ | E | B | D↑ | C↑ | D | E | E | B↑ | C | D |
| Western Health and Social Care Trust | South West Acute Hospital | 67 | 63 | C | A | A | C | B↑ | C | B↓ | B | B | B↑ | E | D↑ | B | C | C |
| **Wales** | | | | | | | | | | | | | | | | | | |
| Abertawe Bro Morgannwg University Health Board | Morriston Hospital | 229 | 226 | C | A | A↑ | C | C | E | C↑ | C↓ | B↓ | A | C | A | B | D | C |
| Abertawe Bro Morgannwg University Health Board | Princess Of Wales Hospital | 93 | 92 | C↑ | A | A↑ | C↑ | C | C↑↑ | D↓ | B↑ | C | D | B | A↑ | B | D | C↑ |
| Aneurin Bevan University Health Board | Royal Gwent Hospital | 234 | 230 | B | A | A | B | A | C↓ | C | A | B↓ | B | A | B | A↑ | B↑ | A |
| Betsi Cadwaladr University Health Board | Glan Clwyd District General Hospital | 116 | 120 | C↓ | A | A | C↓ | C | C | D↓ | B | E↓ | E↓↓ | B↓ | A↑ | A | C | C↓ |
| Betsi Cadwaladr University Health Board | Maelor Hospital | 126 | 122 | C | A | A | C | C | E | D↓ | B↓ | C↑↑ | C↓ | D↓ | B | A | C | C |
| Betsi Cadwaladr University Health Board | Ysbyty Gwynedd | 102 | 100 | C↓ | A | A | C↓ | C | D↓ | E | A | A | A | C↓ | B | A | D | B |
| Cardiff and Vale University Health Board | University Hospital of Wales | 170 | 174 | B↑ | A | A | B↑ | A | D | C↓ | B↑↑ | B↑ | A↑ | C↑↑ | B↑↑ | A | A↑ | B↑ |
| Cwm Taf University Health Board | Prince Charles Hospital | 186 | 187 | C | A | B | C↓ | B↓ | D | D | D | A | B↑ | B↑ | C↓ | A | C↓↓ | C↓ |
| Hywel Dda Health Board | Bronglais Hospital | 46 | 47 | C↑ | A | A↑ | C↑ | A↑ | B | A↑ | C | E | D↑ | C↑↑ | B↑ | A | C | B↑↑ |
| Hywel Dda Health Board | Prince Philip Hospital | 55 | 68 | C | A | A↑ | C | A | C | B | A | D↓ | D | E | B | A | C | C↓ |
| Hywel Dda Health Board | West Wales General | 94 | 94 | D | A | B | D | A | E | E↓ | D↑ | C | B↑ | E | B↑↑ | A | C | D |
| Hywel Dda Health Board | Withybush General Hospital | 64 | 66 | B↑ | A | B | B↑ | A | B↑ | A↑↑↑ | B↑ | C | B | E↓↓ | A↑ | A | C↑ | B↑ |

| Non-Routinely Admitting Acute Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **London - London SCN** | | | | | | | | | | | | | | | | | | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | Queens Hospital Romford SU | TFP | 102 | C | A↑ | D↓↓↓ | B | NA | A | NA | NA | A↑↑ | B↑ | B↑ | NA | D↓ | C | B↑ |
| Barts Health NHS Trust | Newham General Hospital | TFP | 49 | B | A | D | A | NA | A | NA | NA | A | A | B↓ | NA | A↑ | A | A |
| Barts Health NHS Trust | Royal London Hospital SU | TFP | 102 | A | B↓ | A | A | NA | A | NA | NA | A | A | B | NA | A↑ | B↓ | A |
| Barts Health NHS Trust | Whipps Cross University Hospital | TFP | 61 | B | A | A↑ | B↓ | NA | B↓ | NA | NA | B | C↓ | B↓ | NA | A | C↓ | B↓ |
| Chelsea and Westminster Hospital NHS Foundation Trust | Chelsea and Westminster Hospital | TFP | X | TFP | E↓↓ | X | TFP | NA | X | NA | NA | X | X | X | NA | X | X | TFP |
| Croydon Health Services NHS Trust | Croydon University Hospital | TFP | 76 | C | A | D | B | NA | B | NA | NA | B↓ | D↓ | C | NA | A | A | B↓ |
| Epsom and St Helier University Hospitals NHS Trust | St Helier Hospital | TFP | 57 | B↑ | A↑ | D | A | NA | A↑ | NA | NA | B↑ | B↑ | B↓ | NA | A | A | A |
| Guy's and St Thomas' NHS Foundation Trust | St Thomas Hospital | TFP | 65 | A | A | A | A | NA | A↑ | NA | NA | A | A | A | NA | A | A | A |
| Hillingdon Hospitals NHS Foundation Trust | Hillingdon Hospital | TFP | 43 | B | A↑ | D↓ | A | NA | A | NA | NA | A↑ | A↑ | B | NA | A | C | A |
| Homerton University Hospital NHS Foundation Trust | Homerton University Hospital | TFP | 43 | C↑ | A↑↑ | E | A | NA | A | NA | NA | A↑ | A | A | NA | C↑ | B | A |
| Imperial College Healthcare NHS Trust | Charing Cross Hospital SU | TFP | 122 | B | A | D↓↓ | A | NA | A | NA | NA | A | B | C | NA | B | B | A |
| Imperial College Healthcare NHS Trust | Charing Cross Hospital SU - Nine South Ward | TFP | X | TFP | E↓↓↓↓ | X | TFP | NA | X | NA | NA | X | X | X | NA | X | X | TFP |
| King's College Hospital NHS Foundation Trust | King's College Hospital SU | TFP | 52 | A | A | A↑ | A | NA | A | NA | NA | A | A | C↓ | NA | A | A | A |
| King's College Hospital NHS Foundation Trust | Princess Royal University Hospital SU | TFP | 84 | B | A | B↑ | A | NA | A | NA | NA | A↑ | B↓ | D | NA | A | B↓ | A |
| Kingston Hospital NHS Foundation Trust | Kingston Hospital | TFP | 59 | B | B↓ | C↑ | A | NA | A↑ | NA | NA | A | A | B↑ | NA | B↓ | A | A |
| Lewisham and Greenwich NHS Trust | University Hospital Lewisham | TFP | 136 | B↓ | A | A | B↓ | NA | A | NA | NA | C | B | C | NA | B↓ | A | B↓ |
| London North West Healthcare NHS Trust | Northwick Park Hospital SU | TFP | 198 | A | A | B | A | NA | A | NA | NA | A | A | B↓ | NA | A | C | A |
| North Middlesex University Hospital NHS Trust | North Middlesex Hospital | TFP | 58 | C | C↓↓ | D | A↑ | NA | A | NA | NA | A | A | B↓ | NA | B | C↑ | A |
| Royal Free London NHS Foundation Trust | Barnet General Hospital | TFP | 44 | A | A | A | A | NA | B | NA | NA | A | A | B | NA | A↑ | A | A |
| Royal Free London NHS Foundation Trust | Royal Free Hospital | TFP | 67 | B↓ | B↓ | C↓ | A | NA | A | NA | NA | A | A | A | NA | B | A | A |
| St George's Healthcare NHS Trust | St George's Hospital SU | TFP | 80 | B↓ | A | D | A | NA | A | NA | NA | A | A | B↓ | NA | A | A | A |
| University College London Hospitals NHS Foundation Trust | University College Hospital SU | TFP | 71 | A | A↑ | C↓ | A | NA | A↑ | NA | NA | A | A | A | NA | A | A | A |
| West Middlesex University Hospital NHS Trust | West Middlesex University Hospital | TFP | 30 | B | A | D | A | NA | A | NA | NA | A | A | B↑ | NA | C↓ | C↓ | A |
| **Midlands & East - East Midlands SCN** | | | | | | | | | | | | | | | | | | |
| Kettering General Hospital NHS Foundation Trust | Kettering General Hospital | TFP | 34 | E↓ | D↓ | C↑ | D↓↓ | NA | D↓↓ | NA | NA | E↓↓↓↓ | E↓↓↓ | D | NA | B↓ | B↑↑ | D↓↓ |
| **Midlands & East - East of England SCN** | | | | | | | | | | | | | | | | | | |
| Bedford Hospital NHS Trust | Bedford Hospital | TFP | 69 | C↑ | A | B↑↑ | C↑ | NA | A↑ | NA | NA | A↑ | B | E | NA | B↓ | D↓ | B↑↑ |
| Hinchingbrooke Health Care NHS Trust | Hinchingbrooke Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | TFP |
| **Midlands & East - West Midlands SCN** | | | | | | | | | | | | | | | | | | |
| Heart of England NHS Foundation Trust | Good Hope General Hospital | TFP | 72 | B↑↑ | A | B↑ | B↑ | NA | B | NA | NA | B↑ | B | E | NA | A↑↑ | A↑ | B↑ |
| Heart of England NHS Foundation Trust | Solihull Hospital | TFP | 66 | B↑↑ | A | A↑↑↑ | B↑↑ | NA | A↑ | NA | NA | C↑↑ | B↑ | C↑↑ | NA | B↑↑ | A↑ | B↑↑ |
| Shrewsbury and Telford Hospital NHS Trust | Royal Shrewsbury Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| University Hospitals of North Midlands NHS Trust | County Hospital | TFP | 34 | C↓ | A | B | C↓ | NA | C↓ | NA | NA | B | B | C | NA | D | B↓ | C↓ |

| Non-Routinely Admitting Acute Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **North of England - Greater Manchester and Eastern Cheshire SCN** | | | | | | | | | | | | | | | | | | |
| Bolton NHS Foundation Trust | Royal Bolton Hospital | TFP | 81 | B | A | A | B | NA | B↓ | NA | NA | B↓ | B | E | NA | B | A | B |
| Central Manchester University Hospitals NHS Foundation Trust | Manchester Royal Infirmary | TFP | 64 | B↑ | A | A | B↑ | NA | D | NA | NA | A | B↑ | C↑↑ | NA | A↑ | A | B↑ |
| Central Manchester University Hospitals NHS Foundation Trust | Trafford General Hospital | TFP | 45 | A | A | A | A | NA | A | NA | NA | A | A↑ | C↑ | NA | A | A | A |
| East Cheshire NHS Trust | Macclesfield District General Hospital | TFP | 34 | TFP | A | B↑ | TFP | NA | B↑ | NA | NA | C | E↓↓ | D↑ | NA | A | D | TFP |
| Tameside and Glossop Integrated Care NHS Foundation Trust | Tameside General Hospital | TFP | 54 | B↑ | A | A | B↑ | NA | C↑ | NA | NA | A↑ | B↑↑ | D↑ | NA | A | A | B↑ |
| University Hospital of South Manchester NHS Foundation Trust | Wythenshawe Hospital | TFP | 81 | B | A | A | B | NA | C↑ | NA | NA | B | B | C↓ | NA | B↓ | A | B |
| Wrightington, Wigan and Leigh NHS Foundation Trust | Royal Albert Edward Infirmary | TFP | 121 | B↓ | A | D↓↓↓ | A | NA | B | NA | NA | A | A | E↓ | NA | A | A | A |
| **North of England - North of England SCN** | | | | | | | | | | | | | | | | | | |
| Northumbria Healthcare NHS Foundation Trust | Hexham General Hospital | TFP | 32 | B | A | B↑ | B↓ | NA | A | NA | NA | A | A | D↑ | NA | A | C | A↑ |
| Northumbria Healthcare NHS Foundation Trust | North Tyneside General Hospital | TFP | 88 | A | A | A | A | NA | A | NA | NA | B↓ | B | C | NA | B↑↑ | A | A↑ |
| Northumbria Healthcare NHS Foundation Trust | Wansbeck General Hospital | TFP | 62 | B↓ | A | A | B↓ | NA | A | NA | NA | C↓ | C↓↓ | D | NA | B | A | B↓ |
| **North of England - Yorkshire and The Humber SCN** | | | | | | | | | | | | | | | | | | |
| Airedale NHS Foundation Trust | Airedale General Hospital | TFP | 65 | D | A | A | D | NA | B↑ | NA | NA | C | D | B↑ | NA | B | C↑ | C↑ |
| Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Diana Princess of Wales Hospital Grimsby | TFP | 42 | B | A | B↓ | A↑ | NA | C↑ | NA | NA | A | B | C↓ | NA | A | A | A |
| Northern Lincolnshire and Goole Hospitals NHS Foundation Trust | Goole District Hospital | TFP | TFP | TFP | NA | TFP | TFP | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | TFP |
| York Teaching Hospital NHS Foundation Trust | Scarborough General Hospital | TFP | 57 | D | B↓ | D | C↑ | NA | B↓ | NA | NA | B | A↑↑ | E | NA | D | A | B↑ |
| **South England - Wessex SCN** | | | | | | | | | | | | | | | | | | |
| Hampshire Hospitals NHS Foundation Trust | Basingstoke and North Hampshire Hospital | TFP | 44 | C↓ | A↑ | B↓ | C↓ | NA | B↓ | NA | NA | C | B↓ | E↓ | NA | C | B | C↓ |
| **Wales** | | | | | | | | | | | | | | | | | | |
| Abertawe Bro Morgannwg University Health Board | Singleton Hospital | TFP | 29 | D | B↓ | D | C↑ | NA | B↑ | NA | NA | C↑ | B↑↑ | D↑ | NA | A | C | B↑↑ |
| Aneurin Bevan University Health Board | Nevill Hall Hospital | TFP | 49 | D | B | D | C | NA | B↑ | NA | NA | C | C↑ | E | NA | B | B↓ | C |
| Aneurin Bevan University Health Board | Ysbyty Ystrad Fawr | TFP | 27 | D | B | D | B | NA | A | NA | NA | C | D | E | NA | B | B | C |
| Cardiff and Vale University Health Board | Llandough Hospital | TFP | 69 | C↑ | B↓ | D | B↑ | NA | A | NA | NA | C↑↑ | B | D↑ | NA | B↓ | A | B |

| Non-Acute Inpatient Teams | | Number of patients | | Overall Performance | | | | Team Centred Data | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | Team Name | Admit | Disch | SSNAP Level | CA | AC | Combined KI Level | D1 Scan | D2 SU | D3 Throm | D4 Spec Asst | D5 OT | D6 PT | D7 SALT | D8 MDT | D9 Std Disch | D10 Disch Proc | TC KI Level |
| **London - London SCN** | | | | | | | | | | | | | | | | | | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | King George Hospital Inpatient Rehab Team | TFP | 31 | B↑ | A | A↑ | B | NA | A | NA | NA | A | A↑ | B↑ | NA | C↓ | B↑ | A↑ |
| Central and North West London NHS Foundation Trust | St Pancras Hospital | TFP | 24 | D | B | D | B | NA | E | NA | NA | A | A | A | NA | A | D | B |
| **Midlands & East - East Midlands SCN** | | | | | | | | | | | | | | | | | | |
| Leicestershire Partnership NHS Trust | Coalville Community Hospital | TFP | 32 | D↓ | D↓↓↓ | D↓ | B | NA | A | NA | NA | C | C | C↑↑ | NA | A | A | B |
| University Hospitals of Leicester NHS Trust | Leicester City Stroke Rehabilitation Unit | TFP | 45 | C↓ | B | D↓↓ | A↑ | NA | A | NA | NA | A↑ | C↓ | E | NA | A | A | B |
| **Midlands & East - East of England SCN** | | | | | | | | | | | | | | | | | | |
| Anglian Community Enterprise CIC | Clacton Hospital | TFP | 21 | C↓ | A | D | A | NA | A | NA | NA | A | B | E↓ | NA | B↓ | A | B↓ |
| Hertfordshire Community NHS Trust | Danesbury Neurological Centre | TFP | 29 | C | A | C | B | NA | A | NA | NA | A | B | B↑↑↑ | NA | C↓ | D | B |
| Hertfordshire Community NHS Trust | Holywell Rehabilitation Unit - St Albans City Hospital | TFP | 22 | D | D | C | B | NA | A | NA | NA | A | B | E | NA | B | D | B |
| Norfolk Community Health and Care NHS Trust | Norwich Community Hospital - Beech Ward | TFP | 50 | D | A | D↓ | C | NA | A | NA | NA | D↑ | D | D | NA | B | A | C |
| Provide | St Peter's Community Hospital Rehab Unit | TFP | 30 | A | A | B | A | NA | A | NA | NA | A | A | C↑ | NA | A | A | A |
| **Midlands & East - West Midlands SCN** | | | | | | | | | | | | | | | | | | |
| Birmingham Community Healthcare NHS Foundation Trust | Moseley Hall Stroke Rehabilitation Unit | TFP | 44 | C↑ | B↑ | E↓ | A↑ | NA | A | NA | NA | B↑ | B | A↑↑ | NA | B | B | A↑ |
| South Warwickshire NHS Foundation Trust | Feldon Stroke Rehabilitation Unit SWFT | TFP | 38 | A↑ | A | B↑ | A | NA | A | NA | NA | A | A | A↑ | NA | A | C↑ | A |
| Staffordshire and Stoke-on-Trent Partnership NHS Trust | Staffordshire Rehabilitation Team | TFP | 48 | B | A | D↓ | A | NA | A | NA | NA | A | B↓ | E | NA | B↑↑ | A | B |
| **North of England - North West Coast SCN** | | | | | | | | | | | | | | | | | | |
| East Lancashire Hospitals NHS Trust | Pendle Community Hospital - Marsden Stroke Unit | TFP | 46 | D | C↓ | B↑↑ | C | NA | A | NA | NA | B | B↑ | C | NA | A↑ | D↓ | B |
| Lancashire Teaching Hospitals NHS Foundation Trust | Chorley and South Ribble Hospital | TFP | 51 | C | B↓ | D | A | NA | A | NA | NA | A | A↑ | C | NA | A | C | A |
| **North of England - Yorkshire and The Humber SCN** | | | | | | | | | | | | | | | | | | |
| Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Bassetlaw District General Hospital | TFP | 31 | C↓ | A | B↑ | C↓↓ | NA | B↓ | NA | NA | B↓ | D↓↓ | E↓↓ | NA | B | C↓ | C↓↓ |
| Doncaster and Bassetlaw Hospitals NHS Foundation Trust | Montagu Hospital | TFP | 35 | A↑ | A | A | A↑ | NA | A | NA | NA | C | B↓ | B↑ | NA | A↑ | C | B |
| Humber NHS Foundation Trust | Rossmore Unit, Hull Integrated Stroke Service | TFP | 20 | C | A | D | B | NA | A | NA | NA | A | A | D | NA | B | C | B |
| Sheffield Teaching Hospitals NHS Foundation Trust | Beech Hill Rehabilitation Unit | TFP | 23 | D | A↑ | E | C | NA | A | NA | NA | C↓ | C↓ | E | NA | C↓ | B↑↑ | C |
| South West Yorkshire Partnership NHS Foundation Trust | Kendray Hospital | TFP | 48 | A | A | A | A | NA | A | NA | NA | A | B | B | NA | A | C↑ | A |
| **South England - South West SCN** | | | | | | | | | | | | | | | | | | |
| CORNWALL PARTNERSHIP NHS FOUNDATION TRUST | Woodfield Stroke Rehabilitation Unit | TFP | 46 | B↑ | A↑ | D↓ | A | NA | A | NA | NA | A | D↓ | A | NA | D↓↓ | A | B↓ |
| Great Western Hospitals NHS Foundation Trust | Forest Ward - Swindon Intermediate Care Centre | TFP | 36 | D | A | E↓ | D | NA | A | NA | NA | E | C | E | NA | A | C↑ | C↑ |
| Northern Devon Healthcare NHS Trust | Bideford Community Hospital | TFP | 27 | B | A | D | A | NA | A | NA | NA | A | A | B↑ | NA | B | A↑ | A |
| Northern Devon Healthcare NHS Trust | East Devon Community Stroke Rehab Unit | TFP | 42 | C↓↓ | A | D↓↓↓ | B↓ | NA | A | NA | NA | C↓ | C↓↓ | E↓ | NA | A | C | C↓ |
| Plymouth Community Healthcare CIC | Mount Gould Hospital | TFP | 28 | A | A | A | A | NA | A | NA | NA | A | A | B | NA | B↑↑ | A | A |
| Somerset Partnership NHS Foundation Trust | South Petherton Community Hospital | TFP | 38 | C | A | D | B | NA | A | NA | NA | B↑ | C↑ | E | NA | A | A↑ | B↑ |
| Torbay and South Devon NHS Foundation Trust | Newton Abbot Hospital | TFP | 74 | A↑ | A↑ | D | A | NA | A | NA | NA | A | A | A | NA | A↑↑ | A | A |
| **South England - Thames Valley SCN** | | | | | | | | | | | | | | | | | | |
| Oxford Health NHS Foundation Trust | Abingdon Community Hospital | TFP | 30 | B↑ | A | A↑↑↑ | B | NA | A | NA | NA | A | B | C↑↑ | NA | B | D | B |
| Oxford Health NHS Foundation Trust | Witney Community Hospital | TFP | 20 | B | B↓ | A↑ | A↑ | NA | A | NA | NA | B | B | C | NA | B | B↑ | B |
| **Northern Ireland** | | | | | | | | | | | | | | | | | | |
| Southern Health and Social Care Trust | South Tyrone and Lurgan Hospitals | TFP | 27 | D | B↓ | B↓ | C↑ | NA | A | NA | NA | E↓ | B↑ | C↑↑ | NA | B↑ | D↓ | C↑ |
| **Wales** | | | | | | | | | | | | | | | | | | |
| Aneurin Bevan University Health Board | St Woolos Hospital | TFP | 45 | D | A | D↓ | C | NA | A | NA | NA | C↑ | D↓ | E | NA | B | D | D |
| Cwm Taf University Health Board | Ysbyty Cwm Rhondda | TFP | 26 | D↓↓ | C↓↓ | C↓ | C↓ | NA | C↓↓ | NA | NA | B↓ | B | E | NA | B | D↓ | C↓ |

# Conclusion

It is unprecedented to have collected such a high volume of cases with good data quality and a representative sample within three years of initiating a new national audit. Participation in the audit continues to be an unparalleled success. In the latest reporting period 31,971 patient records were submitted to SSNAP for analysis, demonstrating the efforts of all the teams and registered audit users.

Without information and data about stroke services in England, Wales and Northern Ireland it would not be possible to persuade clinicians, commissioners or NHS England that there is still work to be done to ensure that high quality care is provided to patients regardless of where they live or when they have their stroke.

Recent audit results have shown that improvements to stroke services are being made. In January to March 2016 only 25 services achieved an “A” score compared to 41 teams in this reporting period. The consistent decrease in the number of hospitals achieving the lowest scoring band is similarly reassuring. The latest audit results reinforce our belief that whilst the audit sets the bar high to attain the top grade, world class stroke care is achievable.

That clinicians are reviewing their results every reporting period and investigating where changes need to be made to improve the care they provide to patients should be celebrated. It is important that we allow teams the time to conduct a full diagnosis and time to draw up action plans to address issues. We are privileged to have honest self-reporting from providers. We are now increasingly in a position to report what happens to patients after the early part of their recovery and we urge all stroke care providers working in a community setting to participate in SSNAP to make the post-acute data similar in quality to the years spent reporting acute data with resultant improvements to the quality of care and outcomes. This will remain one of our biggest challenges in the year ahead.

## Availability of SSNAP reports in the public domain

SSNAP results are made public each reporting period by named team. This model provides clinicians, commissioners, patients and carers, and the general public with up to date information on the processes of stroke care across the entire pathway and is in line with the Department of Health in England's data transparency policy.

## August - November 2016 report

This report includes complete data for 27,327 stroke patients admitted to and 26,659 stroke patients discharged from inpatient care between 1 April – 31 July 2016. The volume of records collected allows robust conclusions to be drawn at national level. Similar levels of case ascertainment were achieved in previous reporting periods.

**Definitions**

- '**Normal Hours'** refers to patients who arrived at hospital on a weekday between 8am and 6pm (excluding Bank Holidays).
- **'Out of Hours'** refers to patients who arrived at hospital on a weekday before 8am or after 6pm or at any time on a weekend or Bank Holiday.
- **'Inpatient Onset'** refers to patients who were already in hospital at the time of stroke.
- **'Clock Start'** is used to signify the time at which the 'clock starts' for measuring key timings. This is arrival in most instances (patients newly arriving in hospital) but will be the onset of symptoms time for patients already in hospital at time of stroke.
- **'Team'**: SSNAP collects self-reported details of care at the level of individual clinical teams across the stroke pathway e.g. acute teams, inpatient rehabilitation teams.
- **'Routinely Admitting Teams'** are defined as teams who typically directly admit the majority of their stroke patients.
- **'Non-Routinely Admitting Acute Teams'** are teams who provide acute care but who are typically transferred the majority of their stroke patients from other teams.
- **'Non-Acute Inpatient Teams':** teams who provide only rehabilitation care in an inpatient setting.
- **'Early Supported Discharge Teams':** multi-disciplinary teams providing rehabilitation and support to stroke patients in a community setting with the aim of reducing the duration of hospital care for stroke patients.
- **Community Rehabilitation Teams':** teams working in the community delivering rehabilitation services.
- **'Six Month Assessment Providers':** teams who undertake six month reviews of stroke patients. They may be acute teams, domiciliary teams or third sector providers.
- **'Team-Centred Results':** results are attributed to the team considered to be most appropriate to assign the responsibility for the measure to.
- **'Patient-Centred Results':** results are attributed to every team which treated the patient at any point in their care.
- **'Audit Compliance':** measure of completeness of non-mandatory SSNAP data items.

- **'Case Ascertainment':** percentage of all stroke cases entered onto SSNAP. High levels of case ascertainment are essential to ensure representativeness.
- **'Key Indicator':** an important measure of stroke care, e.g. in SSNAP there are 44 Key Indicators which are considered representative of high quality care.
- **'Domain':** an important area of care comprising several key indicators related to that topic i.e. in SSNAP there are 10 domains e.g. scanning.
- **'Total Key Indicator Score':** the average of the 10 domain levels (separately for patient-centred and team-centred results).
- **'Combined Total Key Indicator Score':** the average of the patient-centred and team-centred Total Key Indicator Score.
- **'SSNAP Score':** combined Total Key Indicator Score adjusted for Case Ascertainment and Audit Compliance.

**Denominators**

This report does not contain numerators and denominators for each standard. Please refer to the accompanying 'Full results portfolio' ( www.strokeaudit.org/results/national ) for this level of detail. The table below outlines the key denominators in the report. These vary throughout the report depending on the number of patients included in the analyses for each standard.

| | Three month reporting | | Four month reporting | |
|---|---|---|---|---|
| **Key denominators** | **Oct-Dec 2015** | **Jan-Mar 2016** | **Apr-Jul 2016** | **Aug-Nov 2016** |
| Cases Locked to 72 hours | 20,989 | 20,991 | 28,003 | 27,327 |
| Cases with known onset time | 14,386 | 14,238 | 19,214 | 18,695 |
| Cases with infarct | 18,254 | 18,218 | 24,487 | 23,798 |
| Cases with intracerebral haemorrhage | 2,605 | 2,683 | 3,379 | 3,419 |
| Cases with unknown type of stroke | 130 | 90 | 137 | 100 |
| Inpatient strokes | 1,257 | 1,170 | 1,560 | 1,530 |
| Arrive within 'normal hours' | 9,669 | 9,480 | 12,635 | 12,920 |
| Arrive 'out of hours' | 10,063 | 10,341 | 13,808 | 12,877 |
| Patients who went to a stroke unit | 20,207 | 20,156 | 26,903 | 26,202 |
| Patient who had a brain scan | 20,859 | 20,901 | 27,866 | 27,217 |
| Patients who had thrombolysis | 2,309 | 2,389 | 3,331 | 3,137 |

Technical information on how the results were calculated can be found on the final tab of the 'Full Results Portfolio' www.strokeaudit.org/results

Wherever possible, the audit question numbers have been included in the tables of results to facilitate reference to the actual question wording.

# Glossary

| | |
|---|---|
| **Activities of daily living** | Refers to activities that people normally undertake (e.g. bathing, dressing, self-feeding). |
| **Acute ischaemic stroke** | A type of stroke that happens when a clot blocks an artery that carries blood to the brain, causing brain cells to die. |
| **Acute stroke unit** | An acute stroke unit is one which treats patients usually in an intensive model of care with continuous monitoring and nurse staffing levels. |
| **Anticoagulation** | Treatment to reduce the likelihood of blood clotting. |
| **Antihypertensive** | A drug that reduces high blood pressure. |
| **Antiplatelet** | A drug that helps prevent the formation of blood clots by affecting the function of certain blood cells; examples are aspirin and clopidogrel. |
| **Aphasia** | A condition that affects the brain and leads to problems using language correctly. |
| **Audit** | An audit compares clinical process for individual patients and national guidelines. |
| **Atrial fibrillation (AF)** | This is an abnormal heart beat which can result in the formation of blood clots. Warfarin is prescribed for people with AF to thin the blood and prevent clots forming. |
| **Cardiovascular Disease Outcomes Strategy** | Provides advice to local authority and NHS commissioners and providers about actions to improve cardiovascular disease outcomes. https://www.gov.uk/government/publications/improving-cardiovascular-disease-outcomes-strategy |
| **Care home** | A residential setting where a number of older people live, usually in single rooms, and have access to on-site care services. |
| **Carer** | Someone (commonly the patient's spouse, a close relative or a friend) who provides on going, unpaid support and personal care at home. |
| **Casemix** | A measure of the characteristics of people included in a study such as age, gender, ethnicity and co-existing illnesses. |

| | |
|---|---|
| **CCG Outcome Indicator Set (CCG OIS)** | A set of measures by which commissioners of health services (Clinical Commissioning Groups) are held to account for the quality of services and the health outcomes achieved through commissioning. http://www.england.nhs.uk/ccg-ois |
| **CCU** | Coronary Care Unit. |
| **Cohort** | Group of patients included in analysis for report. It comprises patients admitted and/or discharged to hospital during a defined date range. |
| **Co-morbidity** | The coexistence of two or more diseases. |
| **Community rehabilitation team** | Teams working in the community delivering rehabilitation services. |
| **Continence plan** | A plan to help a patient increase their control over urinary and faecal discharge. |
| **Congestive heart failure** | Poor heart function resulting in accumulation of fluid in the lungs and legs. |
| **Domiciliary Care** | The delivery of a range of personal care and support services to individuals in their own homes. |
| **Dysphagia** | Difficulty in swallowing. |
| **Early Supported Discharge** | A service providing rehabilitation and support to stroke patients in a community setting by a multi-disciplinary team with the aim of reducing the duration of hospital care for stroke patients. |
| **HDU** | High Dependency Unit. |
| **Haemorrhage/ haemorrhagic stroke** | Bleeding caused by blood escaping into the tissues. |
| **Hyperacute stroke unit** | Some stroke services designate the most intensive treatment as hyperacute. This would be where patients are initially treated and usually for a short period of time (i.e. up to three days). |
| **Hypertension** | High blood pressure. |
| **Incontinence** | Inability to control passing of urine and/or faeces. |
| **Infarct** | An area of cell death due to the result of a deprived blood supply. |
| **Interquartile range (IQR)** | The IQR is the range between 25th and 75th centile which is equivalent to the middle half of all values. |

| | |
|---|---|
| **Intermittent Pneumatic Compression (IPC)** | A mechanical method of preventing deep vein thrombosis in the legs. |
| **ITU** | Intensive Treatment/Therapy Unit. |
| **Joint care planning** | A process in which a person and their healthcare professional work together to create a personalised package of care. |
| **Level of Consciousness** | A medical term used to describe a patient's awareness of his or her surroundings and arousal potential. |
| **Lipid Lowering** | Reducing the concentration of lipid, such as cholesterol, in the blood. |
| **MAU** | Medical Assessment Unit. |
| **Median** | The median is the middle point of a data set; half of the values are below this point, and half are above this point. |
| **Mood screening** | Identifying mood disturbance and cognitive impairment using a validated tool. |
| **Motor deficits** | These include phenomena such as lack of coordination in movement, lack of selected movement, and lack of motor control. |
| **Multidisciplinary Team** | Refers to several types of health professionals working together, physiotherapists, occupational therapists, speech and language therapists, nurses and doctors. |
| **Myocardial Infarction** | A heart attack. |
| **National Clinical Guidelines For Stroke (2016)** | National evidence based guidelines for stroke care published by the Intercollegiate Working Party for Stroke fifth edition 2016. www.strokeaudit.org/guideline |
| **National Institutes of Health Stroke Scale (NIHSS)** | A validated international tool used by healthcare professionals to objectively quantify the impairment caused by a stroke. |
| **National Sentinel Stroke Audit (NSSA)** | A national audit conducted by The Royal College of Physicians monitors the rate of progress in stroke care services in England, Wales and Northern Ireland in a two year cycle www.rcplondon.ac.uk/sentinel. The NSSA has been replaced by the Sentinel Stroke National Audit Programme (SSNAP). |
| **National Stroke Strategy** | Provides a quality framework to secure improvements to stroke services, offers guidance and support to commissioners and strategic health authorities. http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/DoH-National-Stroke-Strategy-2007.pdf |

| | |
|---|---|
| **NICE Acute stroke guidelines** | The NICE Clinical Guideline CG68 Stroke Diagnosis and initial management of acute stroke (NICE 2008). http://guidance.nice.org.uk/CG68 |
| **NICE Rehabilitation stroke guidelines** | Stroke rehabilitation: Long-term rehabilitation after stroke (NICE 2013): www.nice.org.uk/CG162 |
| **NICE Quality Standard for Stroke** | NICE quality standards define high standards of care within stroke. It provides specific, concise quality statements, measures and audience descriptors to provide definitions of high-quality care. http://pathways.nice.org.uk/pathways/stroke |
| **Nutritional screening** | A first-line process of identifying patients who are already malnourished or at risk of becoming so. |
| **Palliative care** | Treating symptoms for end of life care. |
| **Rankin score** | A scale used to measure the degree of disability of dependence in the daily activities of living. |
| **Rehabilitation stroke unit** | Stroke units generally accepting patients after 7 days or more and focussing on rehabilitation. |
| **Sentinel Stroke National Audit Programme (SSNAP)** | SSNAP is a new continuous audit that collects data for every stroke patient along the entire stroke care pathway up to six months: www.strokeaudit.org |
| **SINAP** | Stroke Improvement National Audit Programme. A continuous acute stroke audit which measured the process of stroke care in the first 72 hours between May 2010 and December 2012 www.rcplondon.ac.uk/sinap. The Sentinel Stroke National Audit Programme (SSNAP) has replaced SINAP. |
| **Specialist** | A clinician whose practice is limited to a particular branch of medicine or surgery, especially one who is certified by a higher educational organisation. |
| **Thrombolysis** | The use of drugs to break up a blood clot. |
| **Thrombectomy** | The surgical removal of a thrombus from a blood vessel. |
| **TIA** | Transient ischaemic attack – a stroke which completely recovers within 24 hours of onset of symptoms. |
| **Urinary tract infection** | An infection of the kidney, ureter, bladder, or urethra. |

**Intercollegiate Stroke Working Party – List of Members**

**Chair**

Professor Anthony Rudd, Professor of Stroke Medicine, King's College London; Consultant Stroke Physician, Guy's and St Thomas' NHS Foundation Trust

**Associate directors from the Stroke Programme at the Royal College of Physicians**

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**List of Members**

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*British Association of Stroke Physicians*
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*British Society of Rehabilitation Medicine/Society for Research in Rehabilitation*
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*British Geriatrics Society*
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*British Dietetic Association*
Mr Alex Lang, Guy's and St Thomas' NHS Foundation Trust

*British and Irish Orthoptic Society*
Dr Fiona Rowe, Reader in Orthoptics and Health Services Research, University of Liverpool

*British Psychological Society*
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Mr Robert Norbury

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Dr Phil Jones, Clinical Lead for Wales, Hywel Dda University Health Board

Royal College of Physicians | Sentinel Stroke National Audit Programme (SSNAP)

# SSNAP Core Dataset 3.1.1

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

NB. There is a stand-alone intra-arterial proforma available in the support section of the dataset which lists only those additional questions related to this intervention. The changes in the SSNAP Core Dataset 3.1.1 are all related to these new dataset questions.

| Version | Date | Changes |
|---|---|---|
| 1.1.1 | 12 Dec 2012 | – Official core dataset following pilot versions (most recent 3.6.16) |
| 1.1.2 | 18 Feb 2013 | – 1.12.2 – word 'incident' added to question and allowed values changed to 10 characters<br>– 2.8 – sub questions renumbered<br>– 6.10 – word 'First' added |
| 2.1.1 | 02 Apr 2014 | – 1.14 Which was the first ward the patient was admitted to at the first hospital? (wording change from 'Which was the first ward the patient was admitted to?')<br>– 3.1 Has it been decided in the first 72 hours that the patient is for palliative care? (wording change from 'If yes, does the patient have a plan for their end of life care?')<br>– 3.1.2 – If yes, does the patient have a plan for their end of life care? (wording change from 'Is the patient on an end of life pathway?')<br>– 4.4.1 – New question: 'If yes, at what date was the patient no longer considered to require this therapy?'<br>– 4.5.1 Question removed<br>– 4.6.1 Question removed<br>– 6.9.2 – If yes, does the patient have a plan for their end of life care? (wording change from 'Is the patient on an end of life pathway?')<br>– 6.11 - New question: 'Was intermittent pneumatic compression applied? '<br>– 6.11.1 - New question: 'If yes, what date was intermittent pneumatic compression first applied?' *Validations: Cannot be before clock start and cannot be after 7.3*<br>– 6.11.2 - New question: 'If yes, what date was intermittent pneumatic compression finally removed?' *Cannot be before clock start or 6.11.1 and cannot be after 7.3*<br>– 7.1 – Additional answer options: 'Was transferred to another inpatient care team, not participating in SSNAP'; 'Was transferred to an ESD/community team, not participating in SSNAP'. *Validations: Selecting either of these has same effect as selecting 'discharged somewhere else'*<br>– 7.3.1 – 'Date patient considered by the multidisciplinary team to no longer require inpatient care?' (wording change from 'Date patient considered by the multidisciplinary team to no longer require inpatient rehabilitation?')<br>– 8.4 – Additional answer option: 'Not Known'. ('What is the patient's modified Rankin Scale score?')<br>– 8.5 – Additional answer option: 'Not Known'. ('Is the patient in persistent, permanent or paroxysmal atrial fibrillation?')<br>– 8.6.1 – Additional answer option: 'Not Known'. ('Is the patient taking: Antiplatelet?')<br>– 8.6.2 – Additional answer option: 'Not Known'. ('Is the patient taking: Anticoagulant?')<br>– 8.6.3 – Additional answer option: 'Not Known'. ('Is the patient taking: Lipid Lowering?')<br>– 8.6.4 – Additional answer option: 'Not Known'. ('Is the patient taking: Antihypertensive?')<br>– 8.7.1 – Additional answer option: 'Not Known'. ('Since their initial stroke, has the patient had any of the following: Stroke')<br>– 8.7.2 – Additional answer option: 'Not Known'. ('Since their initial stroke, has the patient had any of the following: Myocardial infarction')<br>– 8.7.3 – Additional answer option: 'Not Known'. ('Since their initial stroke, has the patient had any of the following: Other illness requiring hospitalisation') |
| 3.1.1 | 01 Oct 2015 | – 2.11 – New question – 'Did the patent receive an intra-arterial intervention for acute stroke?'<br>– 2.11.1 – New question – 'Was the patient enrolled into a clinical trial of intra-arterial |

| | | |
|---|---|---|
| | | intervention?'<br>– 2.11.2 – New question – 'What brain imaging technique was carried out prior to the intra-arterial intervention?'<br>– 2.11.3 – New question – 'How was anaesthesia managed during the intra-arterial intervention?'<br>– 2.11.4 – New question – 'What was the speciality of the lead operator?'<br>– 2.11.5 – New question – 'Were any of the following used?'<br>– 2.11.6 – New question – 'Date and time of:'<br>– 2.11.7 – New question – 'Did any of the following complications occur?'<br>– 2.11.8 – New question – 'Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):'<br>– 2.11.9 – New question – 'Where was the patient transferred after the completion of the procedure?' |

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

**Demographics/ Onset/ Arrival** *(must be completed by the first hospital)*

1.1. Hospital Number [Free text (30 character limit)]

1.2. NHS Number [10 character numeric] or No NHS Number ○

1.3. Surname [Free text (30 character limit)]

1.4. Forename [Free text (30 character limit)]

1.5. Date of birth [dd] [mm] [yyyy]

1.6. Gender Male ○ Female ○

1.7. Postcode of usual address [2-4 alphanumerics] [3 alphanumerics]

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

1.9. What was the diagnosis? Stroke ○ TIA ○ Other ○ (*If TIA or Other please go to relevant section)*

1.10. Was the patient already an inpatient at the time of stroke? Yes ○ No ○

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

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 ○

1.12. Did the patient arrive by ambulance? Yes ○ No ○
If yes:
1.12.1. Ambulance trust [Default] [Drop-down of all trusts]

1.12.2. Computer Aided Despatch (CAD) / Incident Number [10 characters] or Not known ○

1.13. Date/ time patient arrived at first hospital [dd] [mm] [yyyy] [hh] [mm]

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 ○

1.15. Date/time patient first arrived on a stroke unit [dd] [mm] [yyyy] [hh] [mm]
or Did not stay on stroke unit ○

**Casemix/ First 24 hours** *(if patient is transferred to another setting after 24 hours, this section must be complete)*

2.1. Did the patient have any of the following co-morbidities prior to this admission?
2.1.1 Congestive Heart Failure: Yes ○ No ○
2.1.2 Hypertension: Yes ○ No ○
2.1.3 Atrial fibrillation: Yes ○ No ○
2.1.4 Diabetes: Yes ○ No ○
2.1.5 Stroke/TIA: Yes ○ No ○

2.1.6 If 2.1.3 is yes, was the patient on antiplatelet medication prior to admission? Yes ○ No ○ No but ○

2.1.7 If 2.1.3 is yes was the patient on anticoagulant medication prior to admission? Yes ○ No ○ No but ○

2.2. What was the patient's modified Rankin Scale score before this stroke? 0 - 5

2.3. What was the patient's NIHSS score on arrival? Automated calculation of total score

| | | 0 | 1 | 2 | 3 | 4 | Not known |
|---|---|---|---|---|---|---|---|
| 2.3.1 | Level of Consciousness (LOC) | ○ | ○ | ○ | ○ | | |
| 2.3.2 | LOC Questions | ○ | ○ | ○ | | | ○ |
| 2.3.3 | LOC Commands | ○ | ○ | ○ | | | ○ |
| 2.3.4 | Best Gaze | ○ | ○ | ○ | | | ○ |
| 2.3.5 | Visual | ○ | ○ | ○ | ○ | | ○ |
| 2.3.6 | Facial Palsy | ○ | ○ | ○ | ○ | | ○ |
| 2.3.7 | Motor Arm (left) | ○ | ○ | ○ | ○ | ○ | ○ |
| 2.3.8 | Motor Arm (right) | ○ | ○ | ○ | ○ | ○ | ○ |
| 2.3.9 | Motor Leg (left) | ○ | ○ | ○ | ○ | ○ | ○ |
| 2.3.10 | Motor Leg (right) | ○ | ○ | ○ | ○ | ○ | ○ |
| 2.3.11 | Limb Ataxia | ○ | ○ | ○ | | | ○ |
| 2.3.12 | Sensory | ○ | ○ | ○ | | | ○ |
| 2.3.13 | Best Language | ○ | ○ | ○ | ○ | | ○ |
| 2.3.14 | Dysarthria | ○ | ○ | ○ | | | ○ |
| 2.3.15 | Extinction and Inattention | ○ | ○ | ○ | | | ○ |

2.4. Date and time of first brain imaging after stroke dd mm yyyy hh mm
or Not imaged ○

2.5. What was the type of stroke? Infarction ○ Primary Intracerebral Haemorrhage ○

2.6. Was the patient given thrombolysis? Yes ○ No ○ No but ○ (auto-selected if 2.5=PIH)

2.6.1 If no, what was the reason:

Thrombolysis not available at hospital at all ○ Outside thrombolysis service hours ○
Unable to scan quickly enough ○ None ○

2.6.2 If no but, please select the reasons:

Haemorrhagic stroke (auto-selected if 2.5=PIH) ☐ Age ☐
Arrived outside thrombolysis time window ☐ Symptoms improving ☐
Co-morbidity ☐ Stroke too mild or too severe ☐
Contraindicated medication ☐ Symptom onset time unknown/wake-up stroke ☐
Patient or relative refusal ☐ Other medical reason ☐

2.7. Date and time patient was thrombolysed dd mm yyyy hh mm

2.8. Did the patient have any complications from the thrombolysis? Yes ○ No ○

2.8.1 If yes, which of the following complications:

Symptomatic intracranial haemorrhage ☐ Angio oedema ☐ Extracranial bleed ☐ Other ☐

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

2.9. What was the patient's NIHSS score at 24 hours after thrombolysis? 0 - 42 or Not known ○

2.10. Date and time of first swallow screen dd mm yyyy hh mm
or Patient not screened in first 4 hours ○

2.10.1 If screening was not performed within 4 hours, what was the reason? Enter relevant code (see appendix)

2.11 Did the patient receive an intra-arterial intervention for acute stroke? Yes ○ No ○

2.11.1 Was the patient enrolled into a clinical trial of intra-arterial intervention? Yes ○ No ○

2.11.2 What brain imaging technique(s) was carried out prior to the intra-arterial intervention?

a. CTA or MRA Yes ○ No ○

b. Measurement of ASPECTS score Yes ○ No ○

c. Assessment of ischaemic penumbra by perfusion imaging Yes ○ No ○

2.11.3 How was anaesthesia managed during the intra-arterial intervention?

Local anaesthetic only (anaesthetist NOT present) ○

Local anaesthetic only (anaesthetist present) ○

Local anaesthetic and conscious sedation (anaesthetist NOT present) ○

Local anaesthetic and conscious sedation (anaesthetist present) ○

General anaesthetic ○

Other ○

2.11.4 What was the specialty of the lead operator?

Interventional neuroradiologist ○

Cardiologist ○

Interventional radiologist ○

Other ○

2.11.5 Were any of the following used?

a. Thrombo-aspiration system Yes ○ No ○

b. Stent retriever Yes ○ No ○

c. Proximal balloon/flow arrest guide catheter Yes ○ No ○

d. Distal access catheter Yes ○ No ○

2.11.6 Date and time of:

a. Arterial puncture: dd mm yyyy hh mm

b. First deployment of device for thrombectomy or aspiration dd mm yyyy hh mm

○ Not performed

c. End of procedure (time of last angiographic run on treated vessel): dd mm yyyy hh mm

2.11.7 Did any of the following complications occur?

a. Symptomatic intra-cranial haemorrhage Yes ○ No ○

b. Extra-cranial haemorrhage Yes ○ No ○

c. Other procedural complication resulting in harm to the patient Yes ○ No ○

2.11.8 Angiographic appearance of culprit vessel and result assessed by operator (modified TICI score)

a. Pre intervention 0 ○ 1 ○ 2a ○ 2b ○ 3 ○

b. Post intervention 0 ○ 1 ○ 2a ○ 2b ○ 3 ○

2.11.9 Where was the patient transferred after the completion of the procedure?

Intensive care unit or high dependency unit ○

Stroke unit ○

Other ○

**Assessments – First 72 hours** *(if patient is transferred after 72 hours, this section must be complete and locked)*

3.1. Has it been decided in the first 72 hours that the patient is for palliative care? Yes ○ No ○
If yes:

3.1.1. Date of palliative care decision dd mm yyyy

3.1.2. If yes, does the patient have a plan for their end of life care? Yes ○ No ○

3.2. Date/time first assessed by nurse trained in stroke management dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.3. Date/time first assessed by stroke specialist consultant physician dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.4. Date/time of first swallow screen dd mm yyyy hh mm (If date/time already entered for screening within 4 hours (2.10), 3.4 does not need to be answered)
or Patient not screened in first 72 hours ○

3.4.1 If screening was not performed within 72 hours, what was the reason? Enter relevant code

3.5. Date/time first assessed by an Occupational Therapist dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.5.1 If assessment was not performed within 72 hours, what was the reason? Enter relevant code

3.6. Date/time first assessed by a Physiotherapist dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.6.1 If assessment was not performed within 72 hours, what was the reason? Enter relevant code

3.7. Date/time communication first assessed by Speech and Language Therapist dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.7.1 If assessment was not performed within 72 hours, what was the reason? Enter relevant code

3.8. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.8.1 If assessment was not performed within 72 hours, what was the reason? Enter relevant code

**This admission** *(this section must be completed by every team/ hospital/ care setting)*

4.1. Date/ time patient arrived at this hospital/team dd mm yyyy hh mm

4.2. Which was the first ward the patient was admitted to at this hospital?
MAU/ AAU/ CDU ○ Stroke Unit ○ ITU/CCU/HDU ○ Other ○

4.3. Date/time patient arrived on stroke unit at this hospital dd mm yyyy hh mm
or Did not stay on stroke unit ○

| | 1. Physiotherapy | 2. Occupational Therapy | 3. Speech and language therapy | 4. Psychology |
|---|---|---|---|---|
| 4.4. Was the patient considered to require this therapy at any point in this admission? | Yes○ No○ | Yes○ No○ | Yes○ No○ | Yes○ No○ |
| 4.4.1 If yes, at what date was the patient no longer considered to require this therapy? | | | | |
| 4.5. On how many days did the patient receive this therapy across their total stay in this hospital/team? | | | | |
| 4.6. How many minutes of this therapy in total did the patient receive during their stay in this hospital/team? | | | | |

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

| 4.7.1. If no goals agreed, what was the reason? | |
|---|---|
| Not known ○ | Patient medically unwell for entire admission ○ |
| Patient refused ○ | Patient has no impairments ○ |
| Organisational reasons ○ | Patient considered to have no rehabilitation potential ○ |

**Patient Condition in first 7 days** *(if patient is transferred after 7 days, this section must be complete)*

5.1. What was the patient's worst level of consciousness in the first 7 days following initial admission for stroke? (Based on patient's NIHSS Level of Consciousness (LOC) score): 0 ○ 1 ○ 2 ○ 3 ○

5.2. Did the patient develop a urinary tract infection in the first 7 days following initial admission for stroke as defined by having a positive culture or clinically treated? Yes ○ No ○ Not known ○

5.3. Did the patient receive antibiotics for a newly acquired pneumonia in the first 7 days following initial admission for stroke? Yes ○ No ○ Not known ○

**Assessments – By discharge** *(some questions are repeated from the "Assessments – First 72 hours" section but should only be answered if assessments not carried out in the first 72 hours)*

6.1. Date/time first assessed by an Occupational Therapist dd mm yyyy hh mm
or No assessment by discharge ○
6.1.1 If no assessment, what was the reason? Enter relevant code

6.2. Date/time first assessed by a Physiotherapist dd mm yyyy hh mm
or No assessment by discharge ○
6.2.1 If no assessment, what was the reason? Enter relevant code

6.3. Date/time communication first assessed by Speech and Language Therapist dd mm yyyy hh mm
or No assessment by discharge ○
6.3.1 If no assessment, what was the reason? Enter relevant code

6.4. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment dd mm yyyy hh mm
or No assessment by discharge ○
6.4.1 If no assessment, what was the reason? Enter relevant code

6.5. Date urinary continence plan drawn up dd mm yyyy or No plan ○
6.5.1 If no plan, what was the reason? Enter relevant code

6.6. Was the patient identified as being at high risk of malnutrition following nutritional screening?
Yes ○ No ○ Not screened ○
6.6.1 If yes, date patient saw a dietitian dd mm yyyy or Not seen by a dietitian ○

6.7. Date patient screened for mood using a validated tool dd mm yyyy or Not screened ○
6.7.1 If not screened, what was the reason? Enter relevant code

6.8. Date patient screened for cognition using a simple standardised measure? dd mm yyyy
or Not screened ○
6.8.1 If not screened, what was the reason? Enter relevant code

6.9. Has it been decided by discharge that the patient is for palliative care? Yes ○ No ○
If yes:
6.9.1 Date of palliative care decision dd mm yyyy
6.9.2 If yes, does the patient have a plan for their end of life care? Yes ○ No ○

6.10. First date rehabilitation goals agreed: dd mm yyyy or No goals ○

This question is auto-completed. It will be based on the first date that is entered for 4.7. If no hospitals / care settings in the pathway enter a date (i.e. all select 'no goals'), then 'no goals' will be selected here

6.11 Was intermittent pneumatic compression applied? Yes ○ No ○ Not Known ○

6.11.1 If yes, what date was intermittent pneumatic compression first applied? dd mm yyyy
6.11.2 If yes, what date was intermittent pneumatic compression finally removed? dd mm yyyy

**Discharge / Transfer**

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 ESD / community team ○
Was transferred to another inpatient care team, not participating in SSNAP ○
Was transferred to an ESD/community team, not participating in SSNAP ○

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

7.1.2 Did the patient die in a stroke unit? Yes ○ No ○

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

7.2. Date/time of discharge from stroke unit dd mm yyyy hh mm

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

7.3.1 Date patient considered by the multidisciplinary team to no longer require inpatient care?
dd mm yyyy

7.4. Modified Rankin Scale score at discharge/transfer 0 - 6 (defaults to 6 if 7.1 is died in hospital)

7.5. If discharged to a care home, was the patient: Previously a resident ○ Not previously a resident ○
7.5.1 If not previously a resident, is the new arrangement: Temporary ○ Permanent ○

7.6. If discharged home, is the patient: Living alone ○ Not living alone ○ Not known ○

7.7. Was the patient discharged with an Early Supported Discharge multidisciplinary team?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○

7.8. Was the patient discharged with a multidisciplinary community rehabilitation team?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○

7.9. Did the patient require help with activities of daily living (ADL)? Yes ○ No ○
If yes:
7.9.1 What support did they receive?
Paid carers ○ Paid care services unavailable ○
Informal carers ○ Patient refused ○
Paid and informal carers ○
7.9.2 At point of discharge, how many visits per week were social services going to provide? 0 - 100
or Not known ○

7.10. Is there documented evidence that the patient is in atrial fibrillation on discharge? Yes ○ No ○
7.10.1 If yes, was the patient taking anticoagulation (not anti-platelet agent) on discharge or discharged with a plan to start anticoagulation within the next month? Yes ○ No ○ No but ○

7.11. Is there documented evidence of joint care planning between health and social care for post discharge management? Yes ○ No ○ Not applicable ○

7.12. Is there documentation of a named person for the patient and/or carer to contact after discharge?
Yes ○ No ○

**Six month (post admission) follow-up assessment**

8.1. Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?
Yes ○ No ○ No but ○ No, patient died within 6 months of admission ○
N.B. 'No but' should only be answered for DNAs, patients who are not registered with a GP, or patients who have had another stroke and a new SSNAP record started

8.1.1 What was the date of follow-up? dd mm yyyy

8.1.2 How was the follow-up carried out: In person○ By telephone ○ Online ○ By post ○

8.1.3 Which of the following professionals carried out the follow-up assessment:

| | | | |
|---|---|---|---|
| GP | ○ | District/community nurse | ○ |
| Stroke coordinator | ○ | Voluntary Services employee | ○ |
| Therapist | ○ | Secondary care clinician | ○ |
| Other | ○ | | |

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

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○

8.2 Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?
Yes ○ No ○ No but ○
8.2.1 If yes, was the patient identified as needing support? Yes ○ No ○
8.2.2 If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?
Yes ○ No ○ No but ○

8.3. Where is this patient living? Home ○ Care home ○ Other ○
8.3.1 If other, please specify Free text (30 character limit)

8.4. What is the patient's modified Rankin Scale score? 0 - 6 Not known ○

8.5. Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes ○ No ○ Not known ○

8.6. Is the patient taking:

| | | | |
|---|---|---|---|
| 8.6.1 Antiplatelet: | Yes ○ | No ○ | Not known ○ |
| 8.6.2 Anticoagulant: | Yes ○ | No ○ | Not known ○ |
| 8.6.3 Lipid Lowering: | Yes ○ | No ○ | Not known ○ |
| 8.6.4 Antihypertensive: | Yes ○ | No ○ | Not known ○ |

8.7. Since their initial stroke, has the patient had any of the following:

| | | | |
|---|---|---|---|
| 8.7.1 Stroke | Yes ○ | No ○ | Not known ○ |
| 8.7.2 Myocardial infarction | Yes ○ | No ○ | Not known ○ |
| 8.7.3 Other illness requiring hospitalisation | Yes ○ | No ○ | Not known ○ |

*8.1.5. 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.