

NCAP

NATIONAL CARDIAC AUDIT PROGRAMME

NICOR

Management of heart attack: Myocardial Ischaemia National Audit Project (MINAP)

Interim Report 2026
Data from April to September 2025



BCIS



Between April 2025 and September 2025, there was a 15% fall in the total number of submissions to the audit relating to patients with a heart attack - this may relate to seasonal variation and/or to incomplete data.

Over this period, the proportion of patients with STEMI who received reperfusion within 12 hours of symptom onset increased marginally by 1%.

30% of women >75 years of age with STEMI received reperfusion therapy during the six-month period. This contrasts with men aged 55–64 years, of whom 91% received reperfusion therapy.

Across this period, there was no improvement in the median Call-to-Door (CTD) time or the median Door-to-Balloon (DTB) time for patients undergoing primary percutaneous coronary intervention.

An increasingly large proportion of people with a heart attack are self-presenting to hospital rather than calling emergency services. Between April 2025 and September 2025, 12% of patients with STEMI and 33% of those with NSTEMI arrived at hospital by self-presentation.

Nearly all patients with NSTEMI were reviewed by a cardiology team, and the proportion receiving a coronary angiogram before discharge remained high and stable at 83%. However, older adults were less likely to undergo coronary angiography.

Overall, the use of secondary-prevention medications at hospital discharge after a heart attack remained high and stable.



- 1) Patients should receive high-quality pre-hospital care and timely reperfusion treatment in hospital. To shorten delays in delivering emergency reperfusion for higher-risk STEMI heart attacks, ambulance trusts should:
 - provide a reliable rapid response, including timely performance and interpretation of 12-lead ECGs for patients with a suspected heart attack;
 - work with receiving hospitals to reduce handover delays (allowing ambulances to return to service) and minimise in-hospital delays to intervention.

- 2) Inter-hospital transfer pathways for patients in non-interventional hospitals should be streamlined. This is because the large proportion of patients who self-present to hospital with heart attack is becoming the norm. For patients with higher-risk STEMI who present to hospitals without primary PCI capability, Emergency Departments and Assessment Units should:
 - have systems and processes for rapid triage of patients with a suspected heart attack, including prompt performance and interpretation of 12-lead ECGs; and
 - ensure immediate and effective communication with cardiology teams in nearby interventional centres.

- 3) Participating hospitals should provide data that are timely, accurate and complete to the MINAP audit. This enables rapid checking, curation and analysis, ensuring that MINAP can continue to audit and report on the contemporary management of heart attack.



The Myocardial Ischaemia National Audit Project (MINAP) is part of the National Cardiac Audit Programme (NCAP), which is run by the National Institute for Cardiovascular Outcomes Research (NICOR). This interim report summarises the care provided within hospitals in England, Wales and Northern Ireland to almost 40,000 people admitted to hospitals with a heart attack between April 2025 and September 2025.

A key focus of the audit is to support quality assurance and the improvement of services for people suffering a heart attack. The quality of care they receive is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with two types of heart attacks:

- Higher-risk ST-segment elevation myocardial infarction (STEMI)
- Non-ST-segment elevation myocardial infarction (NSTEMI).

This report is designed to be of value to a wide range of stakeholders. The slides in the report are interactive so you can select and explore the data that interest you.

Additional information is available from the National Institute for Cardiovascular Research (NICOR) [website](#) on:

- The description, derivation and validity of each metric used in the audit
- Individual hospital performance
- Data submission by hospitals (case ascertainment in the MINAP compared with reported admissions)
- The running of MINAP, including contact details of the NICOR project team, and the dataset.

The audit relies on the active contribution of staff in participating hospitals. Detailed information on about the cases has been diligently entered by local clinical and audit teams, with subsequent analysis performed within NICOR. We are very grateful to all these staff for their contributions. We will continue to work closely with hospitals, patients and other stakeholders to improve the quality of audit data and how these are used to improve the provision of high quality care to heart attack patients in the UK.

NICOR MINAP audit team



Number of cases

- Total cases (STEMI and NSTEMI)
- Reperfusion rate for higher-risk STEMI patients
- Reperfusion rates by age and gender

Timeliness of treatment

- Self-presentation to hospital rates
- Timeliness of PPCI
- Overall CTD and DTB times
- CTB treatment times against targets
- DTB treatment times against targets

Quality of treatment

- In-hospital angiography for NSTEMI
- NSTEMI angio by age and gender
- Echocardiography rates
- NSTEMI specialist care
- Secondary prevention medication
- Performance of an angiogram
- Performance of an echocardiogram
- Cardiac rehabilitation
- Cardiology care

Fewer submissions were received on patients admitted with a heart attack which may reflect a seasonal fall in cases or incomplete submissions



42,443
Suspected
heart attacks

38,080
Confirmed
heart attacks

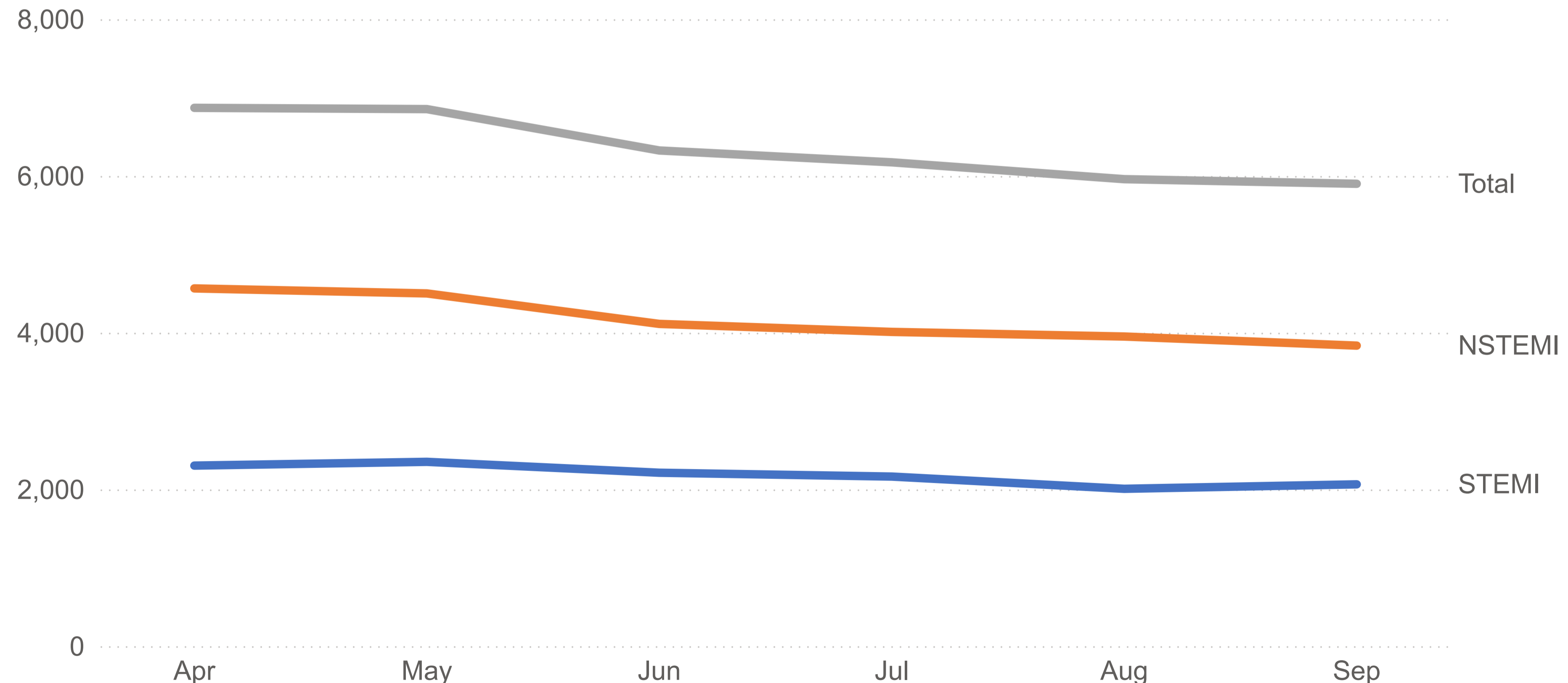
13,106
Higher-risk
STEMI heart
attacks

24,974
Lower-risk
NSTEMI heart
attacks

Between April 2025 and September 2025 there was a 15% decline in the total number of heart attack episodes submitted to the audit. Over that period, the number of higher-risk STEMI heart attacks fell by 11% compared with 16% for NSTEMI cases.

This may represent an effect called 'seasonality', whereby cases of heart attack are less frequent in summer than winter. However, some hospitals may not yet have submitted all their cases of heart attack.

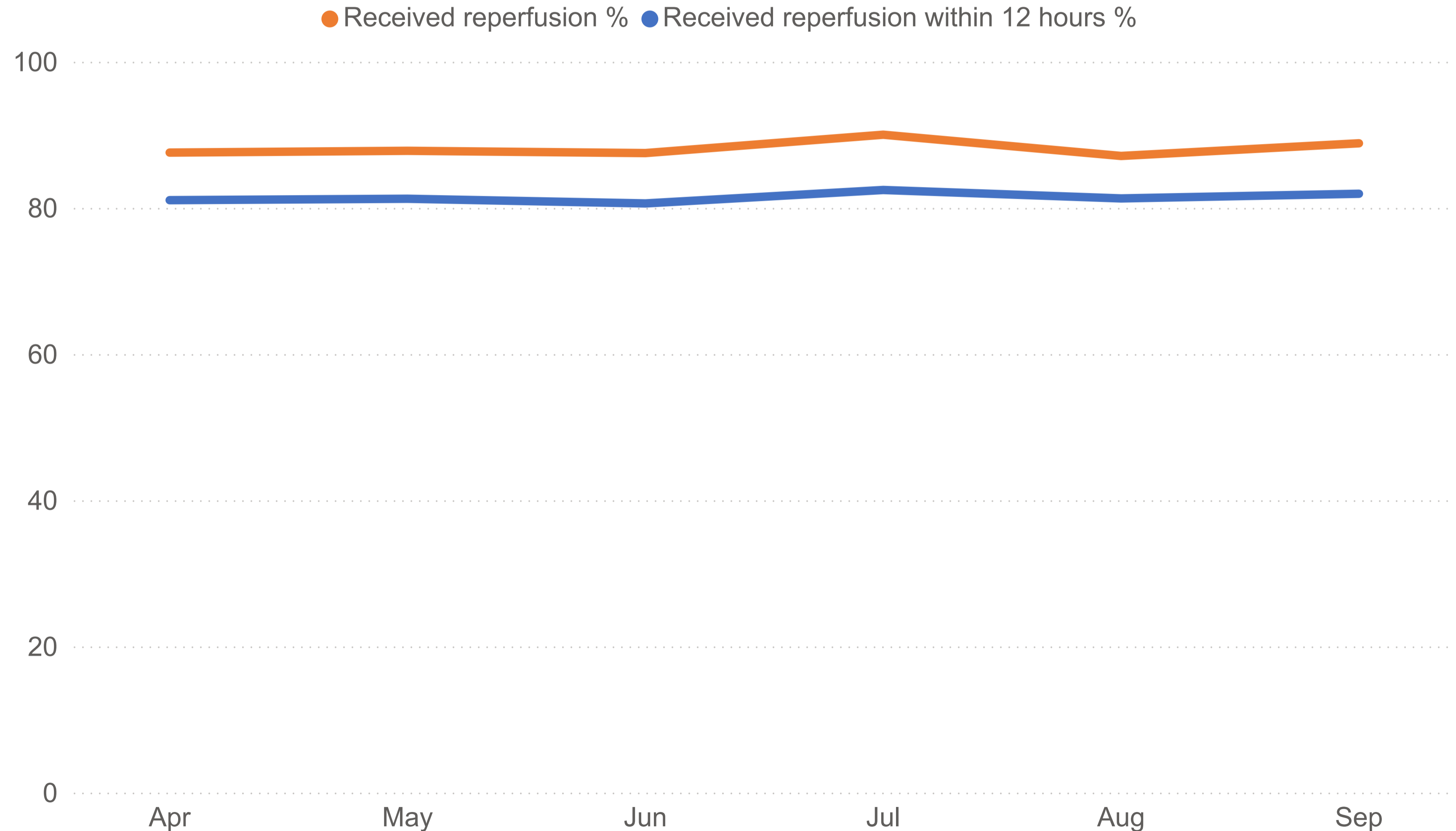
Total STEMI and NSTEMI heart attack cases (April - September 2025)



The proportion of higher-risk STEMI patients receiving reperfusion within 12 hours of symptom onset increased marginally from April to September 2025



Percentage of all STEMI patients who received reperfusion and those who received reperfusion within 12 hours of symptom onset (April - September 2025)



Between April 2025 and September 2025, 86% of patients with a higher-risk STEMI heart attack received reperfusion treatment during hospital admission.

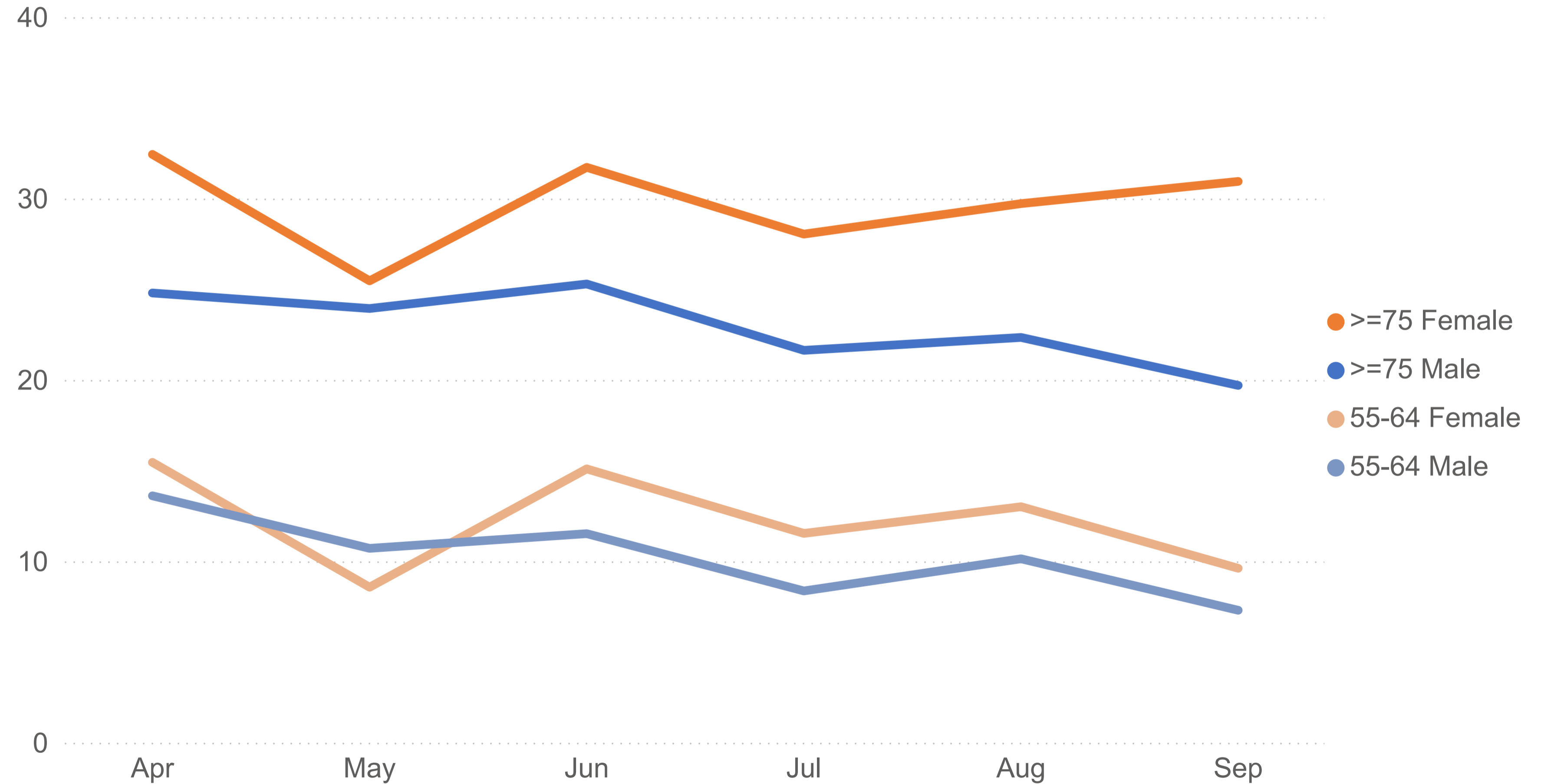
Over this period, the proportion who received reperfusion within 12 hours of symptom onset increased by 1%.

Note: the chart includes data only for those patients who had a valid symptom onset time in their audit submission.

Improvements were seen in the provision of reperfusion treatment for higher-risk STEMI heart attacks by age and sex, but not in older females



Percentage of patients with higher-risk STEMI heart attacks not receiving reperfusion by age and gender (April - September 2025)



In general, between April 2025 and September 2025 there was a 19% reduction in the number of people not receiving reperfusion treatment for higher-risk STEMI.

However, this improvement was not seen for older females during the 6 months studied.

Moreover, 30% of women aged 75 years and over did not receive reperfusion treatment, which contrasts with 10% of men aged 55-64 years who did not receive reperfusion during the 6 months studied.

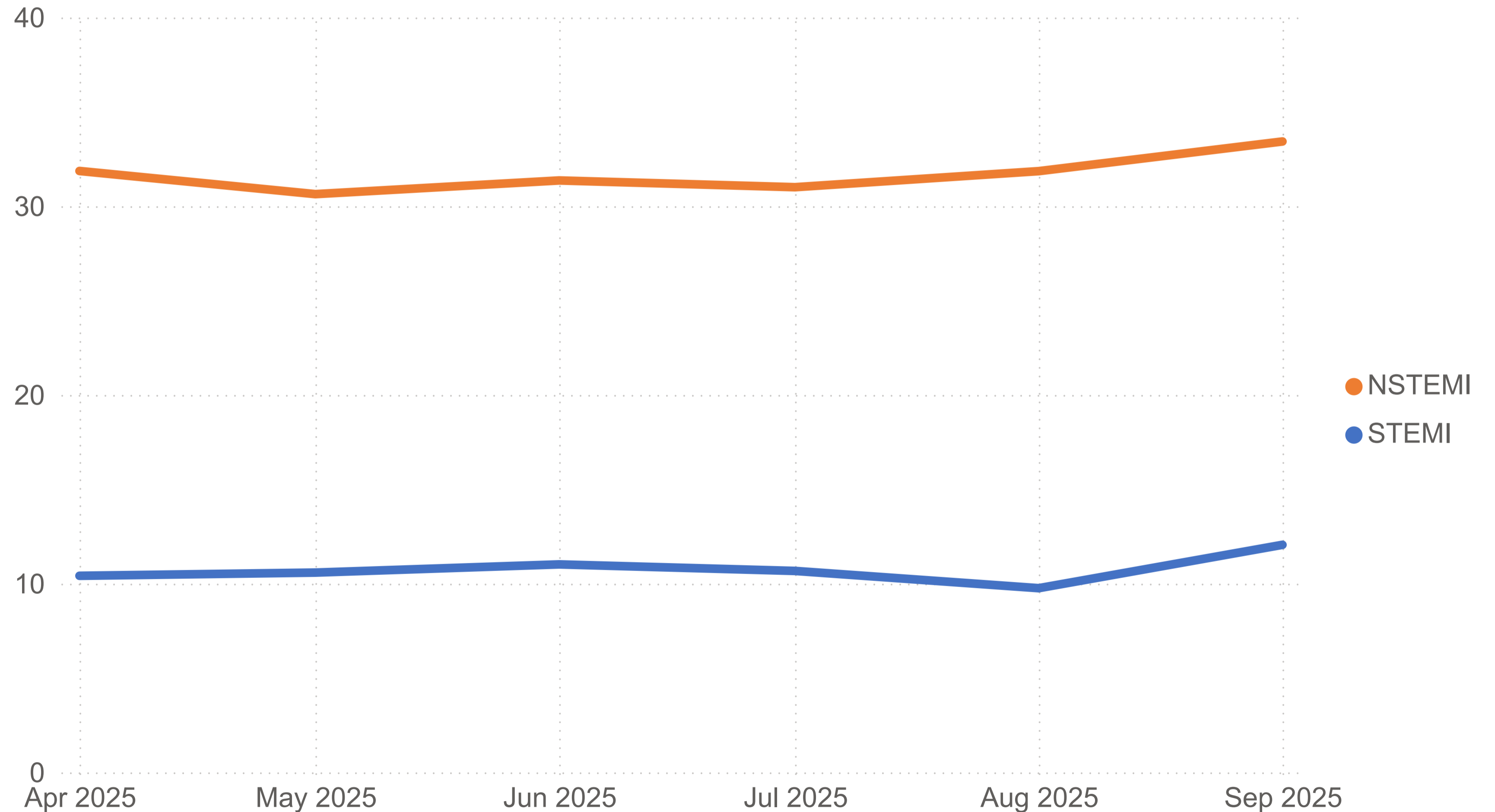
An increasingly high proportion of people with a heart attack self-presented to hospital rather than wait for the emergency services



Percentage of heart attack patients self-presenting to hospital by month (April - September 2025)

Between April 2025 and September 2025, the overall proportion of patients who self-presented to hospital with heart attack was 22% and amounted to 9,319 patients.

On average, over the period, the proportion of people with higher-risk STEMI who self-presented was 12% and for lower-risk NSTEMI was 33%. In September 2025 there was an upturn in the proportion of people who self-presented with higher-risk STEMI and lower-risk NSTEMI.





Delays to treatment reported by those hospitals providing primary PCI (PPCI) for patients admitted directly and those transferred from another hospital with STEMI.

DTB = Door-To-Balloon interval

CTB = Call-To-Balloon interval

CTB150 = proportion treated within 150 minutes of call for help

CTB120 = proportion treated within 120 minutes of call for help

DTB90 = proportion treated within 90 minutes of arrival at hospital

DTB60 = proportion treated within 60 minutes of arrival at hospital

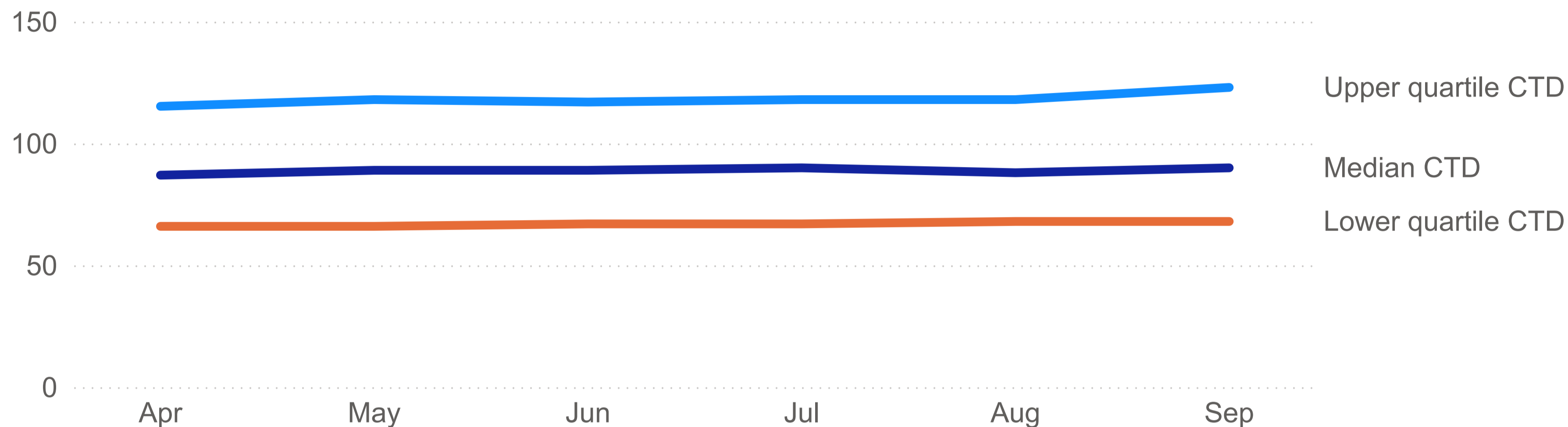
Median is the time within which 50% of patients were treated (following call for help - CTB Median - and arrival at hospital - DTB Median).

Delays are not reported when there were fewer than 20 patients in any particular category. The majority of the hospitals in MINAP are not designated Heart Attack Centres, designed to be continuously able to receive and treat patients with STEMI with primary PCI. However, some of these (non-Heart Attack Centre) hospitals provide primary PCI opportunistically to a limited number of patients, allowing presentation of a median DTB/CTB even when there are fewer than 20 patients.

Call-To-Door and Door-To-Balloon times were static and long



CTD times (minutes) for higher-risk STEMI heart attack patients (April - September 2025)



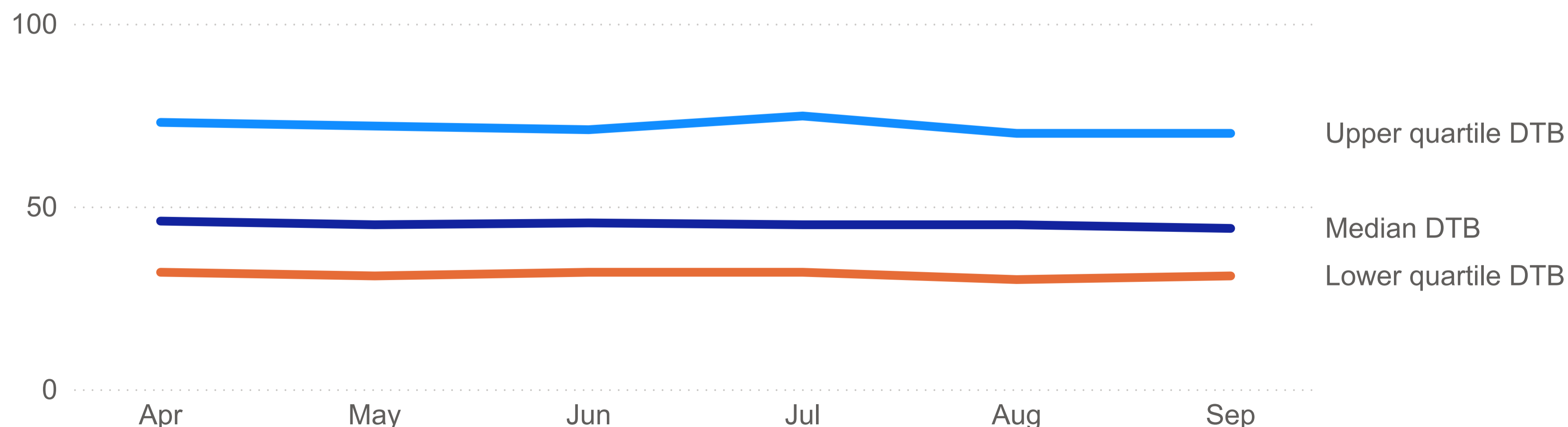
Between April 2025 and September 2025, there was no reduction in the median Call-To-Door (CTD) time.

The interquartile range for CTD (between the 25 and 75 centile) widened from 49 minutes in April 2025 to 55 minutes in September 2025, mainly because of an increase in the upper quartile result to 123 minutes, suggesting proportionately more patients with longer delays in September.

Over this period, the median Door-To-Balloon (DTB) times fell marginally from 46 to 44 minutes, the upper quartile result reducing from 73 minutes to 70 minutes).

Note: DTB times shown are those at the hospital providing primary percutaneous coronary intervention (PPCI).

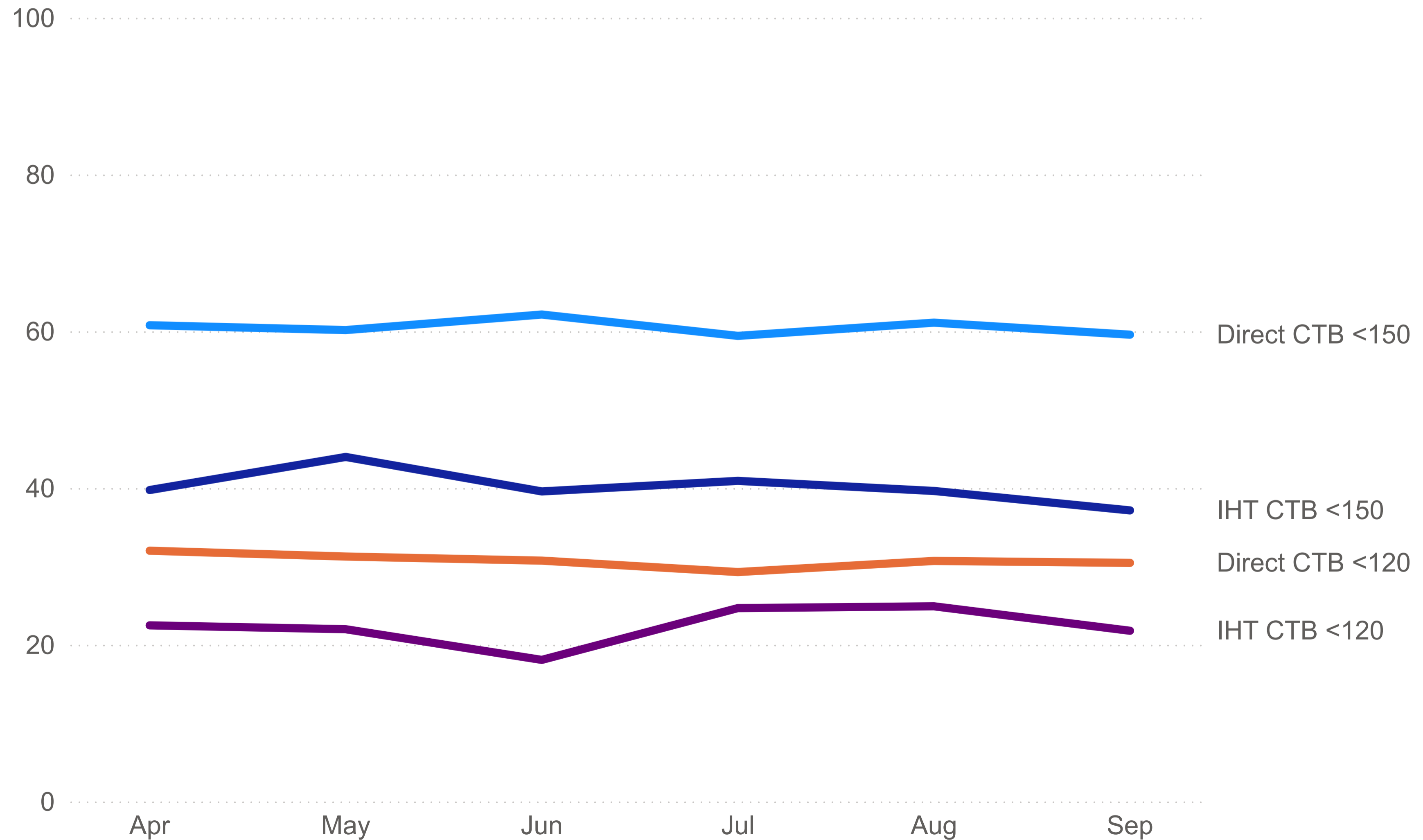
DTB times (minutes) for higher-risk STEMI heart attack patients (April - September 2025)



Call-To-Balloon performance to achieve target times did not improve between April and September 2025



Percentage of higher-risk STEMI patients treated within CTB time targets (April - September 2025)



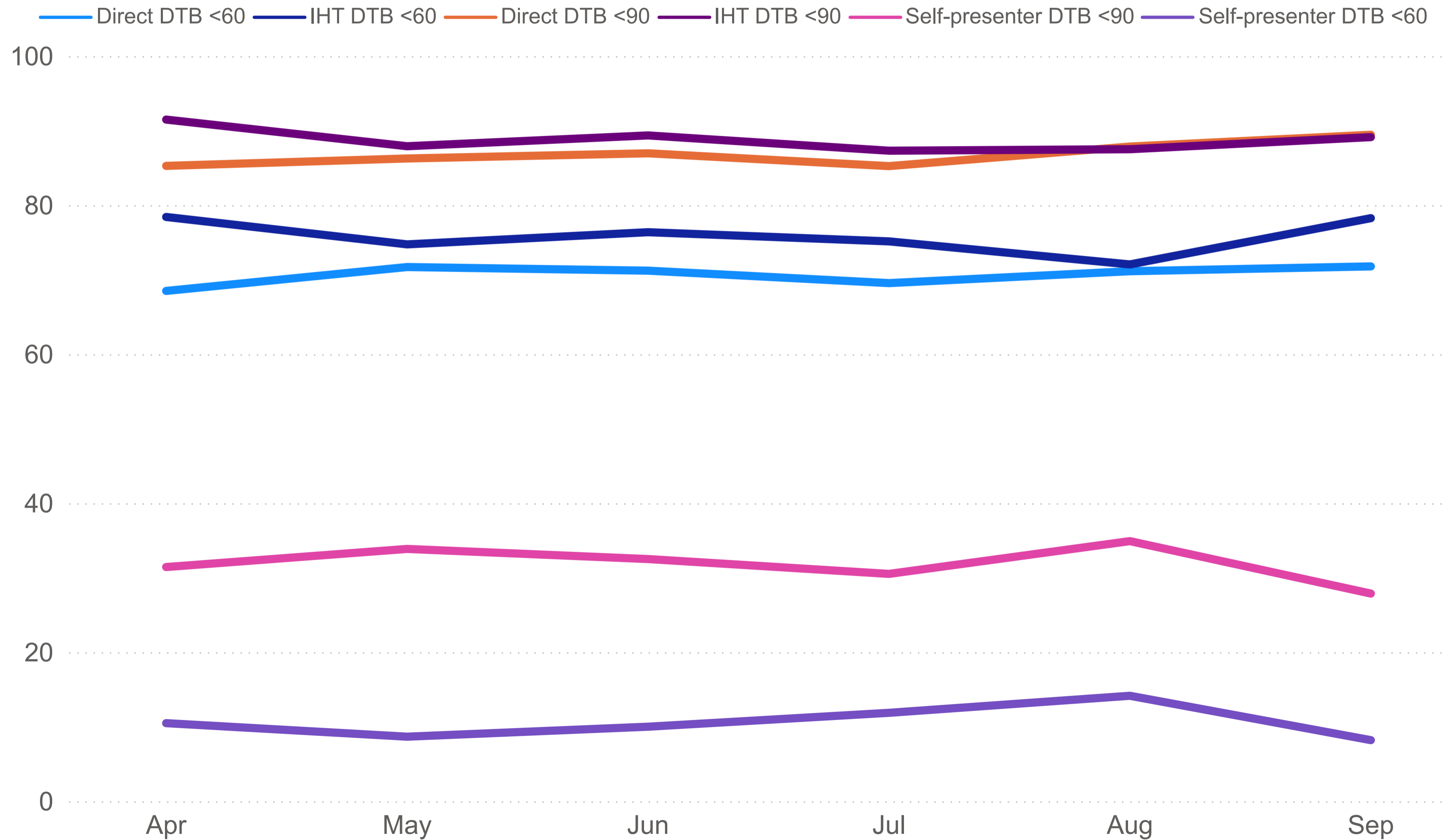
Between April 2025 and September 2025, the Call-To-Balloon (CTB) times for higher-risk STEMI who were directly transferred to hospital did not improve and a high proportion of patients were not treated within the target times.

During this period, patients requiring inter-hospital transfer were less likely to receive timely reperfusion than those taken directly to a hospital with PCI services (39% vs. 59% being treated within 150 minutes).

Door-To-Balloon performance targets did not improve in this time period and were particularly poor for patients self-presenting to hospital



Percentage of higher-risk STEMI patients treated within DTB time targets (April - September 2025)



Between April 2025 and September 2025, for higher-risk STEMI patients who self-present to a PCI-capable hospital, the proportion receiving timely PCI (expressed through the Door-To-Balloon, DTB, time) fell to the lowest recorded levels, with only 8% of patients achieving the DTB target of less than 60 minutes and only 28% of patients reaching the DTB target of <90 minutes.

Note: DTB times shown are those at the receiving PPCI centre.

The proportion of patients with lower-risk NSTEMI who underwent angiography before leaving hospital remained high



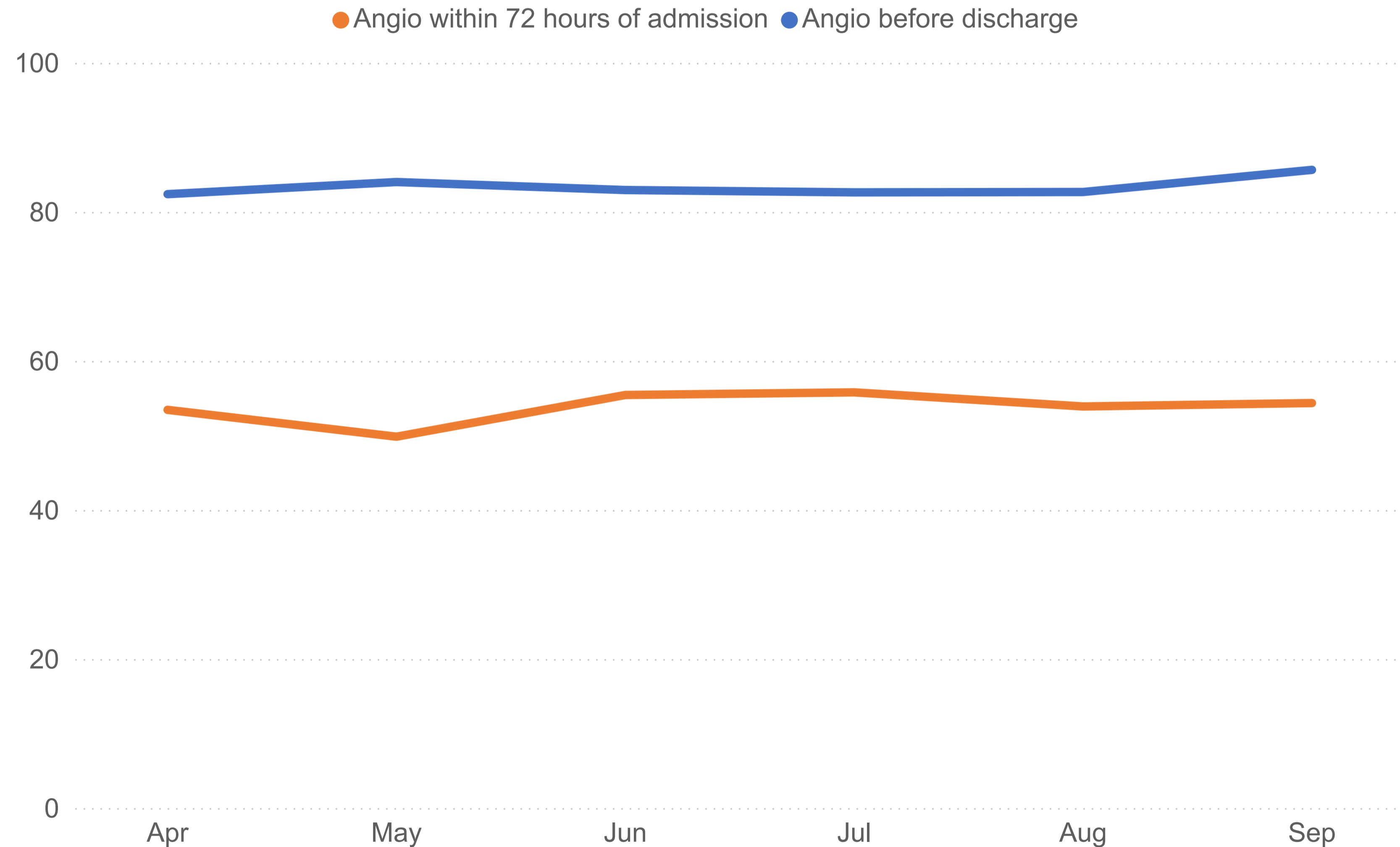
Between April 2025 and September 2025, the proportion of lower-risk NSTEMI patients who received a coronary angiogram before leaving hospital remain high and stable at around 83%.

The proportion who received a coronary angiogram within 72 hours of admission was around 54%.

Select a country/Cardiac Network or hospital below or hover over the graph to see specific data.

Select country or Cardiac Network

Percentage of patients receiving timely angiography after presenting with a lower-risk NSTEMI heart attack (April - September 2025)



Older people with lower-risk NSTEMI less frequently underwent early coronary angiography

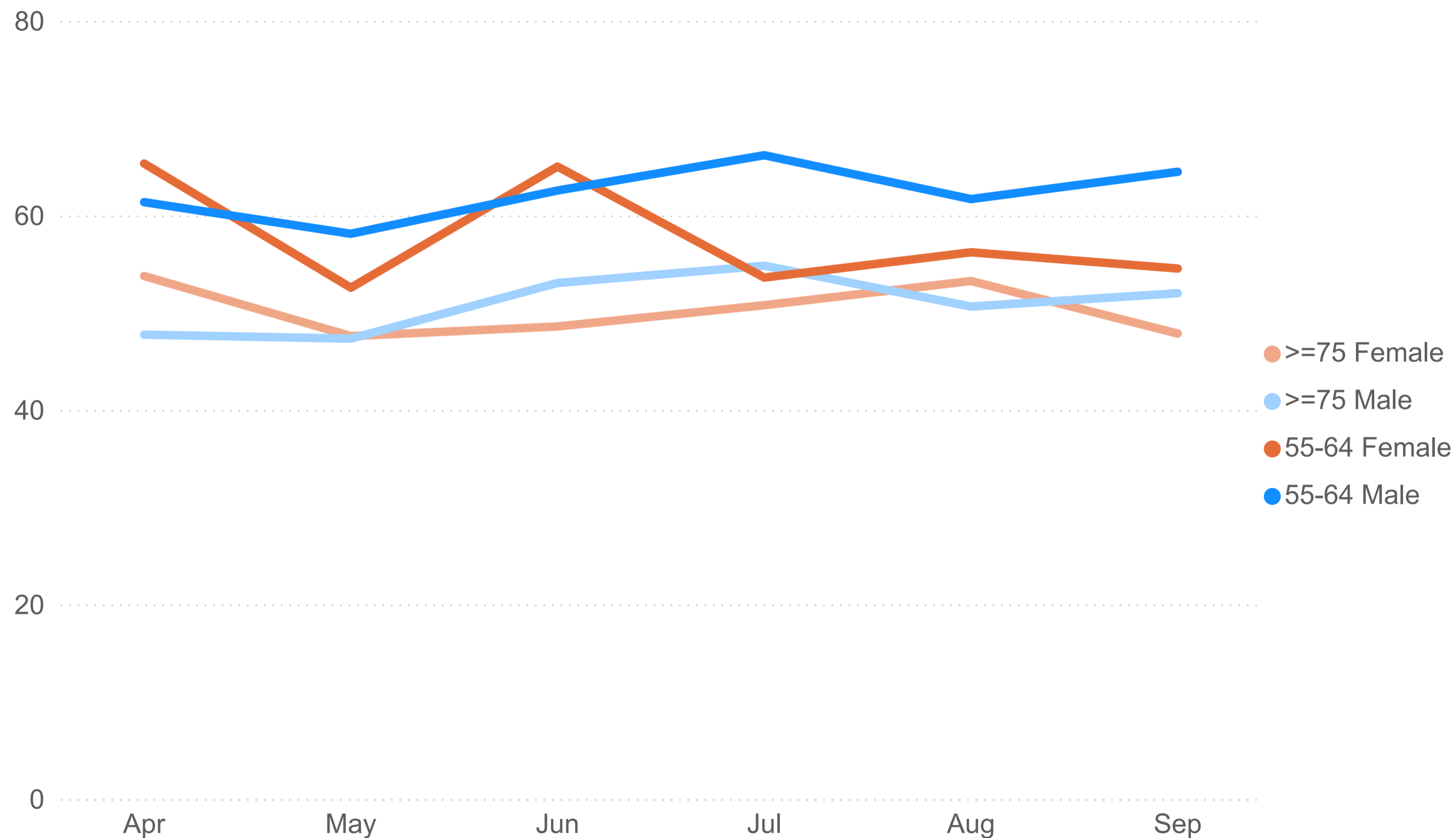


Between April 2025 and September 2025, in general the proportion of patients aged 75 years and over with lower-risk NSTEMI who underwent a coronary angiogram within 72 hours of admission was lower than that for patients aged 55 to 64 years (51% vs. 60%, respectively).

The proportion of men aged 55 to 64 years with lower-risk NSTEMI who underwent a coronary angiogram within 72 hours of admission was higher than for women of that age (58% vs. 62%, respectively).

There were no overall differences between older men and women (50% vs. 51%, respectively), undergoing early angiography.

Percentage of NSTEMI patients receiving angiography within 72 hours of admission by age and gender (April - September 2025)



Most patients with STEMI underwent in-patient echocardiography



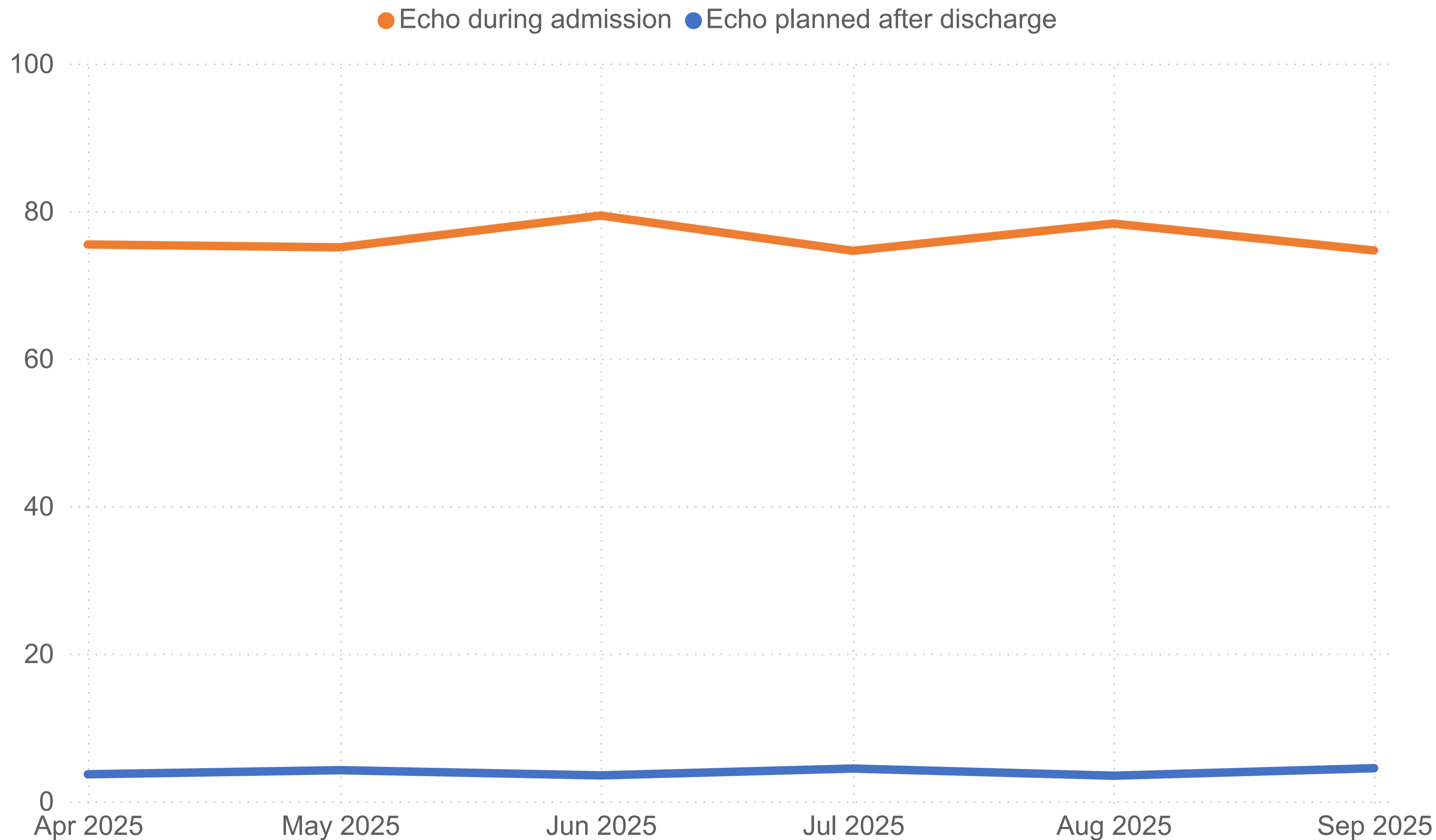
Between April 2025 and September 2025, the proportion of patients with higher-risk STEMI who underwent echocardiography during admission was stable at 78%.

Select a country/Cardiac Network or hospital below or hover over the graph to see specific data.

Note: Approximately a fifth of patients do not receive an echocardiogram. This may reflect the use of other methods to assess cardiac function after a heart attack, the availability of a recently-performed echocardiogram that provides necessary information without the need of a repeat investigation, or, in some cases (as reported to us by some hospitals, an echocardiogram is booked as an outpatient procedure).

Select country or Cardiac Network

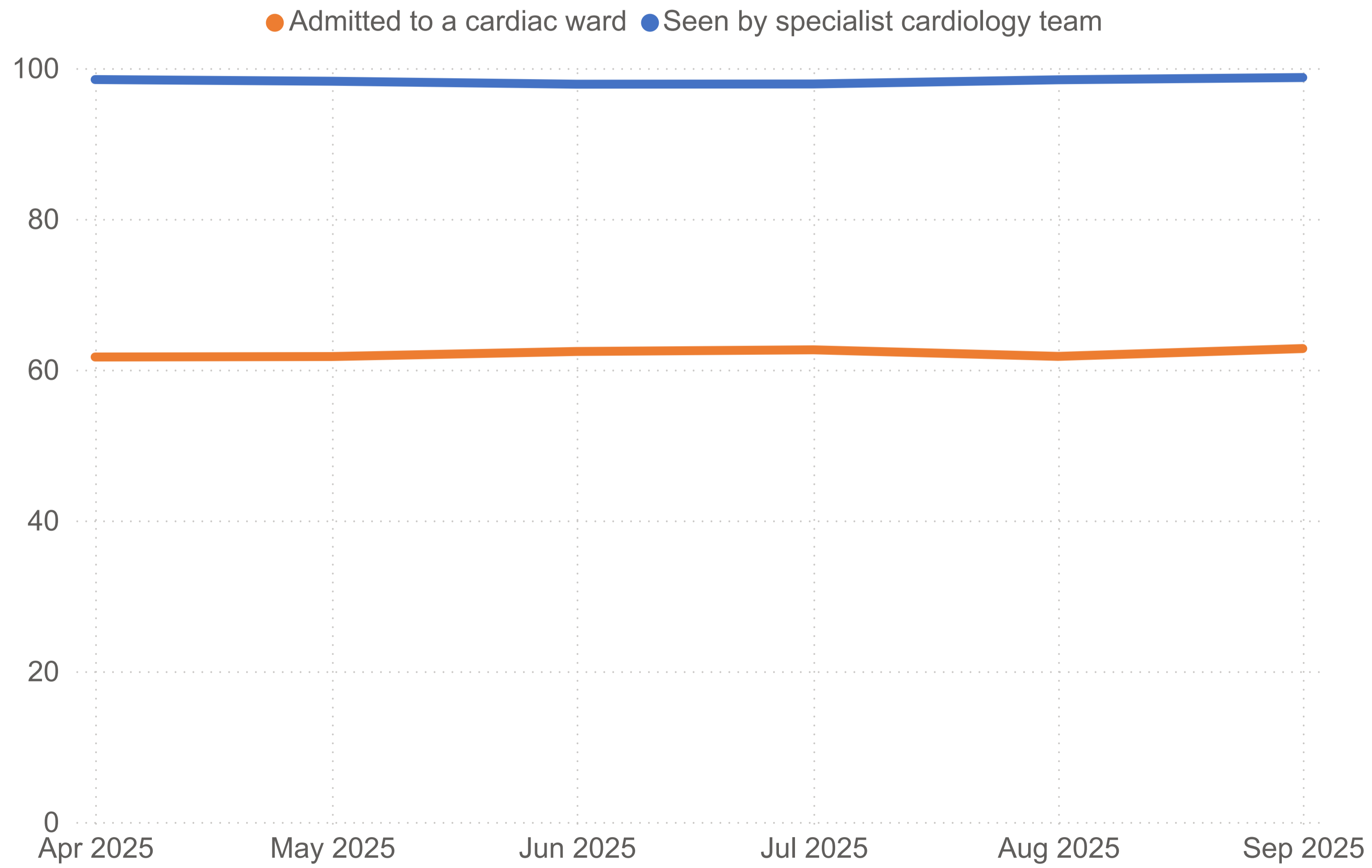
Percentage of STEMI patients undergoing echocardiography (April - September 2025)



Nearly all patients with lower-risk NSTEMI were seen by a cardiology team and 62% of patients were initially admitted to a cardiac ward



Percentage of NSTEMI patients receiving specialist cardiac care (April - September 2025)



Between April 2025 and September 2025, almost all (98%) patients admitted with lower-risk NSTEMI were seen by a specialist cardiology team, and 62% were admitted (within the first 24 hours of arrival at hospital) to a cardiac ward.

Select a country/Cardiac Network or hospital below or hover over the graph to see specific data.

Select country or Cardiac Network

The prescription of secondary prevention medications at the point of discharge remained stable



National guidelines recommend that all heart attack patients should be considered for important secondary prevention drugs that have been shown to improve outcomes – these include a beta blocker, a statin, dual antiplatelet drugs and one of an ACE inhibitor, angiotensin receptor blocker or angiotensin receptor-neprilysin inhibitor. In those with poor heart function aldosterone antagonists are also recommended.

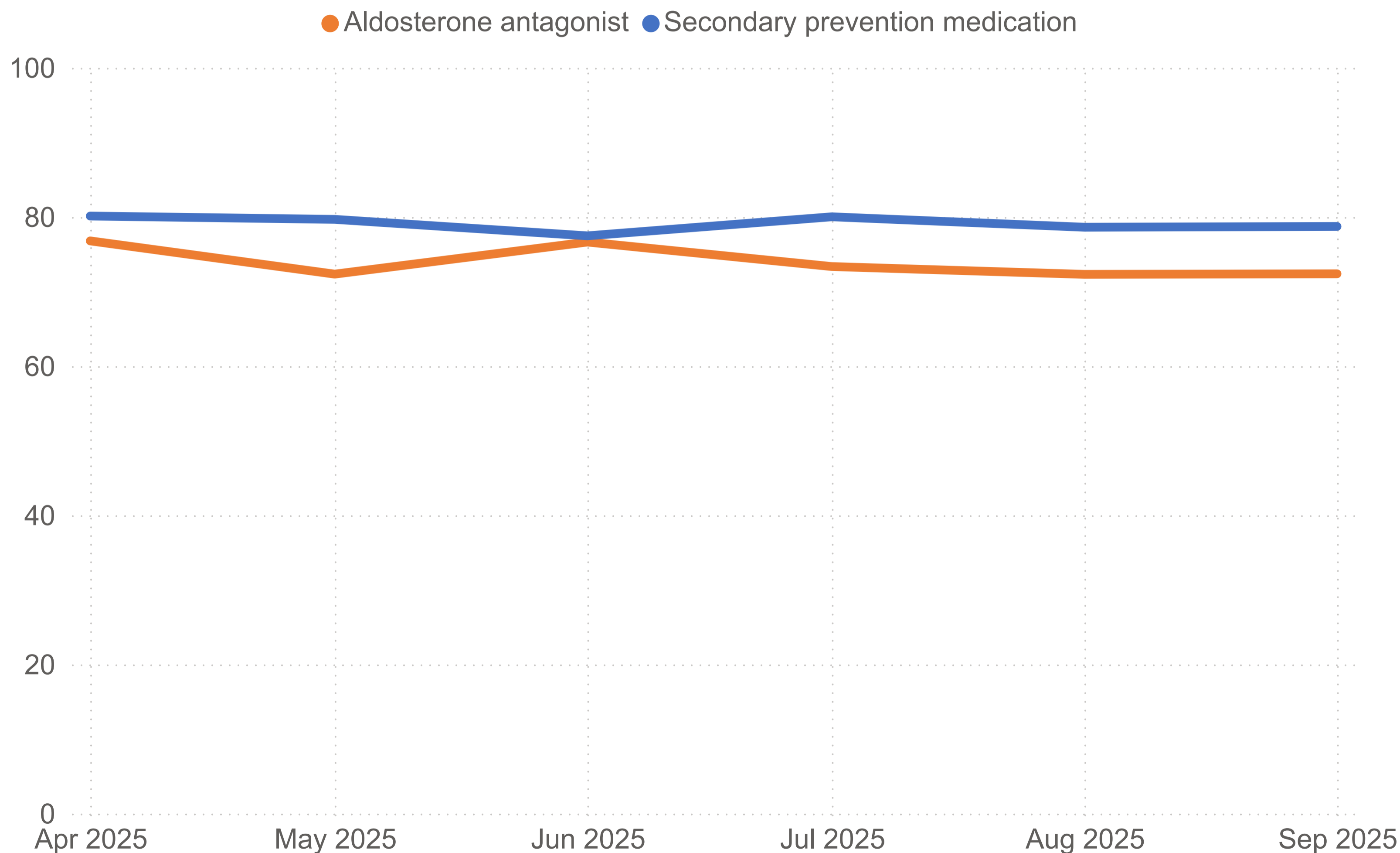
Between April 2025 and September 2025, 79% of patients admitted with a heart attack received all of the secondary prevention drugs for which they were eligible, and 74% received an aldosterone antagonist if they were eligible.

Note: Where participating hospitals have recorded as 'unknown' or left blank the relevant data field, it is assumed that such patients were eligible for treatment yet did not receive it. Actual performance may be slightly better than presented here

Select a country/Cardiac Network or hospital below or hover over the graph to see specific data.

Select country or Cardiac Network

Percentage of eligible heart attack patients receiving guideline drugs (April - September 2025)





Proportion (%) of patients with NSTEMI undergoing angiography during the index admission, and the proportion undergoing an angiogram within 72hr of admission, by hospital (April - September 2025)

Hospital	Number of patients eligible for angiogram	Number of patients undergoing angiogram during admission	Proportion of patients with angiography during admission (%)	Number of patients with valid admission and angiography times	Number of patients undergoing angiography within 72 hours	Proportion of patients undergoing angiography within 72 hours of admission
Addenbrooke's Hospital	73	59	80.8	42	<20	
Airedale General Hospital	159	125	78.6	122	53	43.4
Alexandra Hospital	136	135	99.3	135	82	60.7
Altnagelvin Area Hospital	166	161	97.0	161	97	60.2
Antrim Area Hospital	65	65	100.0	63	20	31.7
Arrowe Park Hospital	181	175	96.7	<20	<20	
Barnet General Hospital	53	38	71.7	37	<20	
Barnsley Hospital	120	72	60.0	72	<20	
Basildon Hospital	248	234	94.4	211	74	35.1
Basingstoke and North Hampshire Hospital	306	238	77.8	235	135	57.4
Bassetlaw Hospital	82	77	93.9	75	<20	
Bedford Hospital	119	119	100.0	115	79	68.7

Select a cardiac network

Select a hospital



Performance of a pre-discharge echocardiogram in patients with a final diagnosis of either STEMI alone, or STEMI and NSTEMI combined (April - September 2025)

The number indicates those eligible for an echocardiogram and the percentage is the proportion of these who underwent an echocardiogram. ['<20' indicates that fewer than 20 relevant patients were submitted]

Hospital	STEMI patients	Number of patients undergoing echo during admission (STEMI)	Percentage of patients undergoing echo during admission (STEMI)	STEMI & NSTEMI patients	Number of patients undergoing echo during admission (STEMI & NSTEMI)	Percentage of patients undergoing echo during admission (STEMI & NSTEMI)
Addenbrooke's Hospital	<20	<20		104	87	83.7
Airedale General Hospital	44	37	84.1	220	183	83.2
Alexandra Hospital	<20	<20		192	190	99.0
Altnagelvin Area Hospital	158	129	81.6	352	321	91.2
Antrim Area Hospital	33	33	100.0	111	111	100.0
Arrowe Park Hospital	42	32	76.2	343	292	85.1
Barnet General Hospital	<20	<20		77	75	97.4
Barnsley Hospital	<20	<20		135	105	77.8
Basildon Hospital	394	393	99.7	737	735	99.7
Basingstoke and North Hampshire Hospital	111	107	96.4	430	399	92.8
Bassetlaw Hospital	<20	<20		159	107	67.3
Bedford Hospital	<20	<20		154	150	97.4
Belfast City Hospital	<20	<20		<20	<20	

Select a cardiac network

Select a hospital



Referral of patients with either STEMI or NSTEMI to cardiac rehabilitation programmes, by hospital (April - September 2025)

This is expressed both for those discharged home from hospital and for patients either discharged home or transferred to another hospital for further treatment.
 ['<20' indicates that there were fewer than 20 relevant patients]

Hospital	Number of eligible patients discharged home	Number referred at time of discharge home	Proportion of eligible patients referred (%)	Number of eligible patients discharged home or transferred	Number referred at time of discharge home or transfer to another hospital	Proportion of all eligible patients referred (%)
Addenbrooke's Hospital	37	<20		94	64	68.1
Airedale General Hospital	159	137	86.2	220	186	84.5
Alexandra Hospital	155	155	100.0	177	176	99.4
Altnagelvin Area Hospital	243	243	100.0	334	334	100.0
Antrim Area Hospital	64	64	100.0	104	100	96.2
Arrowe Park Hospital	88	82	93.2	328	244	74.4
Barnet General Hospital	53	37	69.8	55	38	69.1
Barnsley Hospital	107	87	81.3	119	94	79.0
Basildon Hospital	675	669	99.1	687	678	98.7
Basingstoke and North Hampshire Hospital	364	350	96.2	366	351	95.9
Bassetlaw Hospital	131	117	89.3	146	117	80.1
Bedford Hospital	110	75	68.2	168	89	53.0
Birmingham Heartlands Hospital	420	397	94.5	421	398	94.5

Select a cardiac network

Select a hospital



Admission to a cardiac ward and specialist team review, by hospital (April - September 2025)

['<20' indicates that there were fewer than 20 relevant patients]

Hospital	Total eligible patients	Total number admitted to Cardiac Ward	Percentage admitted to Cardiac Ward	Total number seen by Cardiologist	Percentage seen by Cardiologist
Addenbrooke's Hospital	92	34	37.0	84	91.3
Airedale General Hospital	157	152	96.8	149	94.9
Alexandra Hospital	151	86	57.0	151	100.0
Altnagelvin Area Hospital	196	188	95.9	196	100.0
Antrim Area Hospital	77	72	93.5	77	100.0
Arrowe Park Hospital	278	212	76.3	276	99.3
Barnet General Hospital	54	51	94.4	53	98.1
Barnsley Hospital	121	20	16.5	108	89.3
Basildon Hospital	251	115	45.8	249	99.2
Basingstoke and North Hampshire Hospital	318	150	47.2	306	96.2
Bassetlaw Hospital	109	104	95.4	106	97.2
Bedford Hospital	142	55	38.7	138	97.2
Birmingham Heartlands Hospital	367	352	95.9	367	100.0
Blackpool Victoria Hospital	197	187	94.9	197	100.0
Bradford Royal Infirmary	400	200	50.0	300	75.0

Select a cardiac network

Select a hospital



Prescription of secondary prevention medication at time of discharge home to patients with either STEMI or NSTEMI (April - September 2025)

Performance is not reported when there are fewer than 20 eligible patients. Patients are excluded if they were transferred to another hospital or if they died in hospital. The medication presented in this table includes the use of aldosterone antagonists in patients with poor left ventricular (LV) function, and a combination of: Angiotensin Converting Enzyme (ACE) inhibitors, Angiotensin receptor blockers (ARBs), aspirin, other anti-platelet agents, beta blockers and statins.

Hospital	Number of patients discharged home	Number of patients discharged on all medication for which they were eligible	Percentage discharged on all medication for which they were eligible
Addenbrooke's Hospital	39	29	74.4
Airedale General Hospital	161	69	42.9
Alexandra Hospital	174	174	100.0
Altnagelvin Area Hospital	249	244	98.0
Antrim Area Hospital	65	60	92.3
Arrove Park Hospital	123	107	87.0
Barnet General Hospital	69	30	43.5
Barnsley Hospital	107	58	54.2
Basildon Hospital	694	640	92.2
Basingstoke and North Hampshire Hospital	414	410	99.0
Bassetlaw Hospital	134	96	71.6
Bedford Hospital	116	87	75.0

Select a cardiac network

Select a hospital