SSNAP Dataset Changes 2024

Key Indicators

Inpatient teams

SSNAP | Sentinel Stroke National Audit Programme

Contents

Introduction

Netiquette

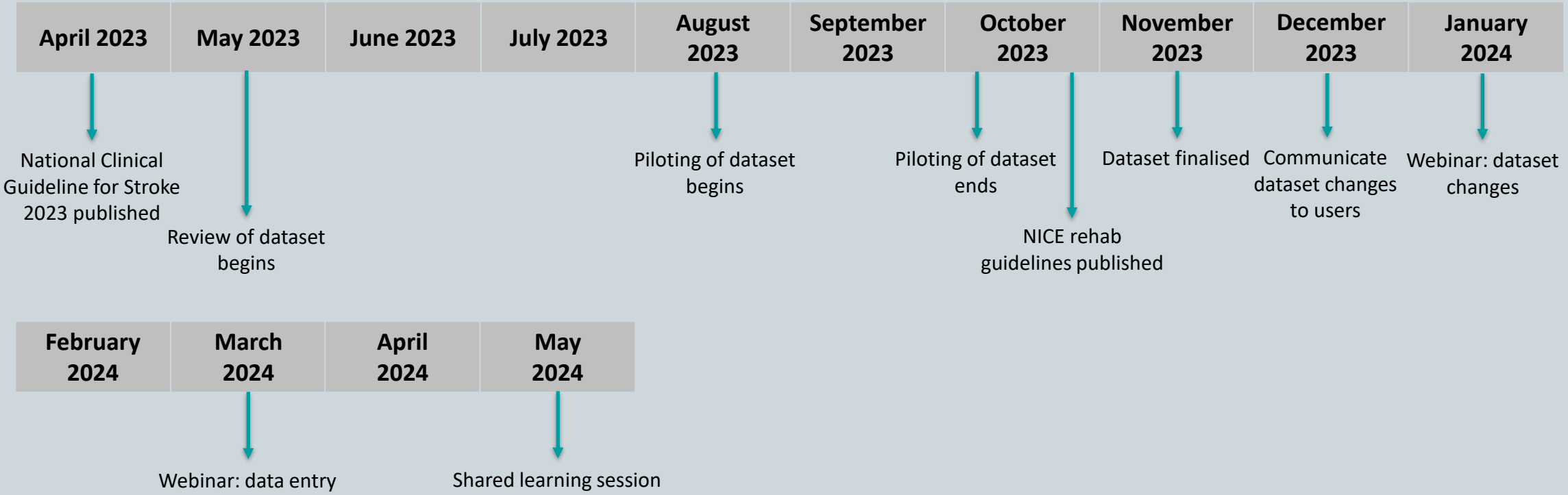
Please do not raise your hand to ask a question as we are not able to hear you!

The Q&A function is available throughout the webinar. We will be addressing questions at the end.

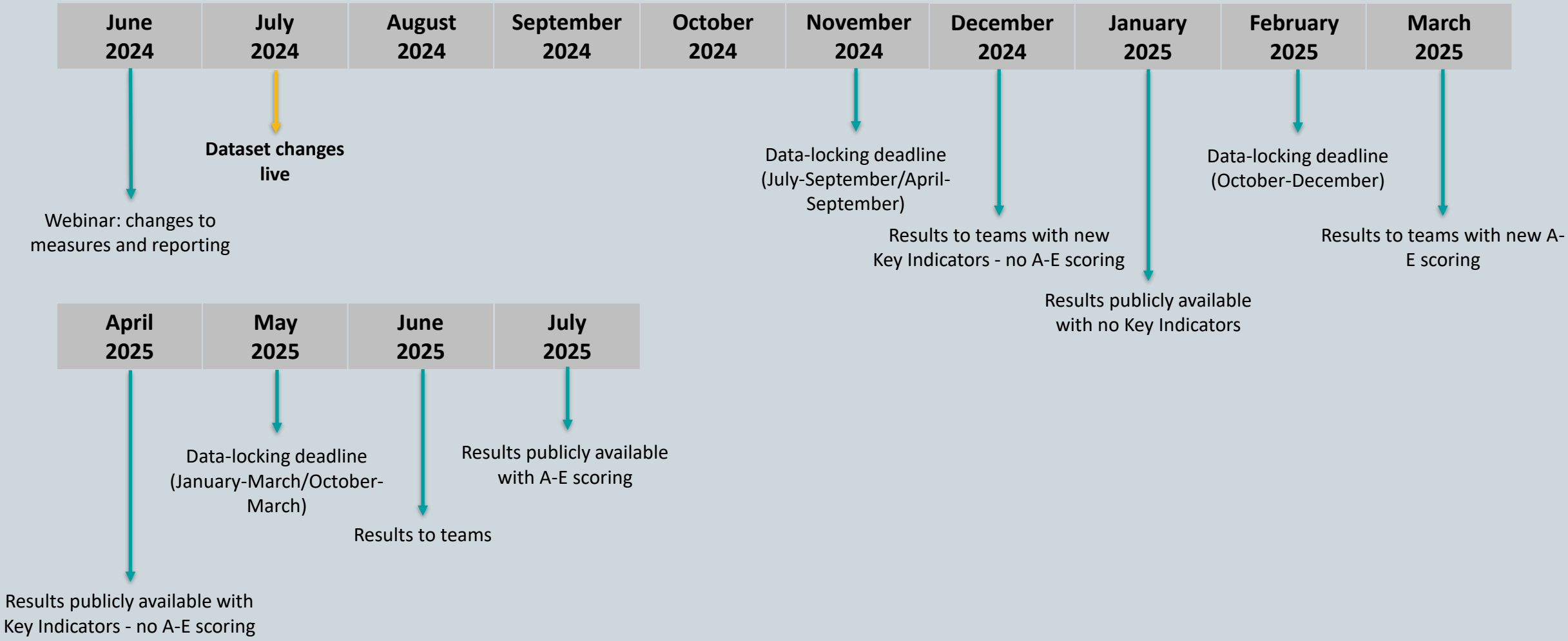
We may not be able to respond to your query during the webinar. However, we will endeavour to include responses to new queries in future resources/ communications.

Timeline of dataset changes

What has happened so far..



Coming up..


June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
March 2025
Webinar: changes to measures and reporting
Dataset changes live
Data-locking deadline (July-September/April-September)
Results to teams with new Key Indicators - no A-E scoring
Results publicly available with no Key Indicators
Data-locking deadline (October-December)
Results to teams with new A-E scoring
April 2025
May 2025
June 2025
July 2025
Results publicly available with Key Indicators - no A-E scoring
Data-locking deadline (January-March/October-March)
Results to teams
Results publicly available with A-E scoring

Changes to key indicators

Existing indicators	Changes
1.1 Percentage of patients scanned within **1 hour** of clock start	Percentage of patients scanned within **20 minutes** of clock start
1.2 Percentage of patients scanned within 12 hours of clock start	*Removed**
1.3 Median time between clock start and scan	*No change*
	NEW Percentage of patients given CTA on first imaging visit
	NEW Percentage of wake-up strokes and strokes with unknown onset time given CTA, CTP or MRI on first imaging visit

**This measure will no longer be a key indicator but will still be reported in outputs*

Existing indicators	Changes
2.1 Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	No change
2.2 Median time between clock start and arrival on stroke unit	No change
2.3 Percentage of patients who spent at least 90% of their stay on stroke unit	No change

Existing indicators	Changes
3.1 Percentage of all stroke patients given thrombolysis (all stroke types)	*Removed**
3.2 Percentage of eligible patients (according to RCP guideline minimum threshold) given thrombolysis	*Removed*
3.3 Percentage of patients who were thrombolysed within 1 hour of clock start	*Removed**
3.4 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	*Removed**
3.5 Median time between clock start and thrombolysis	No change
	NEW Percentage of stroke patients arriving within 4 hours of onset given thrombolysis
	NEW Percentage of stroke patients arriving within 8.5 hours of onset given thrombolysis
	NEW Percentage of stroke patients given thrombolysis compared with bespoke site-specific target

**This measure will no longer be a key indicator but will still be reported in outputs*

Existing indicators	Changes
4.1 Percentage of patients assessed by a stroke specialist consultant within **24 hours** of clock start	Percentage of patients assessed by a stroke specialist consultant within **14 hours** of clock start
4.2 Median time between clock start and being assessed by stroke consultant	*Removed**
4.3 Percentage of patients who were assessed by a nurse trained in stroke management within **24 hours** of clock start	Percentage of patients assessed by a nurse trained in stroke management within **4 hours** of clock start
4.4 Median time between clock start and being assessed by stroke nurse	*Removed**
4.5 Percentage of applicable patients who were given a swallow screen within 4 hours of clock start	No change
4.6 Percentage of applicable patients who were given a formal swallow assessment within **72 hours** of clock start	Percentage of applicable patients who were given a formal swallow assessment within **24 hours** of clock start
	NEW Percentage of patients assessed by a stroke-skilled clinician (including consultant) within 1 hour of clock start

**This measure will no longer be a key indicator but will still be reported in outputs*

Existing therapy indicators - *Removed*

Domain 5: Occupational therapy	Domain 6: Physiotherapy	Domain 7: Speech and language therapy
5.1 Percentage of patients reported as requiring occupational therapy	6.1 Percentage of patients reported as requiring physiotherapy	7.1 Percentage of patients reported as requiring speech and language therapy
5.2 Median number of minutes per day on which occupational therapy is received	6.2 Median number of minutes per day on which physiotherapy is received	7.2 Median number of minutes per day on which speech and language therapy is received
5.3 Median % of days as an inpatient on which occupational therapy is received	6.3 Median % of days as an inpatient on which physiotherapy is received	7.3 Median % of days as an inpatient on which speech and language therapy is received
5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (Target = 45 minutes x (5/7) x 0.8 which is 45 minutes of occupational therapy x 5 out of 7 days per week x 80% of patients)	6.4 Compliance (%) against the therapy target of an average of 27.1 minutes of physiotherapy across all patients (Target = 45 minutes x (5/7) x 0.85 which is 45 minutes of physiotherapy x 5 out of 7 days per week x 85% of patients)	7.4 Compliance (%) against the therapy target of an average of 16.1 minutes of speech and language therapy across all patients (Target = 45 minutes x (5/7) x 0.5 which is 45 minutes of speech and language therapy x 5 out of 7 days per week x 50% of patients)

New therapy indicator
NEW Percentage of patients achieving the NICE target for total therapy dose received
NEW Median number of minutes of total therapy received per day the patient is an inpatient
NEW Percentage of patients receiving 3 hours of motor function therapy per day motor function therapy received
NEW Median percentage of days as an inpatient on which motor function is received
NEW Percentage of patients receiving 45 minutes of psychological function therapy per day psychological function therapy received
NEW Median percentage of days as an inpatient on which psychological function is received
NEW Percentage of patients receiving 45 minutes of communication/swallowing therapy per day communication/swallowing therapy received
NEW Median percentage of days as an inpatient on which communication/swallowing is received

Existing indicators	Changes
8.1 Percentage of applicable patients who were assessed by an occupational therapist within **72 hours** of clock start	Percentage of applicable patients assessed by an occupational therapist within **24 hours** of clock start
8.2 Median time between clock start and being assessed by occupational therapist	*Removed**
8.3 Percentage of applicable patients who were assessed by a physiotherapist within **72 hours** of clock start	Percentage of applicable patients assessed by a physiotherapist within **24 hours** of clock start
8.4 Median time between clock start and being assessed by physiotherapist	*Removed**
8.5 Percentage of applicable patients who were assessed by a speech and language therapist within 72 hours of clock start	No change
8.6 Median time between clock start and being assessed by speech and language therapist	*Removed**
8.7 Percentage of applicable patients who have rehabilitation goals agreed within 5 days of clock start	*Removed**
8.8 Percentage of applicable patients who are assessed by a **nurse within 24 hours** AND at least **one therapist within 24 hours** AND **all relevant therapists within 72 hours** AND have rehab goals agreed within 5 days	Percentage of applicable patients who are assessed by a **nurse within 4 hours** AND **occupational therapist and physiotherapist within 24 hours** AND **speech and language therapist within 72 hours** AND have rehab goals agreed within 5 days

**This measure will no longer be a key indicator but will still be reported in outputs*

Existing indicators	Changes
9.1 Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge	Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge **(or seen by a dietitian before screening)**
9.2 Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start	*Removed**
9.3 Percentage of applicable patients who have mood and cognition screening by discharge	*Removed**
	NEW Percentage of applicable patients who have **mood** screening by discharge
	NEW Percentage of applicable patients who have **cognition** screening by discharge

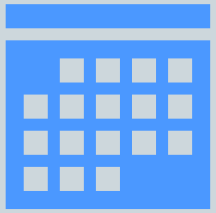
**This measure will no longer be a key indicator but will still be reported in outputs*

Existing indicators	Changes
10.1 Percentage of applicable patients receiving a joint health and social care plan on discharge	*Removed**
10.2 Percentage of patients treated by a stroke skilled **Early Supported Discharge team**	Percentage of patients treated by a stroke specialist **community rehabilitation team (ESD, CRT or combined)**
10.3 Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation	*Removed**
10.4 Percentage of those patients who are discharged alive who are given a **named person to contact after discharge**	Percentage of those patients discharged alive who are given a **named contact for information, support and advice**

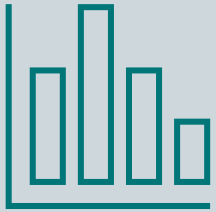
**This measure will no longer be a key indicator but will still be reported in outputs*

New indicators
NEW Percentage of all patients given thrombectomy
NEW Median time between arrival and discharge at first admitting team (door-in-door-out) for patients receiving thrombectomy *Applies only to referring sites (ASCs)*
NEW Median time between arrival at thrombectomy centre and arterial puncture (door to puncture) *Applies only to receiving sites (CSCs)*
NEW Infection rate: percentage of patients with a urinary tract infection in the first 7 days and percentage of patients given antibiotics for newly acquired pneumonia in the first 7 days
NEW Percentage of applicable patients assessed by a psychologist by discharge
NEW Percentage of applicable patients who have vision screening by discharge
NEW Percentage of applicable patients assessed by an orthoptist by discharge (or have an orthoptic outpatient appointment scheduled by discharge)

Summary



These KIs will be introduced from July 1st but WILL NOT be scored for July-September 2024 and scores will not be made public until January-March 2025.



Some KIs have been removed, this data will still be collected and reported on going forward.

Details on domains and scoring thresholds will be shared in September.

Audit compliance measure updates

Audit compliance		
NIHSS at arrival	15%	NIHSS at arrival fully complete
NIHSS 24h	10%	NIHSS 24h after thrombolysis/thrombectomy is fully complete
Transfers	20%	Records which are ready to transfer and have been transferred to next team
		Number of days from patient transferred to next team to when the record is transferred on the webtool
		Patients who were recorded as discharged with either ESD or CRT in Q7.7 or Q7.8, and transferred to an ESD or CRT on the webtool
Data entry	20%	Number of days from when patient is admitted/onset to when the record is started
		Number of days from when the patient is discharged from the team's care to when the record is locked to discharge
72h measures	15%	Ethnicity is known
		Reason for no swallow screen within 4h is known
		Reason for no swallow screen within 72h is known
		Reason for no OT assessment within 72 is known
		Reason for no PT assessment within 72 is known
		Reason for no SALT communication assessment within 72 is known
		Reason for no formal swallow assessment within 72 is known

Audit compliance		
Post-72h measures	20%	Reason for no rehabilitation goals is known
		Development of urinary tract infection is known
		Receipt of antibiotics for pneumonia is known
		Reason for no urinary continence plan is known
		Reason for no OT assessment by discharge is known
		Reason for no PT assessment by discharge is known
		Reason for no SALT communication assessment by discharge is known
		Reason for no SALT swallow assessment by discharge is known
		Reason for no psychologist assessment by discharge is known
		Reason for no orthoptist assessment by discharge is known
		Reason for no mood screening by discharge is known
		Reason for no cognition screening is known
		Reason for no vision screening is known
		Patients discharge home and living alone is known
		~~**Number of social service visits is known**~~
		Number of carer visits is known
		Number of carers is known
		Patient asked for consent by inpatient discharge

Summary

More weighting will be placed on transferring records promptly, including discharging and transferring patients to ESD/CRT services.

More weighting will be placed on the timely starting and locking of records.

Whether patients were asked for consent by inpatient discharge will now be included in the measure.

Resources and tools available

Resources and Engagement

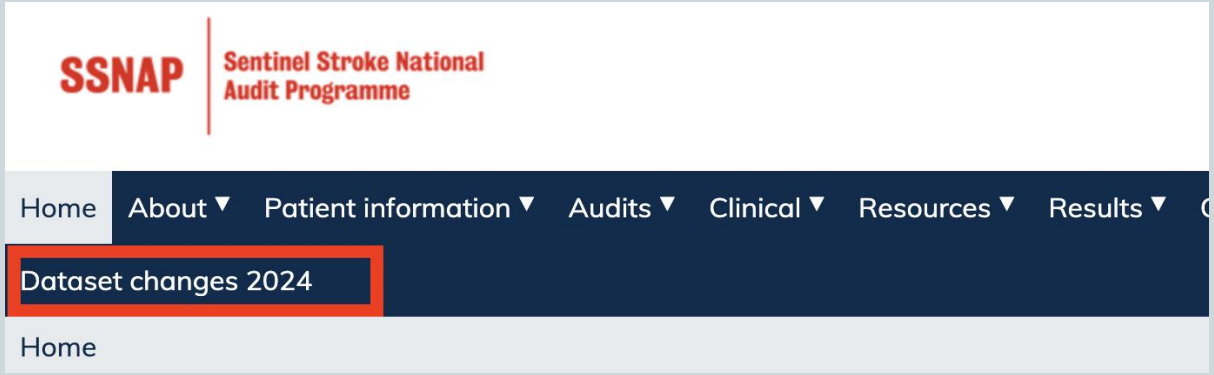
Resources:

Further Resources

Resource	Description	Link	Date updated
Therapy fact sheet		Download	13/02/2024
Dataset and help note FAQs		Download	24/05/2024
Import and export specification 6.0.0	Import/export specification for the core inpatient dataset	Download	08/04/2024
Printable form	Printable form for manually entering community data	Download	24/04/2024
Data entry FAQs		Download	25/04/2024
Therapy Calculators	Updated therapy calculators for new dataset	1. Inpatient teams 2. Community teams	06/06/2024
Key steps checklist	Checklist of key steps for users prior to data entry	Download	10/06/2024
Import and export specification 4.0.0	Import/export specification for the community dataset	Download	10/06/2024
DIY Analysis Tool	Updated DIY analysis tool for new dataset	Coming July 2024	

Upcoming engagement:

- Webinar – community measures
- Shared learning sessions
- Technical sessions



https://www.strokeaudit.org/Dataset-changes-2024.aspx

Next steps and Q&A

Thank you

Thank you to all the ambulance trusts, hospitals and community teams for continuing to participate in SSNAP. Their participation and commitment to the audit ensures that quality, rich data is available which can be used to improve stroke services.

Sentinel Stroke National Audit Programme (SSNAP)
ssnap@kcl.ac.uk
www.strokeaudit.org