National Joint Registry
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NJRSC (O5) 15

NATIONAL JOINT REGISTRY STEERING COMMITTEE

MINUTES

Meeting: Steering Committee meeting Date: Thursday 28 April 2005

Location: BOA, The Royal College of Surgeons, 35 – 43 Lincoln's Inn Fields, London WC2A 3PN

Present:	Bill Darling	BD	Chair
	Paul Gregg	PG	Vice chair
	Judy Murray	JM	British Orthopaedic Association (representing the surgical profession)
	Jan van der Meulen	JvdM	Royal College of Surgeons (representing the surgical profession)
	Alex MacGregor	AM	University of East Anglia (representing public health and epidemiology)
	Martyn Porter	MPo	British Hip Society
	Tim Wilton	TW	British Association for Surgery of the Knee
	Mick Borroff	MB	DePuy International Ltd (representing the orthopaedic device industry)
	Andy Smallwood	AS	NHS Purchasing and Supply Agency
	Colin Thomson	CT	All Wales Community Health Councils (patient group representative
	Mark Noterman	MN	Department of Health
	Judith Hind	JH	Department of Health
	Ramila Mistry	RM	Department of Health
	Gunnar Nemeth	GN	Capio Healthcare (representing the independent sector)
	Fiona Davies	FD	AEA Technology (contractor)

The following AEA Technology staff were also present:

Leigh Mapledoram	LM	NJR Programme Manager
Sue Mercer	SM	NJR Project Administrator
Holly Firmin	HF	NJRStakeholder Consultant
Richard Coombes	RC	NJR Regional Audit Co-ordinator for
Martin Pickford	MPi	NJR Orthopaedic Adviser

Apologies:	Ken Bateman	KB	Smith & Nephew Healthcare Ltd (representing the orthopaedic device industry)
	Andy Crosbie	AC	Medicines and Healthcare products Regulatory Agency (MHRA)
	Chris Dark	CD	BUPA Hospitals (representing the independent sector)
	Dominic Worsey	DW	National Assembly for Wales
	Christine Miles	CM	Royal Orthopaedic Hospital (representing NHS Trust management)
	Christine Edwards	CE	Arthritis Care (patient group representative)

Item	Welcome and Introductions	Action by
1	BD opened the meeting by welcoming all attendees. RM was introduced as a new member of the Committee replacing Judith Hind as the Department of Health NJR Contract Manager. Also present at the meeting for the first time was Gunnar Nemeth from Capio, who has taken over the role of representing the independent sector from Chris Dark. Chris is leaving BUPA. BD continued by thanking Martyn Porter for inviting the NJR to the recent British Hip Society meeting. Apologies had been received from Ken Bateman, Dominic Worsey, Andy Crosbie Christine Miles, Christine Edwards, Chris Dark and David Forsythe.	
2	**Status of the NJR Steering Committee – NJRSC (05) 08** BD advised that due to the importance of this subject he wished it to be discussed ahead of other items. JH introduced the paper by advising that the Cabinet Office had recently undertaken a review of all public bodies and committees across Whitehall, as requested by the House of Commons Public Administration Select Committee. As part of that review, the status of the NJRSC was considered and the Cabinet Office decided that the Steering Committee should have the status of an Advisory Non-Departmental Public Body (ANDPB). This decision reflects the Committee's role in giving expert independent advice to the Department and Ministers. JH wished to encourage discussion among Committee members. Whilst the NJRSC current Terms of reference and operation are largely compliant with ANDPB status, JH advised there are a number of responsibilities placed on ANDPBs that require the NJRSC to make changes to the way it operates. BD said that before discussion commenced he would like to add that he was delighted with the change of status for the NJRSC as it reflects work done by the NJR and should clarify the role that the Committee has in relation to its advice given to the Department and Ministers. JH continued that there was a list of key characteristics expected of an ANDPB which she wished the NJRSC to discuss: ***1. Holds annual Open Meetings, where practicable and appropriate*** JH asked the Committee if they supported an annual open meeting. PG supported such a meeting, advising that it should include patients as he believed that the NJR should be driven by patients rather than the NJRSC. He suggested that the meeting should be held just before or just after the British Orthopaedic Association Congress. MN felt that holding the meeting alongside the BOA Congress would be positive in that the profession would be there but agreed that it was important to open out the meeting to other bodies (e.g. related to arthritis and rheumatism) and patients. He saw the meeting as being associated with, but not part of, the BOA Congress. PG questioned if attendance at the meeting would be open to anyone and if it would include a formal agenda. JH replied that there was no guidance as to what the meeting should cover and therefore the NJRSC would need to decide on its contents. In relation to members of the public attending, CT advised that similar meetings he had attended in Wales included the public and had a fixed agenda that included speakers covering subjects of interest to the expected mix of attendees.	

	FD confirmed that she had attended similar meetings where there had been little, if any, public involvement despite the meetings being open. The structure and content of the NJR meeting would need to interest the public. She suggested that an annual open 'event' rather than a meeting might be more appropriate. BD suggested that the 'event' agenda should be of interest to professionals, stakeholders and the public and could form part of an orthopaedic meeting. He further suggested that possibly an NJRSC meeting could have a later start, allowing an open meeting to take place first. He further suggested inviting the press, which those present supported. **[Action 2005/14]** NJR Centre / DH / BD to discuss potential timing, format and location of first NJR open meeting. ***2. Releases summary reports of meetings*** JH stated that this expectation would not be an issue as the minutes of NJRSC meetings are already available on the NJR website. ***3. Consults with users by means of questionnaires, public meetings and other forms of consultation*** The SC has always directed the NJR to consult with stakeholders. TW said that he believed the NJR did not make enough contact with patients and that they should be advised of the open meeting. BD responded by saying that there is patient representation on the SC (and the NJR Research Sub Committee, the PROMS advisory group and the Annual Report Editorial Board) but consideration could be given to consulting a wider range of patients' groups. MPi added that the Hip Owners Manual could include reference to the NJR holding open annual meetings and details of where to obtain further details. **[Action 2005/15]** Include reference to NJR annual open meetings in Hip Owners Manual. ***4. Adheres to the Freedom of Information Act*** JH advised that adherence with the Freedom of Information Act was essential though it was helpful that a great deal of information relating to NJR data was already available on the website, including minutes of NJRSC meetings. ***5. Has a code of conduct for board members and holds a register of members' interests*** JH advised that members of an ANDPB must at all times observe high standards of impartiality, integrity and objectivity and also be accountable to Parliament and the public for carrying out the NJRSC's business. A register of members' interests would need to be set up. ***6. Produces annual reports and makes them publicly available*** JH said that the NJRSC annual report only needed to consist of 1 to 2 pages and could be included as an Annex to the NJR Annual Report if timescales allowed or alternatively just be made available on the NJR website. MN added that he believed the two reports could be best launched together. **[Action 2005/16]** NJR Centre to liaise with DH regarding preparation of the first NJRSC annual report. ***7. Has members who have been appointed in accordance with the Commissioner for Public Appointments' Code of Practice.*** JH advised that current members of the NJRSC were not appointed in accordance with the above Code of Practice as the NJRSC was not classified as a public body when first established. JH confirmed that the Department of Health does not intend	**NJR Centre / DH / BD** **NJR Centre** **NJR Centre / DH**

	to cut current terms of appointment short. However, the NHS Appointments Commission will be asked to appoint members in line with the Code when current members' terms of office come to an end. JH stressed that it was expected that the make up of the NJRSC in terms of the expertise it harnesses would remain broadly the same as it was now. TW pointed out that many current members were nominated by bodies (examples relating to the surgical profession are nominations by the BOA, RCS, BHS and BASK). JH repeated that she believed that the range of expertise on the NJRSC was appropriate. She believed that appointments would in future be subject to open competition that would allow candidates to put themselves forward. RM would check this. JM questioned who would fund the appointment process. JH confirmed that this would be covered by the Department of Health. MN continued by advising that, when there was a vacancy on the NJRSC, the balance of membership would be examined to enable appointment to an appropriate stakeholder area. There was discussion regarding the logistics of future representation from the surgical profession. Current BOA, BHS and BASK SC members believed that the existing system was sound and were concerned that what was being proposed could lead to disenfranchisement of the professional bodies. Their preference would be for the BOA, BHS and BASK to nominate candidates to go forward for consideration by the NHS Appointments Commission. JH indicated that the Department of Health would expect surgical representatives on the NJRSC to be both practising surgeons and to be able to speak on behalf of the profession. The Department would look at the criteria that could be employed by the NHS Appointments Commission to confirm that an applicant would be able to speak on behalf of the profession. This *might* make reference to BOA, BHS and/or BASK membership but she felt it unlikely that initial applications could be restricted in this manner. PG expressed concern as he believed the NJR had made good progress in obtaining the support of the surgical profession from a hostile start in a short time. He felt this could be jeopardised if the proposed changes had not been well thought out. MN told the meeting that his experience of ANDPBs was positive. The Department would provide the Commission with a brief that identifies stakeholders and where potential candidates might be found. JM added that in the future upper limbs might be included on the NJR and that a representative from this surgical area would be required. AS asked about the position of PASA and MHRA. JH confirmed that reference to NJRSC membership including representatives from the Department of Health should be interpreted also including PASA and MHRA. Whether Department of Health representatives are NJRSC members or observers is to be confirmed. JH commented that no changes to the NJRSC were needed at present. With regards to the NJRSC Terms of Reference, JH confirmed that she would look again at the wording relating to the surgical profession, taking account of the views expressed in the meeting. JH drew discussion to a close by concluding that a revised Terms of Reference that took into account the points summarised above was acceptable to the NJRSC. **[Action 2005/17]** (a) RM to check that appointments would in future be subject to open competition that would allow candidates to put themselves forward. (b) DH to look at the criteria that could be employed by the NHS Appointments Commission to confirm that an applicant would be able to speak on behalf of the profession. (c) RM to confirm whether DH representatives are NJRSC members or observers. (d) With regards to the NJRSC Terms of Reference, JH to look again at the wording relating	**(a) RM; (b) DH; (c) RM; (d) JH**

	to the surgical profession, taking account of the views expressed in the meeting.	
3a	.**Progress on actions** BD advised that full support had been obtained from the Harrogate and District NHS Foundation Trust and that Harrogate District Hospital was expected to recommence data submission with effect from 1 April 2005. He asked that the situation be checked and reported back to the SC. **[Action 2005/18]** NJR Centre to provide an update on the NJR data submission situation at Harrogate District Hospital. [Post-meeting note: Harrogate District Hospital recommenced data submission in March 2005. March 2005 -187 completed operations entered in month, NJR consent rate 86%; April 2005 – 172 completed operations entered in month, NJR consent rate 83%. Reference: NJR StatsOnline.]	**NJR Centre**
3b	**Approval of minutes – NJRSC (05) 06** The minutes of the SC meeting held on 24 January 2005 were approved with no changes. **[Action 2005/19]** Approved minutes to be posted on the NJR website.	**NJR Centre**
4	**Quarterly Management Report – NJRSC (05) 07** *Before moving on to the main business of the meeting, BD advised those present that he considered that patient consent and the importance of increasing consent levels obtained should be borne in mind throughout the meeting. Discussions in the earlier NOPAG meeting had highlighted further the importance of being able to link records for the NJR to be able satisfy a wide range of expected and potential functions. Ways in which patient consent levels could be increased more quickly should be sought.* BD asked if there were questions regarding the quarterly management report. PG requested an update on progress on the patient feedback process (PROMS). LM advised that 20,000 questionnaires had been sent out in the interim study. As of close of business on 27 April, 16,693 completed questionnaires had been returned to the NJR Centre, a response rate of 83%. LM continued that 75% of questionnaires had been returned from the first mailing. A second mailing for patients who had not replied had been sent and a final figure of 88% was expected by the cut-off date. TW made reference to the increase in NJR Helpline calls (roughly an additional 200) mentioned in the report as being related to the PROMS questionnaire. He asked if the Helpline were able to answer clinical enquiries. LM responded that the NJR had expected an increase in Helpline calls, that there had only been 200 enquires in relation to 20,000 questionnaires sent out and that callers with clinical enquiries (a small number) had been advised to contact their GP or consultant.	
5	**NJR Financial Report – NJRSC(05) 09** BD asked for any questions regarding the financial report. Lord Warner had agreed that the levy for 2005/06 should remain at £25 per leviable implant. BD drew the SC's attention to the fact that Lord Warner had requested that the Department of Health ensure that the NJR does not build up a large surplus of levy funds and had noted that the amount of levy charged may need to be reviewed if the NJR has a large surplus that it is not able to manage. BD stated that any usage of surplus funds would have to be responsible expenditure.	

	MB asked if there was anything to report back yet on the review of the Memorandum of Understanding. JH advised that the DH would begin the review process and report back to the July SC meeting.	
6	**NJR Statistics Report (Reporting Period: 1 April 2004 to 31 March 2005) – NJRSC (05) 10** FD introduced the Statistics Report, advising that key summary statistics could be found in Section 1 (page 3). FD highlighted the minimal overall increase in patient consent over this reporting period. This was largely as a consequence of communication with units that procedures carried out between 1 January and 31 December 2004 and submitted to the NJR would be included in analyses in the 2nd Annual Report. This had resulted in large volumes of 'backlog' data being submitted that often had a low rate of NJR patient consent. MN asked if there was anything the SC could do to encourage units to enter data regularly. FD replied that she believed that NJR StatsOnline should help level out data entry and improve consent rates. [Post-meeting note: NJR StatsOnline went 'live' on 3 May. An RAC visit to a large orthopaedic centre with low consent rates, included showing a manager this area of the NJR website. The manager was concerned that his hospital's consent rate compared unfavourably with that of other Trusts in the area. So much so that he immediately authorised extra hours for the NJR Hospital Data Entry (HDE) person to work on the NJR to improve consent capture – on a permanent basis if that was what was required.] PG raised the issue of the remaining nil returning hospitals. Some nil returning hospitals have advised that they are waiting for Bulk Upload before entering data to the NJR. MPi mentioned that the Bulk Upload facility has been available for some time and a range of communications had been sent out to hospitals, especially those that had previously indicated they wished to use this facility. There is also a related article in the April issue of the NJR Joint Approach newsletter. What hospitals have always been told is that they have to carry out work to ensure that their systems are fully compatible. Few hospitals have taken things forward to date. PG asked what the next step should be in dealing with those nil returning hospitals who have been using Bulk Upload as an excuse. BD suggested that a letter should be sent on behalf of him and PG to senior management at these hospitals alerting them to the situation. The NJR Centre should provide appropriate wording for such a letter. BD requested the Committee's approval for this action, which was agreed. **[Action 2005/20]** NJR Centre to draft letters to send to senior management at 'Bulk Upload' hospitals on behalf of BD / PG.	**NJR Centre**
7	**The NJR – Business Plan for FY 2005/06 – NJRSC (05) 11** LM introduced the Business Plan for FY 2005/06. Due to length of the paper, a presentation handout was used. This contained the NJR team structure, then the following slides (shaded). Key discussion is shown at relevant points. **•Stakeholder Networking** •NJR Outlier Performance Advisory Group •Regional Clinical Coordinators Network •NJR Research Sub-Committee •Annual Report Editorial Board •Stakeholder Networking - Healthcare Commission - National Patient Safety Agency - National Institute for Clinical Excellence	

- Others

• Attendance At Key Conferences

LM added that Stakeholder Networking was led by FD and that the NJR would have communication with the stakeholders mentioned throughout the year. LM also advised that the NJR will be attending key conferences in connection with BOA, BASK, BHS and the NATN.

Communications

•Stakeholder Reporting – Paper NJRSC (05) 12
•Annual Report communications
•NJR Website
•NJR StatsOnline – Launch on 3 May
•Patient Feedback – Interim study ongoing
•Hip Owners Manual
•Newsletters/Good Practice Guides
•Media enquiries

Data Quality

•7 RACs in post
•Targetting nil-returning units
•Completeness of compliance
•Working to improve consent
•Data Integrity Audits

LM added that 2 new RACs had recently been recruited and undergone an induction process at the NJR Centre. He further advised that the 7 RACs were focussing on nil returning hospitals, increasing compliance, increasing patient consent and carrying out audits.

Data Analysis

•Developing area of activity for NJR Centre
•Production of statistics
•Providing data for research needs
•Identifying outliers
•Specific enquiries

Information Technology

•Bulk upload – Ready for implementation
•Barcoding – Testing during May
•Public Key Infrastructure – Release in July
•MDSv1 shut down
•9 new Surgeon Default Techniques
•Post code validation

Programme Management

•Steering Committee
•Levy collection
•Audit of levy returns
•Development of protocols

Outcomes

•Annual Report launched at BOA Conference

- Stakeholder Reporting Strategy implemented
- NJR StatsOnline launched
- No nil-returning units
- Over 115,000 procedures submitted
- Patient consent rate reaches 85%
- All nnits take part in Data Integrity Audit
- Provision of accurate data for stakeholder groups
- Bulk upload working in hospitals
- Barcode readers distributed
- PKI project delivered to surgeons
- Additional default techniques delivered
- Post code mandatory

LM added that the NJR's target is for there to be no nil-returning units within six months from 1 April 2005 (i.e. by 30 September 2005). LM also advised that the expectation of over 115,000 procedures submitted in 2005/06 was an increase of 10% over last year.

MB commented that he believed volumes of orthopaedic surgery would increase by 10% during 2005/06 so what was being forecast was compliance with the NJR remaining unchanged. TW advised that his belief was that orthopaedic surgery would increase by more than 10%, to which MPi replied that a 10% increase in levy was not expected.

Budget

Financial Year	Core Work (inc VAT)	Variation Orders (inc VAT)	Total For NJR Centre (inc VAT)	Expected Levy Returns (inc VAT)
Apr 05 – Mar 06	£1,935,753	£870,020	£2,805,774	£3,490,386

Discussion indicated that some trusts with previously high reporting rates were now classed as poor or even nil returners. There could be various reasons for this, not least that trusts did not feel they were getting anything useful back from the NJR and that they would not be 'punished' if they did not comply. This attitude was likely to change with: (a) the launch of NJR StatsOnline; (b) the forthcoming development of standard reporting to stakeholders.

MB asked that there be a focus on low compliance trusts in FY 2005/06. BD agreed that this activity should be incorporated into the Business Plan.

BD asked that the Business Plan be amended to include confirmation that the launch of the 2nd Annual Report at the BOA Congress would devote 30 mins to the clinical and professional elements of the NJR (in a presentation by PG). The patient element – which is very important – would be addressed via a press release that morning. This had been agreed previously and the Business Plan should reflect it. BD also asked that the NJR Centre more clearly identify targets for the reporting period.

[Action 2005/21] (a) There being a focus on low compliance trusts in FY 2005/06 should be incorporated into the Business Plan. (b) The Business Plan should be amended to include confirmation that the launch of the 2nd Annual Report at the BOA Congress would devote 30 mins to the clinical and professional elements of the NJR (in a presentation by PG). (c) Minor errors pointed out by SC members

NJR Centre

	should be corrected. (d) Targets should be more clearly identified in the Business Plan. AS indicated that ODEP intended to write to NICE supporting their decision not to review Hip guidance at present providing they endorse the work of ODEP. ODEP would include a statement in their submission encouraging hospitals to comply with the NJR. It was agreed that a parallel letter should be sent by the NJR. **[Action 2005/22]** NJR Centre to draft a letter to send to NICE on behalf of PG / BD. JvdM questioned the cost of the RAC team for 2005/06 and suggested the Committee should consider evaluating the cost-effectiveness of RAC activity. BD stated that the decision regarding the cost of the RAC team had been made at a previous NJRSC meeting. FD reminded those present that additional information clarifying the breakdown of costs relating to provision of the expanded RAC team had been appended to the minutes of the January 2005 SC meeting. AEAT had also provided further supporting information to the satisfaction of the DH. This could not be circulated further due to it containing commercially sensitive details. JvdM continued that the Business Plan should be reviewed in relation to costs involved. FD pointed out that CM had provided comments on some SC papers just ahead of the meeting. CM believed that the RAC team is a very valuable asset to the NJR but considered that an independent evaluation of the RAC role and their future activities should be carried out. AEAT supported such an evaluation being conducted. **[Action 2005/23]** NJR Centre to meet DH to discuss logistics for carrying out an evaluation of the RAC role. Discussion broadened out to consideration of how the functioning, value and success of the NJR might be assessed now – perhaps to define baselines and benchmarks – and in the future. It was agreed that, following an initial meeting between the NJR Centre and DH, a further meeting should be set up that also involves BD and PG. **[Action 2005/24]** NJR Centre to arrange an initial meeting between NJR Centre and DH, and a further meeting also involving BD and PG to consider how the functioning, value and success of the NJR might be assessed now and in the future. CM had advised that the NJR consider take a stand at the NHS Confederation Conference in June 2005. As every NHS CEO and Chair attend the conference – and the number of Chief Executives that know about the NJR is still low – having a presence at the Conference could be very worthwhile. It was agreed that the NJR Centre should follow up CM's suggestion, although it may be too late to secure a stand for this year. BD warned that the costs of stands might be high. **[AEAT 2005/25]** NJR Centre to follow up potential attendance at the NHS Confederation Conference in June 2005. JM suggested that the NJR could include information in publications such as Saga magazine, which is widely read by over 50s. RM and BD added that the Health Service Journal is another outlet to be considered, perhaps for publicity related to the 2nd Annual Report or the launch of stakeholder reporting.	**NJR Centre** **NJR Centre/DH** **NJR Centre** **NJR Centre**
8	**The NJR Reporting Strategy and its Implementation – NJRSC (05) 12** MPi introduced this paper by firstly referring to a handout of the presentation, the slides are shown (shaded). Key discussion is included at relevant points.	
	Stakeholder Survey **Patients and public**	

- Local Probus Group
- BOA Patient Liaison Group

Hospital Managers
Surgical Profession
RCC Network
Government bodies

- PASA
- ODEP
- MHRA
- DH

Suppliers

MPi advised that a Stakeholder survey had taken place between November 2004 and February 2005, using various means. The patients and public groups were contacted through meetings, whereas hospital managers and the surgical profession were the subject of mailings. The February RCC Network meeting included a workshop session to obtain members' views, as did a Suppliers Day in December 2004. The views of PASA, ODEP, MHRA and the DH were obtained via meetings.

The survey showed that Stakeholders' requirements tended to be similar:

Requirements

Procedure numbers

- Total
- Hospital
- Type
- Implant type/brand
- Technique

Outcomes

- Implant type/brand
- Patient group
- Hospital
- Indication

Patient procedures

- PKI

MPi added that the NJR had not been collecting data long enough to show the outcomes details requested.

MPi advised that consideration had been given to the details required for standard stakeholder reports. Proposed draft report templates (as included in the paper) are also included at Appendix 2 of these minutes for completeness. It is envisaged that these reports will be available via the NJR website and / or the NJR data entry system subject to required security and password access being put in place. MPi further advised that consultation with surgeons would be necessary to agree a format for surgeon reports that supports appraisal.

GN commented that he was familiar with reporting from 8 international orthopaedic registries and believed the report templates were a very good summary of what is provided elsewhere.

Action Plan

May ~ July

Development of standard reports

- Initial feedback from stakeholder groups
- Call for participation in trialling

July ~ September

Trialling and further development

- Awareness raising via website and mailings
- Review of surgeon requirements

	➢Publication of Annual Report **October** Launch of standard quarterly reporting	
	PG continued that the proposed surgeons' report template should be presented to the RCC Network and then priority be given to agreeing the format and quickly commencing providing the information. TW agreed as he said that the expectations of surgeons had been raised that information would be provided and he was concerned how much longer they would be prepared to wait. FD pointed out that the current timetable for provision of reports covered three forms of standard reporting: (a) Report template for total numbers of joint replacement procedures per hospital / Treatment Centre; (b) Report template for implant usage per hospital / Treatment Centre; (c) Report template for brand usage in England and Wales. Each of these would have variations depending on end user – e.g. for (c), suppliers would receive reports relating to usage of their implants only. PASA / MHRA would receive reports for all suppliers. While inclusion of reporting to surgeons was a priority, there would be cost and resourcing implications if it was to be delivered in parallel to the other forms of reporting described. FD also considered that delaying any other work already committed to (e.g. delivery of barcode reading facility) could adversely affect hospitals' perceptions of the NJR. **[Action 2005/26]** NJR Centre to determine cost, resource and timeframe implications for standard reporting including reports to surgeons. Details to be submitted to the DH. [Post-meeting note: NJR Centre staff will be meeting MPo in w/c 9 May to determine a first draft template for surgeon reporting that takes account of appraisal requirements. The next meeting of the RCC network (24 May) will include review of the template.]	**NJR Centre**
9	**The NJR –Data Integrity Audit process – Review of Pilot – NJRSC (05) 13** RC introduced this paper by firstly referring to a handout of the presentation, the slides are shown (shaded). Key discussion is included at relevant points.	
	Background to this Paper •Proposed audit process was outlined in the paper "The NJR Data Effectiveness Audit- Overview" •Steering committee requested the piloting of: –the proposed site visit process –self assessment audit –an SHO led audit of medical records	
	Audit Tools •Audit form •Targeted fields data - Details values submitted by the unit for particular data fields in MDSv2 – Audit report- contains recommendation plus review dates	
	RC advised that the targeted fields data gave RACs the ability to foresee issues that units might have, for example, why they are excessively using the 'override' option or recording overseas surgeons incorrectly.	
	Self-Assessment Audit •**Pros** - Perceived to be less threatening	

	- Convenient option for hospitals **•Cons** -Some audit forms not returned -Some units experienced difficulty **•Suitability** - Units that have good submission rates, consent rates, quality data (as detailed by the target fields report) and where the RAC has had recent and good contact	
	RC advised that 15 self-assessment audit forms had been sent to units and that 5 had been returned to date. PG challenged the assumption that self-assessment could currently be considered an appropriate audit option for *any* hospitals when this was based on such a low number of responses and a 33% return rate. PG believed that it was too early for the pilot to provide sound findings to the SC. He requested that work should continue and a report regarding the pilot be submitted to the July SC meeting. BD agreed. FD pointed out that reporting back in July would allow inclusion of aggregated (anonymised) findings from the audits and early outcomes, thus giving preliminary indications of the value of the Data Integrity Audit process. **[Action 2005/27]** RACs to continue audit pilot and NJR Centre to report back to the July SC meeting, including aggregated (anonymised) findings from the audits and early outcomes, thus giving preliminary indications of the value of the Data Integrity Audit process. RC was asked to continue with the presentation, although its contents should be viewed as interim findings to date	**NJR Centre**
	Site Visit Audit **•Pros** –Unit is appreciative of a visit –Face to face contact is vital to improving compliance –Elicit more information than a stand alone self-assessment audit –Many issues can be resolved on the day of the visit –Reinforces the RAC-unit relationship **•Cons** –None reported during the pilot phase **•Suitability** –It is considered that all units would benefit from this type of audit	
	Self-assessment Prior to Visit **•Pros** –Time for preparation –Unit is appreciative of a visit –Face to face contact is vital to improving compliance –Elicit more information than a stand alone self-assessment audit –Many issues can be resolved on the day **•Cons** –None reported during the pilot phase **•Suitability** –All units would benefit from this type of audit	
	SHO Audit **•Pros** –None reported **•Cons** –Not available in the independent sector –Difficult to initiate –No forms have, as yet, been returned –Does not fully investigate the NJR process	

	–Cost to the unit in SHO time and the retrieval of case notes •**Suitability** -All units that use patient case notes to obtain the information to input into the NJR data entry system	
	Feedback From NJR Users •Most units were agreeable to audit and saw it as an opportunity to review their practice and benefit from good practice elsewhere •All units involved in the audit pilot have been grateful for feedback received	
	Recommendations •The most beneficial audit process involves sending the unit the self-assessment questionnaire prior to site visit •There may be instances where the RAC decides that a unit is suitable for a self-assessment audit alone •It is not recommended that SHO audits be routinely performed •It is suggested that the routine frequency be increased to an annual audit for the majority of units -The benefits to the unit and NJR has been highlighted in the pilot phase -NJR processes can break down with staff changes/sickness –Expansion of the RAC team, coupled with an adjusted workload that emphasises audit activity, now allows increased frequency of routine audits	
	Further discussion continued with MN questioning whether it was necessary for all units to have an annual audit. JH responded that each unit should have an initial audit that would set a baseline. Further audits should be carried out on a proportionate basis – e.g. high levels of compliance and NJR patient consent rate, plus timely submission of records may indicate that a unit only needs to be audited every 2 or 3 years. TW added that there was no point in auditing for the sake of auditing and that it must prove to be useful as the exercise is costly. As no SHO audits had been submitted to date, BD questioned the value of pursuing this option. JM was supportive of SHO audits and would encourage SHOs in her area to assist the NJR Centre in this way. PG asked JvdM and AM if they had any concerns about the audits to which AM replied that some type of sampling process might be preferable as there would be a high cost involved in auditing all units. JvdM advised that an alternative would be to use HES data more rigorously – are all procedures captured?, how many missing values are there? MPi reminded the meeting that the overall aims of the Data Integrity Audit process were for hospitals to look at their own NJR processes and how they might improve them, and to identify and share good practice. BD brought the discussion to a close by stating that no definitive decisions could be reached at the meeting. Discussion would re-open at the July SC meeting.	
10	**The NJR Research Sub Committee – Update on progress and activities – NJRSC (05) 14** JvdM introduced this paper by advising that the current work programme was: 1. Identification of priority areas for research 2. Developing a programme of research 3. Developing protocols for requests for access to NJR data (where NJR funding is not being requested) FD pointed out that the NJR RSC's intention was that a contractor be employed for 2 to 3 months (May to July) to consult with both SC members and the wider	

	stakeholder community. The responses received would be passed back to the NJR RSC for prioritisation. The tight timescale was required if the NJR RSC's aim of publishing its 'NJR research strategy and priorities' document in parallel with the BOA Congress (mid September 2005) was to be achieved. FD sought the advice of SC members present regarding identification of someone suited to this role who would be available at short notice. The consensus of the meeting was that it would not be possible to fill this post on the desired timescale. JvdM advised that he could put his unit forward for this work if funding were made available. He believed the work should not be divided between different researchers. GN put forward the view added that this was not the way such research should be carried out, that researchers from relevant fields should be invited to complete the work and that two months was not sufficient time for completion. **[Action 2005/28]** NJR Centre / DH / JvdM to review how to take this work forward in an appropriate manner whilst minimising delays to the proposed delivery schedule of the NJR RSC.	**NJR Centre / DH / JvdM**
11	**Any Other Business** ***Italian contact – COST project*** FD said that the NJR Centre had been contacted by Roberto Giardino (University of Bologna). This was on behalf of Prof. Rolando Barbucci, General Coordinator of the COST project Action 537 "Core Laboratories for the Improvement of Medicine Device in Clinical Practice from the Failure of the Explanted Prostheses Analysis (FEPA)". At their last meeting, the Opinion Leaders of the Orthopaedic Implants Working Group suggested that the NJR be invited to join the project. An invitation to a meeting in Bologna on 30 June 2005 was sent. FD forwarded the email for consideration to BD, PG and the DH. She also contacted Gerold Labek, Co-ordinator of the European Arthroplasty Register to see if he was aware of your project as the reference to: '*the Working Group will discuss the possibility of organizing a European Register on Orthopaedic Prostheses and retrieval analyses*' sounded as if it might overlap with EAR's activities. GL has since been in email contact with RG, suggesting a meeting at the EFORT Congress in Lisbon in June, if he or any of his co-workers are intending to be there. **Action 2005/29]** FD to contact RG and inform him that, at this stage, the NJR will not be joining the COST project action. However, we would be interested in hearing how the project progresses. ***Time of next SC meeting*** FD advised that the next SC meeting - on Monday 18 July - would start at 11.00. This was to allow a NOPAG meeting to be held on the same day, starting at 9.00. An Editorial Board meeting would be held following the SC meeting, starting at 14.30.	**NJR Centre**

Sue Mercer / Fiona Davies

NJR Centre

9 May 2005

APPENDIX 1 PROGRESS ON ACTIONS FROM PREVIOUS MEETINGS

2004/214B	**Ongoing** NJR Centre to investigate whether the related data entry (visiting overseas surgeons) to the NJR system is carried out in the correct manner. **Details of this activity were provided in s1.4 of the FY 2004/05 Q3 Management Report (for the January 2005 SC meeting). The pilot of the Data Integrity Audit process includes examination of related data entry.**	**NJR Centre**
2004/223B	**Completed (see outcome of Action 2005/28 on page 5 of April 2005 SC meeting draft minutes)** BD to contact North and East Yorkshire and Northern Lincolnshire SHA regarding the situation at Harrogate Healthcare Trust. **BD reported back on progress at the January and April SC meeting.**	**BD**
2004/205	**Ongoing** NJR Centre and MPo to work up a full set of questions from the set provided by John Timperley, draft answers and circulate to the SC for review. **The NJR – ownership, access to data & associated issues – NJRSC (05) 05 – was circulated to SC members and JT in advance of the January SC meeting. Some SC members have provided comments as requested. Revision of the paper is on hold while FD prepares a paper on a number of information - related issues that require consideration by Departmental solicitors.**	**NJR Centre/ MPo**
2005/001	**Ongoing** NJR Centre to ensure that the draft minutes of the first NOPAG meeting are circulated to all members of the NJR SC. **Draft minutes of the first NOPAG meeting to be circulated to all NJR SC members.**	**NJR Centre**
2005/005	**Completed** Departmental solicitors were currently determining the legal status of the NJR. JH will advise SC members of the outcome of this activity, as well as provide confirmation on the Welsh and independent sector elements of the surplus. **JH will advise SC members at the April 2005 SC meeting on the legal status of the NJR. The issue of surplus funds is addressed in the NJR Financial Report (NJRSC (05) 09), which is an agenda item at the April SC meeting.**	**JH**
2005/012B	**On hold** Taking account of comments received under Action 2005/212A, NJR Centre to revise paper NJRSC (05) 05 and submit to the April SC meeting. **Some SC members have provided comments as requested. Revision of the paper is on hold while FD prepares a paper on a number of information - related issues that require consideration by Departmental solicitors.**	**NJR Centre**

APPENDIX 2 – PROPOSED STAKEHOLDER REPORT TEMPLATES

ANNEX 1

Annex 1A: Example Report template for Total numbers of joint replacement procedures per Hospital / Treatment Centre

Hospital name: ……. Reporting period: …….
NJR patient consent rate …….. %

Procedure type	Hips	Knees
Primary conventional hip		N/A
Primary resurfacing hip		N/A
Revision hip		N/A
Primary knee	N/A	
Revision knee	N/A	
TOTALS		

Notes

One table per hospital / Treatment Centre

Target Group All stakeholders with variations

Annex 1B: Example report template for implant usage per Hospital / Treatment Centre

Hospital name: ……. **Reporting period: …….**

Implant type	Brand	Supplier	Numbers used
Cemented hip stem	**Charnley** **…..**	**De Puy** **…..**	
Cemented hip cup	**OGEE** **…..**	**De Puy** **…..**	
Cementless hip stem	**Cfit** **…..**	**Corin** **……**	
Cementless hip cup	**Dcfit** **……**	**Corin** **……**	
Hip resurfacing prostheses	**BHR** **…..**	**Smith & Nephew** **…..**	
Total condylar knee	**Kinemax Plus** **…..**	**Stryker** **…..**	
Unicondylar knee	**Oxford** **…..**	**Biomet** **…..**	
Patello-femoral joint	**Leicester** **…..**	**Corin** **…..**	

Notes

One table per hospital / Treatment Centre
Implant Type is hip / knee component: replacement / resurfacing
Brand is manufacturer's product name / description
Example data included in table for illustrative purposes

Target Group Some stakeholders with variations

Annex 1C: Example report template for brand usage in England and Wales

Reporting period: …….

Supplier	Implant type	Brand
De Puy **…..** **…..**	**Cemented hip stem** **…..** **…..**	**Charnley** **…..** **…..**

Hospital	Number used

Notes

Implant Type is hip / knee component: replacement / resurfacing
Brand is manufacturer's product name / description
Item / Product number is supplier's code number
Example supplier / implant type / brand entry for illustrative purposes
For each supplier, reports would be prepared for each brand within each implant type

Target Group Suppliers would receive reports relating to usage of their implants only. PASA / MHRA would receive reports for all suppliers