Supplementary Helpnotes for Early Supported Discharge & Community Rehab Teams

Version	Date	Changes	To be reviewed
1.1.1	30.03.2015	Supplementary Helpnotes for community providers following pilot versions	30.03.2016

These supplementary helpnotes have been produced specifically for stroke care providers treating patients in the community. Only the sections of the SSNAP dataset (sections 4, 7, and 8), and accompanying guidance text relevant to community teams on SSNAP are provided in this document. In contrast, the SSNAP Core Dataset Helpnotes also available on the SSNAP webtool include every section of the dataset and not only those pertaining to community providers. There is also additional help text included in these helpnotes which provide further guidance to community users on the most appropriate way of capturing every stroke patient on SSNAP. This will help ensure that consistent, high quality data are being submitted to SSNAP by all teams working in a community setting.

For more information on the SSNAP Clinical Audit, including the background, aims, and timeframes of the audit, please refer to the SSNAP Core Dataset helpnotes in the Support section of the webtool, or visit the SSNAP website, www.strokeaudit.org.

There is also a 'Therapy data in SSNAP' document available on the webtool (Support>Resources for logged in users) which gives a detailed breakdown of the rationale for collecting therapy data on SSNAP. It also includes additional information on the submission of data, FAQs, and an explanation of how data are presented.

These helpnotes have been created in collaboration with the East Midlands Academic Health Science Network and East Midlands Strategic Clinical Network.

- The RCP Stroke Programme -

On behalf of the Intercollegiate Stroke Working Party

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Number	Question	Answer options	Guidance/definitions
	Hospital	Auto-completed on web tool	This is used for identification and analysis of individual centre data.
	Patient audit number	Auto-completed on web tool	A record of the patient audit number should be kept by the team for future reference. Each patient audit number is only used once (even if the same patient is later re-admitted as a new care spell, they will have a new patient audit number). This number is useful to identify records within the audit whilst observing confidentiality of patient information.
1.1	Hospital number	Free text (30 character limit)	This information is already populated and cannot be altered.
1.2	NHS number	Either 10 character NHS number or 'No NHS number'	This information is already populated and cannot be altered.
1.3	Surname	Free text (30 character limit)	This information is already populated and cannot be altered.
1.4	Forename	Free text (30 character limit)	This information is already populated and cannot be altered.
1.5	Date of birth	Dd/mm/yyyy	This information is already populated and cannot be altered.
1.6	Gender	Male/female	This information is already populated and cannot be altered.
1.7	Postcode of usual address	First box: 2-4 alphanumeric Second box: 3 alphanumeric The full postcode of the patient's normal place of residence.	This information is already populated and cannot be altered.
4.1	Date/time patient arrived at this hospital/team	Dd/mm/yyyy hh:mm	For community providers this is the date of the first face to face assessment. This does not include clinical phone calls.
4.2	What was the first ward the patient was admitted to at this hospital?	MAU/AAU/CDU, Stroke Unit, ITU/CCU/HDU, Other	This question is greyed out and populated from the core dataset.
4.3	Date/time patient arrived on stroke unit at this hospital	Dd/mm/yyyy hh:mm or did not stay on stroke unit	This question is greyed out and populated from the core dataset.
4.4	Was the patient considered to require this therapy at any point in this admission? 1. Physiotherapy	Yes/No for each	If a patient is assessed and does not need any further therapy then the patient was not considered to require therapy at any point in this admission. Answer 'No'.

Number	Question	Answer options	Guidance/definitions
	2. Occupational therapy 3. Speech & language therapy 4. Psychology		If a patient is assessed and requires further therapy, answer 'Yes'. If Yes is selected, the assessment time should be included (in minutes) as part of the total therapy time. (Assessment + Therapy sessions time = Total amount of therapy received) NB: For Psychology this refers to the delivery of care by psychologists or psychologist assistant. Only psychological support delivered by a psychologist or psychologist assistant can be recorded. If patients have received psychological support from other members of the team e.g. mental health nurse/OT/nurse this question should be recorded as no for Psychology. Where appropriate, details of care provided by other members of the multidisciplinary team (e.g. nurses and rehabilitation assistants) can be recorded using SSNAP user defined custom fields. Details on how to create these custom fields is provided in the Support>Userguides section of the SSNAP webtool. By creating custom fields ESD/CRT teams can collect additional data not mandated by SSNAP which can be analysed and shared locally.
4.4.1	If yes, at what date was this patient no longer considered to require this therapy? 1. Physiotherapy 2. Occupational therapy 3. Speech & language therapy 4. Psychology	Dd/mm/yyyy for each	This refers to the date when each specific type of therapy ended and not the date when all therapy has ended.
4.5	On how many days did the patient receive this therapy across their total stay in this hospital/team?		This is the total number of days on which the patient received each type of therapy from the day they arrived at the team to the day they left the team. Therapy includes assessment and goal-directed therapy (e.g. towards goals that have been set and agreed by the team).

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	1. Physiotherapy 2. Occupational therapy 3. Speech & language therapy 4. Psychology		Therapy includes individual and group therapy, home visits where the patient is present, and training patients and carers. SLT refers to communication therapy and swallowing therapy. Direct therapy does not include time for patient transport, documentation, environmental visits, MDTs, case conferences or case reviews. Therapy can be provided by qualified or non-registered therapy assistants, including rehabilitation assistants, under supervision.
4.6	How many minutes of this therapy did the patient receive during their stay in this hospital/team? 1. Physiotherapy 2. Occupational therapy 3. Speech & language therapy 4. Psychology		This must be answered in minutes, which must be a whole number. If two therapists of the same profession treat a patient at the same time, record the number of therapy minutes provided as the duration of the session e.g. two physiotherapists treating a patient for 45 minutes counts as 45 minutes of physiotherapy. If two therapists of different professions treat a patient at the same time, record the number of minutes for each therapy e.g. a physiotherapist and an occupational therapist treating a patient for 45 minutes counts as 45 minutes of physiotherapy and 45 minutes of occupational therapy. If one therapy assistant works on two different therapies during a 45 minute session the times should be split e.g. 25 minutes for one, 20 minutes for the other. In the Support>Resources section of the SSNAP webtool there is a downloadable Excel Spreadsheet that can be used to calculate therapy minutes.
4.7	Date rehabilitation goals agreed	Dd/mm/yyyy or 'No goals'	
4.7.1	If no goals were agreed, what was the reason?	Not known, patient refused, organisational reasons, patient medically unwell for entire admission, patient has no	Organisational reasons mean any issues with the service which meant that rehab goals could not be agreed with the patient e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious

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		impairments, patient considered to have no rehabilitation potential	or deemed to be unable to tolerate an assessment by clinical staff. Rehabilitation potential should be assessed by the MDT. In those assessed as having no rehabilitation potential it is expected the rationale is clearly documented in the case notes (e.g. advanced dementia).
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/CST, Was transferred to another inpatient care team not participating in SSNAP, Was transferred to an ESD/CST team not participating in SSNAP	'Somewhere else' is a discharge from the care pathway to a place which is neither a care home nor the patient's home (e.g. to a relative's home). 'Inpatient care team' is any team (team as defined within SSNAP) which treats patients in an inpatient setting (e.g. an acute hospital, a community hospital, a bed based rehabilitation setting, an intermediate care setting). ESD/Community team is for stroke/neurology specific or non-specialist early supported discharge teams and community rehabilitation teams (e.g. treating patients outside of an inpatient setting). Only one option can be selected in this question. The option selected influences whether further questions become available or remain greyed out.
7.1.1	If the patient died, what was the date of death?	Dd/mm/yyyy	This question is greyed out unless 'Died' is selected in 7.1
7.1.2	Did the patient die in a stroke unit?	Yes/No	This question is greyed out.
7.1.3	Which hospital/team was the patient transferred to?	Enter hospital/team code	Team codes can be found on the webtool: Support > Resources > team codes.
7.2	Date/time of discharge from stroke unit	Dd/mm/yyyy hh:mm	This question is greyed out.
7.3	Date/time of discharge/transfer from team	Dd/mm/yyyy hh:mm	

Number	Question	Answer options	Guidance/definitions
7.3.1	Date patient considered by multidisciplinary team to no longer require inpatient care	Dd/mm/yyyy	This question is greyed out.
7.4	Modified Rankin Scale score at discharge/transfer	0-6	Defaults to 6 if 7.1 is patient died. 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all the usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention 6: Dead
7.5	If discharged to a care home, was the patient:	Previously a resident, not previously a resident	'Not previously a resident' should be answered if the patient is going to a care home where they did not live before, or if they are going to the same care home but requiring a different level of care (e.g. they have moved from residential care to nursing care).
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	A stroke specific team is one that treats stroke/neurology patients solely. A generic/non-specialist team treats other patients in addition to stroke and neurology patients.
7.8	Was the patient discharged with a multidisciplinary community rehabilitation team	Yes, stroke/neurology specific Yes, non-specialist No	A non-specialist team would typically be part of a generic intermediate rehabilitation team.
7.9	Did the patient require help	Yes, no	

Number	Question	Answer options	Guidance/definitions
	with activities of daily living (ADL)?		This question is greyed out.
7.9.1	If yes: What support did they receive?	Paid carers, Informal carers, Paid and informal carers, Paid care services unavailable, Patient refused,	This question is greyed out.
7.9.2	At point of discharge, how many visits per week were social services going to provide?	0-100 or 'not known'	This question is greyed out.
7.10	Is there documented evidence that the patient is in atrial fibrillation on discharge?	Yes, no	This question is greyed out
7.10.1	If yes, was the patient taking anticoagulation (non-antiplatelet agent) on discharge or discharged with a plan to start anticoagulation within the next month?	Yes, no, no but	This question is greyed out
7.11	Is there documented evidence of joint care planning between health and social care for post discharge management?	Yes, no	This question is greyed out
7.12	Is there documentation of a named person for the patient and/or carer to contact after discharge?	Yes, no	This question is greyed out

Six Month Assessment Entry on SSNAP (post admission)

Number	Question	Answer options	Guidance/definitions
8.1	Did this patient have a follow-up	Yes, No, No but, No, patient	This forms part of the CCG Outcome Indicator Set for Domain 3 (Improving

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	assessment at 6 months post admission (plus or minus two months)?	died within 6 months of admission	recovery from stroke); people who have had a stroke who receive a follow-up assessment between 4-8 months after initial admission. Where provision of six month reviews does not exist, the last team to treat the patient in the SSNAP record pathway should enter 'no' even though they would not know about patient status. SSNAP can correlate this with mortality data and adjust it for patient deaths. Though there are concerns over a lack of data when teams enter no, this information can still be used as a tool to highlight to commissioners where 6 month assessment services do not currently exist. It should not be seen as negative. ESD and CRT team should be registered as individual SSNAP teams. However, a 6 month assessment provider may be either registered as another individual team or form part of an ESD or CRT team on SSNAP. This decision can be made at local level. If a patient is still receiving therapy from CST at the time of their 6 month assessment, and this therapy is being recorded on SSNAP, the 6 month data can only be entered once the CST care has been completed and the record locked to discharge. 'No but' should be answered: • For patients who decline the assessment or who do not attend an appointment offered • Where an attempt is made to contact the patient, but they cannot be contacted as they are not registered with a GP or have moved overseas. • For patients who have another stroke after being discharged from inpatient care and are readmitted into hospital

Number	Question	Answer options	Guidance/definitions
8.1.1	What was the date of the 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 assessment?	GP, Stroke coordinator, Therapist, District or community nurse, Voluntary Services Employee, Secondary Care Clinician, Other	If a stroke nurse carried out the 6 month assessment you should select 'stroke coordinator' if he/she is a stroke nurse coordinator. If he/she is not a stroke nurse coordinator you should enter 'secondary care clinician' when the nurse is working in secondary care or 'district/community nurse' if he/she is working in the community.
8.1.4	If other, please specify	Free text	
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	This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board. If the patient refuses consent, all patient identifiable information will be wiped from the webtool. Every effort should be made to seek consent. However if this has not occurred we will still want the 6 month follow up information collected, this is why the dataset has the 'patient not asked' option. Where there is a comparatively high rate of 'patient not asked' option selected, SSNAP may seek assurance from the teams in question that there is an action plan in place to improve this.
8.2	Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?	Yes, No, No but	The term 'discharge' here is referring to discharge from an inpatient setting, not discharge from the entire stroke pathway. For patients that have followed an agreed mood pathway answer 'yes'. For patients who have not been seen by services before (e.g. those who had

Number	Question	Answer options	Guidance/definitions
			been seen out of area) the information should be available through the clinical systems. Otherwise the 6 month assessment provider teams will need to contact GPs.
8.2.1	Was the patient identified as needing support?	Yes, No	Some patients may not have been screened but may still require support. Unless the patient has been screened, this question is unavailable and this information cannot be recorded in SSNAP.
8.2.2	If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?	Yes, No, No but	This question is not limited to support provided by clinical psychologists and assistant psychologists. Teams who have provided support (e.g. from a mental health nurse) should tick 'yes'. A comment can also be added if needed for local recording purposes
8.3	Where is this patient living?	Home, Care home, other	
8.3.1	If other, please specify	Free text	
8.4	What is the patient's modified Rankin Scale score?	0-6, Not known	The NHS outcomes framework stipulates that a modified Rankin Scale score is collected at six months – hence this needs to be carried out as part of the six month review. If this is not done, or when six month reviews are completed over the phone, and/ or the patient was previously unknown to the 6 month assessment team, previous information regarding their Modified Rankin Scale score and asking questions about their level of ability could be used to assist with scoring. However, scoring needs to be conducted at six months with the patient, meaning that a previous score should not be filled in.
8.5	Is the patient in persistent, permanent or paroxysmal atrial fibrillation?	Yes, No, Not known	'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so. Using the 'not known' option can be used as a tool to highlight to commissioners where data sharing processes and agreements should be in place.
8.6 (8.6.1-8.6.4)	Is the patient taking: Antiplatelet, Anticoagulant, Lipid Lowering, Antihypertensive?	Yes, No, Not known	
8.7 (8.7.1-	Since their initial stroke, has the patient had any of the following:	Yes, No, Not known	

Number	Question	Answer options	Guidance/definitions
8.7.3)	stroke, myocardial infarction, other illness requiring hospitalisation?		