

NEWSLETTER 24

March 2008

The newsletter for participating MINAP hospitals

The Newsletter aims to bring you and your colleagues up to date with the progress of MINAP. We appreciate all the hard work you put in, and wish to thank all those involved.

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1. Key messages

- Please upload and check all your data for April 2007 – March 2008 before 31 May.
- The 7th MINAP Public Report will be published on the RCP website on Wednesday 18 June. Analyses for the Public report will be available to hospitals and cardiac networks in the MINAP database and for ambulance services in the Ambulance outcome database on 1 June.
- Please check that call times, ambulance trust codes, post codes and GP practice codes are completed on all patients that received thrombolytic treatment.
- If you are an interventional centre, please ensure that your primary PCI data are entered in MINAP as the number of primary PCIs performed and median door to balloon will be published in this year's Public report
- The data will be analysed on 1 June for both the Healthcare Commission performance indicators and the MINAP public report.
- We will provide the Healthcare Commission with numerators and denominators for CTN60, data completeness and whether a hospital participated in the annual data validation study on 1 June.
- The Healthcare Commission will adjust the thrombolysis target in interventional centres depending on the percentage of patients that received primary PCI as their reperfusion strategy. Interventional centres must therefore ensure that all their primary PCI cases for April 2007 – March 2008 are entered in MINAP.
- Please ensure that you notify us of changes in your hospital's MINAP contact details as we rely on them to send you the newsletters and keep you informed of important news.

2. Public Report

The 7th MINAP Public Report will be published on the Royal College of Physicians website on 18 June. For the first time this year we will publish data by cardiac network, see below. The data will be analysed

on 1 June and hospital's and ambulance service's results will be available on 1 June in the 'Public Report' button in the MINAP database for both hospitals and cardiac networks and in the Ambulance outcome database.

Get your data in

It is important that you get all your data for April 2007 – March 2008 uploaded onto the servers as soon as possible. This will allow you time to generate audit reports and look at the online views to make sure that your results are what you expect. Please do not rely on reports created by other applications as these may use different data analysis criteria and therefore may give you misleading or incorrect results. MINAP analysis criteria are available in the help buttons in the online views and in the explanatory text at the end of the quarterly and annual reports. You can download your data into Excel and check analyses using these criteria.

The Public Report will show:

By hospital

- The percentage of eligible patients receiving thrombolytic treatment within 30 minutes of arrival in hospital for 2006/7 and 2007/8.
- The percentage of eligible patients receiving treatment within 60 minutes of a call for professional help for 2006/7 and 2007/8.
- The percentage of patients that survive to leave hospital who are prescribed aspirin, statins, beta blockers and clopidogrel for 2007/8.
- The number of patients receiving primary PCI by interventional centre.
- Median interventional centre Door to Balloon with interquartile ranges. No delay to treatment will exclude from Door to balloon analysis. Patients that are transferred from a non interventional centre to an intervention centre for primary PCI will be excluded from Door to balloon where Method of admission is 9. Transferred for PCI surgery
- The percentage of patients receiving primary PCI within 90 minutes of arrival at the interventional centre in 2007/8.

By ambulance service

- The percentage of eligible patients receiving treatment within 60 minutes of a call for professional help for 2006/7 and 2007/8.
- The number (and percentage) of patients receiving pre-hospital thrombolytic treatment.

By cardiac network

- The percentage of eligible patients receiving thrombolytic treatment within 60 minutes of a call for professional help for 2006/7 and 2007/8.
- The percentage of patients that survive to leave hospital who are prescribed aspirin, statins and beta blockers, and clopidogrel for 2007/8.
- The number of patients receiving primary PCI.
- The number (and percentage) of patients receiving pre-hospital thrombolytic treatment.

National data

Trends over time in

- The percentage of patients receiving thrombolytic treatment within 30 mins hospital arrival
- The percentage of patients receiving thrombolytic treatment within 60 mins of call for help
- The number of patients receiving pre-hospital thrombolysis
- The number of patients receiving pPCI
- The percentage of patients that survive to leave hospital who are prescribed aspirin, statins and beta blockers

- 30 day mortality for STEMI
- The proportion of patients that receive pre-hospital thrombolysis, thrombolysis in hospital and pPCI

Be involved in the report

In the last Public report, the case studies from hospitals and ambulance trusts on how they have used their MINAP data were very well received. We would again like hospitals, ambulance trusts and cardiac networks to contribute to this year's report by including case studies where you have used MINAP data to improve services, describing how you have made these improvements or improved collaborative working between hospitals, ambulance trusts and cardiac networks. Please email your examples to the helpdesk and we will include the best examples in the Public Report, acknowledging the contributors.

3. Healthcare Commission Annual Health Check

We will provide the Healthcare Commission with data on 3 June so it is essential that your data is uploaded and checked by 31 May. As MINAP data is used for the thrombolysis indicator for ambulance trusts and PCTs, please try to obtain missing data on patients that received thrombolytic treatment for

- call times from your ambulance trust control if necessary, as missing call times will impact on acute trust, ambulance trust and PCT analyses
- ambulance trust codes which allocate patients for ambulance service analyses
- post codes and GP practice codes/PCT codes which allocate patients to PCTs.

Existing national target: thrombolysis – 60 min call to needle time

The construction of the indicator for acute trusts is available at

<http://www.healthcarecommission.org.uk/nationaltargets2007-2008/existingnationaltargets/acuteandspecialisttrusts/indicators/thrombolysis-60minutecalltoneedletime.cfm>

In summary achievement is an absolute performance level of at least 68% in 2007/2008 OR a 20 percentage point improvement from 2003/2004 to 2007/2008 AND an absolute performance level which is equal to or greater than 38% or the trust's own 2005/2006 performance, whichever is the higher.

The construction for the indicator for ambulance trusts is available at

<http://www.healthcarecommission.org.uk/nationaltargets2007-2008/existingnationaltargets/ambulancetrusts/indicators/thrombolysis-60minutecalltoneedletime.cfm>

In summary achievement is an absolute performance level of at least 68% in 2007/2008 OR a 10 percentage point improvement between October to March 2004/2005 and October to March 2007/2008 AND an absolute performance level which is equal to or greater than 38% or the trust's own 2005/2006 performance, whichever is the higher.

We will provide the Healthcare Commission with the numerators, denominators and percentage of eligible patients that received thrombolytic treatment within 60 minutes of a call for professional help for the financial years 2003/2004, 2005/6 and 2007/8 for acute, ambulance trusts and PCTs.

Extenuating circumstances and adjustment to the thrombolysis (CTN) indicator

The Healthcare Commission define an extenuating circumstance as being where trusts' performance or their ability to submit accurate, comprehensive data within data collection deadlines has been adversely affected by unforeseen or emergency circumstances outside of the organisation's control and where the organisation could not reasonably be expected to have contingency in place to mitigate or remove this effect. In such cases trusts may request that this is taken into consideration. The Healthcare Commission

has agreed that cases could include those with long ambulance journey times when the initial ECG is not diagnostic of STEMI and so the patient is not eligible for prehospital lysis but ST segment elevation develops in later ECGs and the patient is subsequently thrombolysed with a longer CTN time. The Healthcare Commission will evaluate evidence on individual cases and cases upheld will be removed from both the numerator and denominator. It is therefore vital to have comprehensive evidence to present for a particular case where

- the initial ECG was not diagnostic, so the patient was ineligible for pre-hospital thrombolysis
- the ECG became diagnostic on arrival at hospital
- and there was a long journey time

Last year the Healthcare Commission also proposed an adjustment of the thrombolysis target in interventional centres to account for the small number of patients receiving thrombolytic treatment. These changes will depend on the percentage of patients that received primary PCI as their reperfusion treatment. The Healthcare Commission has not yet agreed the criteria but they will be published on their website. In the meantime it is essential that interventional centres ensure that they have entered all their primary PCI cases in MINAP.

New national targets 2007/8: participation in audits indicator

Achievement is based on whether a trust has greater than or equal to 90% completion for the key fields recorded by MINAP and whether a trust took part in the annual (2007) MINAP data validation exercise. The construction of the indicator is available at

<http://www.healthcarecommission.org.uk/nationaltargets2007-2008/newnationaltargets/acuteandspecialisttrusts/indicators/participationinaudits.cfm>

We will provide data completeness scores and confirmation that a hospital participated in the annual data validation study for 2007.

4. Change in the definition of call time: call connect

From 1 April 2008 Call connect will change the way that response times to emergency calls are measured. The new clock start time will be from the moment an emergency call is connected to the local ambulance control room. At present it starts only after key information has been collected, which means that on average the clock starts 90 seconds after the call has been made and been answered. It will also mean that response times can be more accurately and consistently recorded, and performance more effectively compared. The definition of the call time will be amended in the MINAP dataset when it is revised in April 2009.

5. Angiography following nSTE MI infarction

As you will know angiography within 48 hours of admission with nSTE MI is a recommendation that appears within European and American published Guidelines. Here are some MINAP data on the position over the last few years in England and Wales. First of all the number of patients recorded with a final diagnosis of STE MI is roughly stable at about 41, 000 per year, and as there is a small fall in recorded STE MIs and fewer other diagnoses recorded the proportion of nSTE MI recorded in MINAP has increased from 42 to 52% between 2003 and 2007.

During this time there has been a substantial increase in the use of angiography (and at the same time a considerable improvement in completion of the field concerning use of angiography). In 2003 22% patients were reported to have had angio after nSTE MI, and by 2007 this had doubled to 45%. Use of angiography is, internationally, age dependent, and the MINAP data are in line with this. For those < 65 years about 75% patients have angiography, between 65 and 80 this falls to 55% and for those over 80 years it is about 15%. Although one might expect very elderly patients to receive less angiography

because of good reasons such as non-cardiac co-morbidity, it is perhaps more surprising that the angiography rate in the large group between 65 and 80 is much lower at 55%. To a small extent the existence of co-morbidities reduces angiography rates, but even for patients not having any reported comorbidities (previous medical history, either cardiac or non cardiac) the angio rate is only 58%. So what difference to outcome does performing angiography make to patients with nSTEMI? A huge amount of work has been performed on both sides of the Atlantic on this subject over many years, generally but not always showing lower morbidity and mortality, and emerging MINAP analyses strongly support both mortality and re-infarction benefit for all age groups, and are beginning to show differences in outcome between hospitals with different angiography rates. We will let you know more detail of our findings in a future newsletter.

On a practical level, please continue to record details of referral or performance of angiography; data completeness for this field is now over 96% for the first time.

6. Data entry

First responders and time of arrival of ambulance

As a result of the introduction of ambulance service first responders we need to distinguish between the date/time of arrival of a first responder and the date/time of arrival of the ambulance. We will be revising the dataset in April 2009 but in the meantime 3.03 Date/time of first professional help should be used for date/time of the first responder which includes paramedics in cars, community first responder and GPs. 3.04 Date and time of arrival of emergency services should be used for the arrival of ambulance ie a vehicle capable of transporting the patient. This will help address concerns about prolonged call to hospital times (not infrequently a first responder can be there much earlier than the ambulance.)

Time of arrival at hospital for patients receiving primary PCI

Interventional centres should use 3.06 Date/time of arrival at hospital as the date/time of arrival at the hospital performing the primary intervention and use the candidate field C1.01 Date/time of arrival at first (non interventional hospital) for arrival at the non interventional hospital.

Coronary angiography

4.13 Coronary angiography does not refer to coronary angiography preceding primary PCI. If a patient has primary PCI then it follows that they will not require an angio outside of the initial reperfusion strategy. Up to now we have recommended that it should be left blank when a patient has primary PCI. However we have been reminded that Coronary angiography is a data completeness field, so please use 8. *Not performed* in future and do not leave it blank.

Call time and ambulance job number/trust code

As the call time and ambulance job number/ ambulance trust code are essential to calculate call times and allocate a record to an ambulance trust, from 2008/9 hospitals will be penalised if the completeness of the fields for call time and ambulance job number/trust code are less than 80%.

Missed STEMIs

Patients with ST elevation AMI in whom the diagnosis is not recognised on the admission ECG should be entered as 1. Definite MI as these patients are now included in analysis if they receive thrombolytic treatment.

Missing NHS numbers/PCT codes

Prisoners, travellers and the armed services do not have NHS numbers and PCT codes. Please enter these patients as 5. *Visitor* as this removes them from the data completeness scores. We will tidy this up at the next revision of the dataset with an option for 'Other'.

Accuracy of the Patient Case Record Number

The patient case record number is an important field which used to identify when a patient is re-admitted. Please try to ensure that it is recorded accurately. When the local case record number reaches CCAD it is encrypted, and the original is no longer accessible to anyone outside of your hospital.

Use of delay to treatment

We have examined the use frequency with which delay to treatment is used for patients who have STEMI and who receive thrombolytic treatment. Across all MINAP hospitals the average is 24% so that about one in four patients is excluded from CTN analysis. However about 10 hospitals are using delay to treatment for almost one in every two cases. Nationally around 9% of delays to treatment are recorded as 9. Other but it is apparent that some hospitals are overusing this option. Please can we suggest that you check your own data for the last two months to see if your own use is within reasonable limits, and if not examine whether such use is really justified in the light of what the majority are doing. A number of hospitals are rather obvious outliers, and while there may be good explanations for this we hope that you do not mind a timely hint to review your practice. Perhaps this is something that the cardiac networks would like to look at. Please do not use Delay to treatment = 9. *Other* for patients with long journey times. As mentioned above, we will submit the CTN data to the Healthcare Commission in June and you will then have the opportunity to apply for extenuating circumstances.

7. Data validation study

The Data Validation Study for 2007/2008 has now been completed online and all but 4 hospitals participated. Analysis is currently being performed and individual hospital reports will be sent out in April. These will be in the same format as previous years comparing local results with those of the national averages. The MINAP team would like to thank all those that dedicated their time and resources completing 2007-2008 data validation study.

8. CSV analyser tool

CCAD still receives non standard data responses and while this has much improved over time this continues to occur. This increases the amount of work that has to be done in preparing data for analysis. A csv analyser tool is now available in the MINAP database. It is aimed at those who import their data, rather than use the MINAP data application, and is intended to help iron out any errors that may arise with incorrectly formatted data. Each time an upload is performed, the csv file is backed up on the database, replacing any previously created csv files so that the database only contains the latest csv file at any one time. From this backup, found in the CSV Analyser section under Import/Export, an analysis can be performed on the csv and emailed to an address entered at the start of the analysis. The analysis is done by going through each field for each record and comparing its value to its corresponding field in the Reference Values. Any instances where a match cannot be made on values, field type or data type will be listed in the analysis report. These errors and recommendations should then be used to fine-tune the export process from the external database to create an import file to MINAP with error-free data.

9. Regional roadshows

We held the first of our all day roadshows in Fulbourne, Cambridge on 29 January. We currently planning roadshows in Wales and Northern Ireland; details will follow shortly.

10. Contact details

Use of MINAP User IDs

MINAP User IDs are given to named individuals and not to the hospital and passing on User IDs to other individuals is a serious security breach. If you leave the MINAP role, please can you notify the CCAD helpdesk and give them the name of your successor who will be given a new MINAP User ID.

How can I request additional User IDs?

Request must come from the main MINAP contact within your hospital and must contain the new user name, phone number, job title and email address. By default generally you will have one Notes licence allowing us to create you one user ID. If while processing your request we discover that no licences are spare we will cancel the user creation and request proof that additional licences have been purchased.

Are your hospital contact details up to date?

We rely on the accuracy of your contact details to send you newsletters and inform you of changes and developments so please notify us of any changes.

12. Helpdesks

We value your feedback on any aspect of the project especially on topics covered in this newsletter. Your feedback informs future developments. For questions and comments please contact the appropriate helpdesk. Please note our new email address and telephone number.

Clinical, process and general project issues:

MINAP

E-mail: minap@uclh.nhs.uk

Tel: 0207 504 8958

Technical issues:

CCAD

E-mail: helpdesk@ccad.org.uk

Tel: 0845 300 6016 option 2

