National Joint Registry
www.njrcentre.org.uk

NJRSC (O5) 06 Final

NATIONAL JOINT REGISTRY STEERING COMMITTEE

MINUTES

Meeting: Steering Committee meeting Date: Monday 24 January 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)
	Christine Miles	CM	Royal Orthopaedic Hospital (representing NHS Trust management)
	Andy Crosbie	AC	Medicines and Healthcare products Regulatory Agency (MHRA)
	Colin Thomson	CT	All Wales Community Health Councils (patient group representative
	Christine Edwards	CE	Arthritis Care (patient group representative)
	Mark Noterman	MN	Department of Health
	Judith Hind	JH	Department of Health
	Fiona Davies	FD	AEA Technology (contractor)
	Dominic Worsey	DM	National Assembly for Wales

The following AEA Technology staff were also present:

Leigh Mapledoram	LM	NJR Programme Manager
Sue Mercer	SM	NJR Project Administrator
Ian Calcutt	IC	NJR IT Manager
Claire Newell	CN	NJR Data Quality Manager
Martin Pickford	MPi	NJR Orthopaedic Adviser

Apologies:	Ken Bateman	KB	Smith & Nephew Healthcare Ltd (representing the orthopaedic device industry)
	Andy Smallwood	AS	NHS Purchasing and Supply Agency
	Chris Dark	CD	BUPA Hospitals (representing the independent sector)

Item	Welcome and Introductions	Action by
1	BD welcomed all attendees to the meeting, especially those for whom this was their first Steering Committee meeting. New members of the SC present were Mark Noterman (policy) and Judith Hind (NJR contract manager – temporary) both representing the Department of Health, and Dominic Worsey, representing Welsh Assembly Government. Round the table introductions followed. Apologies had been received from Ken Bateman, Andy Smallwood and Chris Dark.	
	Matters arising Before moving on to the main business of the meeting, BD advised those present that he wished to bring them up to date with developments in relation to outlier surgeon and hospital performance. He summarised discussion that took place under agenda item 2a at the November 2004 SC meeting and the creation of NOPAG, the (NJR Outlier Performance Advisory Group). The expanded remit of the group – as compared to the remit originally envisaged – meant that representation now included MHRA, those representing the orthopaedic surgical profession on the NJR SC, orthopaedic implant suppliers, and the Department of Health, with the NJR Centre providing the secretariat function. Unfortunately, it had not been possible to hold the initial meeting in advance of the January SC meeting as had been hoped for. The meeting was now scheduled for Wednesday 26 January. In preparation for the meeting, the NJR Centre had investigated, amongst other issues, the current situation with regards to data submission to the NJR from Treatment Centres generally, and data submission from Treatment Centres / hospitals in relation to lead surgeons that are visiting the UK from overseas. BD had written to Lord Warner on 7 January on these issues but also highlighting that the most common problem encountered is the patient consent issue. Differing interpretations have been placed on the wording of the relevant minimum care standard[1], A20.6, which states: 'There are written policies and procedures to ensure that surgeons comply with the National Joint Registry.' There appears to be a need to expand the current wording to cover electronic submission of all required data to the NJR, embedding the NJR patient consent process within organisations' existing systems and processes, and assigning responsibilities in an unambiguous manner. MB queried whether the remit of NOPAG extended to implant performance. BD confirmed that it does, although the initial focus of attention should be on agreeing a procedure with the BOA whereby the NJR provides a way of highlighting higher than usual readmission rates after surgery, as previously requested by Lord Warner. Tackling the patient consent issues outlined earlier was also an immediate priority. PG pointed out that consideration of implant performance could not be divorced from surgeon performance. As statistical issues play an important role, JvdM asked whether NOPAG membership included statistical expertise. Currently, it did not. [Post-meeting note: JvdM tabled a draft paper on use of continuous monitoring techniques to evaluate joint prostheses at the Editorial Board meeting following on from this SC meeting. He was then asked to give an associated presentation at the NOPAG meeting.] BD stressed the importance of the full SC being aware of, and engaged in, the work of NOPAG. To support this, the draft minutes would be circulated all SC members.	

[1] Department of Health Independent Health Care National Minimum Standards Regulations, February 2002. Regulation A20.6 is on page 67.

	[Action 2005/ 001] AEAT to ensure that the draft minutes of the first NOPAG meeting are circulated to all members of the NJR SC.	**AEAT**
2a	.**Progress on actions** An update of progress on actions had been circulated in advance of the SC meeting. Where actions linked to items later in the agenda, related discussion was deferred. FD raised two Actions where she wished to inform the SC of developments and request their views. ***Action 2004/212A – Developing an NJR response to the Healthcare Commission consultation*** Since the November SC meeting, the Commission had published a range of consultation material, as described by the following extract from their web site. 'The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England. We are currently developing new ways of doing this, in partnership with practitioners and health service managers. But we need your input! We would like to hear your views on specific areas of our work - including the elements, prompts and evidence we use to assess whether the Government's standards* (National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 - 2007/08 - July 2004) are being met, as well as how we will carry out our annual assessment of each healthcare provider in England in order to produce performance ratings. We have prepared a range of consultation materials outlining our suggested new approach. - The document 'Assessment for improvement' outlines our strategic approach. - The document 'Understanding the standards' outlines the suggested elements, prompts and evidence that could be used to show how well a provider is meeting the standards. - The patient/public summary provides a summary version of our approach - drawing together the information that is directly applicable to patients and the public.' The NJR now had potentially closer links to the Commission via MN, who is a member of the Department of Health's Standards and Healthcare Commission relations team. FD sought MN and the SC's views regarding whether the NJR should respond to the consultation exercise, or if direct liaison should take place with the Commission. MN confirmed that he considered it appropriate for the NJR to respond to the Healthcare Commission consultation. Those present agreed. The focus should be on informing the Commission of the data being collected by the NJR that could be used by hospitals to support their self-assessments demonstrating that they are meeting the proposed core standards laid down by the Commission. This same data could also potentially be accessed by the Commission to verify self-assessments. The final set of criteria should be ready by early April 2005, with trusts having to complete self-assessments by September. BD asked that FD produce a submission for the Healthcare Commission consultation, with support and input from other SC members as appropriate. **[Action 2005/002 – Superseding Action 2004/212A]** FD to write a submission to the Healthcare Commission consultation, with assistance from other SC members as appropriate. ***Action 2004/190 - "Criteria Standards and Evidence document" (CSE)*** This document, titled *Guidance on Surgical Practice – Criteria, Standards and Evidence* was published on the Royal College of Surgeons web site in January 2005. It can be accessed via:http://www.rcseng.ac.uk/surgical/career_grades/csecpd/index_html FD indicated that an outstanding action was for SC members to decide whether there is a need for the NJR to produce an additional but complementary statement. **[Action 2005/003 – Superseding Action 2004/190]** SC members should advise whether they consider there is a need for the NJR to produce an additional but	**FD/SC members** **All SC**

	whether they consider there is a need for the NJR to produce an additional but complementary statement to the new RCS *Guidance on Surgical Practice – Criteria, Standards and Evidence*. Views should be emailed to FD by **Friday 11 March.**	**members**
2b	**Approval of minutes – NJRSC (04) 29** FD advised that Item 2a of the draft minutes had erroneously stated that a meeting arranged between David Carter and Welsh Assembly Government had been cancelled due to ongoing reorganisation within WAG. The meeting had been cancelled at short notice due to lack of availability of key NJR Centre staff. The minutes would be amended to reflect this. With this amendment, the draft minutes were approved. **[Action 2005/004]** FD to amend the draft minutes of the Nov 2004 SC meeting to correctly reflect the reason for cancelling the planned meeting with Welsh Assembly Government. Approved minutes to be posted on the NJR web site.	**AEAT**
3	**Quarterly Management Report – NJRSC (05) 01** FD introduced this paper advising that this was the last quarterly management report to be completed in the current format. Future reports will be more comprehensive – thus decreasing the number of separate papers needed for SC meetings. They will have a format that prevents repetition, and include reporting on progress against the Implementation Plan. BD asked if there were any issues regarding the current report, to which PG requested an update on progress relating to the Patient Reported Outcomes Measurement Studies (PROMS). MPi advised that quotes were currently being obtained from organisations that could be subcontracted to cover the more routine elements of the survey such as mailout, scanning returns and running preliminary analyses. It was expected that Questionnaires would be distributed by mid February. The PROMS Advisory Group would next meet on 1 February 2005. The questionnaire would be reviewed by Group members at that meeting. AM and JvdM confirmed that they are members of the Group. [Post-meeting note: Following the February meeting of the PROMS Advisory Group, questionnaire distribution is scheduled for the first week of March.]	
4	**NJR Financial Report – NJRSC(05) 02** JH introduced this paper by first advising of a slight error in the calculation of VAT under para 5. The correct figures proposed for FY2005/06 are: NJR Element - £19.57 VAT - £3.43 Administration element - £1.70 VAT - £0.30 Total - £25.00 JH advised the meeting that the DH finance branch had informed her that surplus funds at the end of 2004/05 could not be carried over to 2005/06. She was currently in discussion with finance branch about refunding elements of the surplus to the Welsh NHS and independent sector. There will be little cost to the DH in arranging refunds. JH continued that DH solicitors were currently determining the legal status of the NJR. **[Action 2005/005]** 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. There followed considerable discussion regarding what would happen to unspent	**JH**

	funds at the end of March 2005 and whether any work planned for FY2005/06 could be brought forward. Key points of this discussion were: • JH confirmed that appropriate proportions of unspent funds would be returned to the Welsh NHS and the Independent Sector. There would be little cost involved in arranging this. • JH advised that the possibility of surplus funds should be taken into account when fixing the levy, and that a levy of £25 for 2005/06 will cause a further surplus to be generated. • All agreed that the NJR programme needs to learn from the experience of the first two years of levy collection and ensure that the programme of activity for Year 3 is planned and monitored to ensure that the level of unspent funds at year end is low. (JH reminded SC members that the programme may not run at a loss so it is necessary to plan for a small surplus.) • JH confirmed that all work completed and invoiced within FY2004/05 would use levy funds collected in the current financial year. Therefore if any work planned for FY2005/06 and approved by the SC could be brought forward this could make use of unspent funds. Also, any new activities that would contribute to the aims of the NJR, and could be completed and invoiced in the current financial year could be considered. BD requested that SC members should e-mail their suggestions to FD for consideration by BD/PG and the Department. • JM commented that Welsh trusts were considerably behind England in terms of IT infrastructure and support and asked if it would be possible for Wales to be given assistance in this area. JH replied that central funding of IT equipment, IT support and administrative support (e.g. for data entry) could not be considered. All hospitals should be treated equally; any distribution of unspent funds over all NJR-related hospitals would result in a sum per hospital that would result in minimal impact. Also, most hospitals have managed to comply with the requirements of the NJR within their existing budgets. They would be unhappy to see late compliers receiving financial assistance and a drop off in their compliance levels could be expected. • CM asked for confirmation that the option of funds being carried over had been fully pursued and suggested that it might be beneficial to contact Richard Douglas, NHS Director of Finance and Investment. BD indicated that he would contact Richard Douglas, although he felt sure that the answer would be negative. BD believed that it would be better if the NJR programme could be advanced, subject to SC approval, so that funds were not lost from it. **[Action 2005/ 006]** SC members to email FD any suggestions for appropriate spend of levy funds in 2004/05, e.g. bringing forward activities planned for FY2005/06. FD informed the meeting that LM was coordinating production of a business plan for NJR activity and expenditure in FY 2005/06. BD requested that the business plan be completed and submitted to the April 2005 SC meeting for endorsement. **[Action 2005/007]** AEAT to prepare a business plan for NJR activity and expenditure in FY 2005/06. First external draft to be submitted to DH for review. Revised draft to be circulated in advance of the April 2005 SC meeting. AC queried the costs related to provision of the RAC team, as indicated in the financial report. LM pointed out that this amount covered costs additional to	**All SC members** **AEAT**

	salaries. BD asked that AEAT provide the required detail outside of the current meeting. **[Action 2005/008]** Clarification on the breakdown of costs relating to provision of the expanded RAC team was required. [Note: This information is provided in Appendix 1.]	**AEAT**
5	**NJR Statistics Report (Reporting Period: 5 January 2004 to 2 January 2005) – NJRSC (05) 03** CN introduced this paper stating that this was the first statistics report for a 52 week period, that the reporting period was from 5 January 2004 to 2 January 2005 and that over 100,000 records had been submitted during this timeframe. CN summarised that patient consent for this reporting period was 62.1% although patient consent for the last two months had reached 70%. CN asked for agreement for consent figures to be broken down into monthly rates as this would give a clearer picture of the current position and trends. This was agreed. PG expressed concern over the December 2004 figures but CN assured him that the lower level of records submitted was due to the Christmas holiday period and that a similar decrease had occurred at the same time the previous year. JM commented that the number of surgeons registered at some hospitals (Table 6: Summary of Registrations) appeared high and asked if surgeons of all grades were included. CN advised that all surgeon grades are included. Some numbers may be incorrect as, unless the Hospital Data Manager removes the names of surgeons who have moved away from their hospital, their names would remain associated to the hospital. This is a particular concern with SpRs who rotate around different hospitals. CN indicated that this an issue that the proposed audit process (see agenda item 7) would investigate and seek to rectify. JM also questioned how a hospital could have submitted over 100% of its HES data comparison figure, as is the case for some hospitals. CN confirmed that the HES data used for comparison was for the period 1 April 2002 to 31 March 2003 (HES year 2002/03). Therefore, where hospitals were carrying out more NJR-related operations in 2004 than in the period April 2002 to March 2003, the comparison percentage would be greater than 100%. There was discussion centred on the validity of using this 'historic' HES data for comparison purposes. MPi believed that comparing 2004/05 data for the whole of England to 2002/03 HES data gave a good picture of the current position, although comparison at an individual hospital level is not consistently representative. FD pointed out that 2003/04 HES data (i.e. for the year 1 April 2003 to 31 March 2004) will be used for the next NJR Statistics Report. She also pointed out that, as part of preparing data for the 2nd Annual Report, all hospitals and Treatment Centres will be sent summaries of their 2004 data entry to the NJR, along with HES (PEDW in Wales) comparator figures. It was expected that some hospitals would challenge the figures reported and, where justified, this would be accepted and acknowledged in NJR reporting. Discussions are ongoing relating to appropriate comparator figures for use in the independent sector. MB reminded the meeting that he had liaised with Chris Dark (BUPA, representing the independent sector) regarding the possibility of the independent sector agreeing to provide their NHS /non-NHS THR and TKR volume data to the NJR Centre in confidence for aggregation. This would allow determination of a baseline for compliance measurement as well as allowing estimation of the THR volume being done in trauma settings. Alternatively, there could be investigation of obtaining this information from suppliers. **[Action 2005/009]** From the April 2005 SC meeting, the SC Statistics report will	**AEAT**

	include a monthly breakdown of consent rate, so that trends can be seen more readily. The report will also name those hospitals that say they are waiting for bulk upload to be introduced before submitting data. Progress at each of these hospitals will be summarised.	
6	**IT Update** IC provided a verbal update, covering 5 main areas. ***Bulk Data Upload Facility*** The bulk data upload facility has been developed, tested internally and pilot testing was being carried out by Bluespier, York District General Hospital, James Paget Hospital, Nottingham City Hospital and Ashford Hospital. Norfolk & Norwich University Hospital have since requested the possibility of being included in the pilot testing and are in communication with Lee Sims, NJR IT Project Manager. The process for hospitals to come on board is on track and by the April SC meeting it is expected that data will be being submitted through the Bulk Upload live system. ***Facility for HDMs to enter a Surgeon Default Technique*** This function is now in place and should greatly reduce hospitals' 'edit stacks'. ***Bar Code Reader Facility*** The next step in development of the bar code reader facility is to visit suppliers and set up 'mini' systems, which will need to link in to the overall application. Following this, the bar coders will be purchased. ***PKI*** The variation order related to PKI is now in place. Work is on track for July 2005 completion, although this is to a tight schedule. ***Closure of MDSv1*** Currently, MDSv1 is still available to those users specifically requesting that they need access to input outstanding data. IC advised that the phasing out of MDSv1 is now necessary to maintain a robust IT system. He would like to see closure of MDSv1 within a 2-3 month period, to which the Committee agreed. Communications would be planned to ensure that hospitals have sufficient notice of the closure of MDSv1. MB asked what would happen to the MDSv1 data awaiting bulk upload. IC reminded SC members that bulk data upload was being developed for use on MDSv2 data only. This had been made clear to hospitals in a series of communications. **[Action 2005/010]** Phased closure of access to MDSv1 is to take place by 31 March 2005. This timescale will allow for necessary changes to the IT system, linked communications with hospitals, and sufficient time for those hospitals that are currently dealing with backlogs of MDS v1 proformas to complete this activity. Linking to earlier discussion, FD commented that once bulk upload was available, hospitals that have given this as their reason for non-compliance would be contacted and monitored to ensure compliance is reached.	**AEAT**
7	**NJR Data Effectiveness Audit – policy into practice – NJRSC (05) 04** CN introduced this paper and summarised that the aims of the proposed 'NJR Data Effectiveness Audit' were: • Overall, to assess the effectiveness of the data that a unit submits to the NJR	

	• to check the robustness of the processes within each unit to ensure complete submission of quality data • to initiate improvement to existing processes in units, to increase data effectiveness MPo questioned whether the audit process took into account data validation; it was important to look at both quality and accuracy. MPi pointed out that there is a need to look at individual data sets, but what was being described was auditing of processes and procedures. CN indicated that a more in-depth audit could be undertaken if initial findings indicated this was necessary. MPo suggested that sampling the data for accuracy could be carried out by referring to patient notes. CN queried whether NJR auditors (predominantly RACs) would have the authority to access such notes. MPo advised that a clinician (probably a SHO) would refer to the patient's notes (having previously informed the surgeon who completed the procedure that this process was taking place) and compare them to the data recorded within the NJR and held by the NJR visiting RAC. This is along the lines of standard practice for hospital internal audit, whereby patients' notes are compared to the hospital's electronic recording of surgery undertaken. The Committee agreed that 'NJR Data Integrity Audit' was a more appropriate descriptor than 'NJR Data Effectiveness Audit', and this term would be used in future. JvdM considered the planned audit process would involve an enormous amount of work. He suggested that the process should be made much simpler and more targeted. FD advised that hospitals participating in the NJR were expecting to be audited and CN added that the aim of the audit was not to 'mark' hospitals but to develop good practice processes which could be spread to other units whose procedures were less robust. CM suggested that it may be more appropriate to allow hospitals to carry out a 'self assessment' of their data and then their RAC could visit to compare conclusions. TW believed that an apparently 'good' NJR record should not preclude a unit being audited. For example, a unit may declare they have 100% patient consent, but do their systems and records support this? CN indicated that the form of audit process proposed would result in each unit being visited on a 2 year cycle, unless there were reasons to audit particular units outwith the usual cycle. There was a consensus that the NJR Centre should take note of comments made and run a pilot set of audits, reporting back to the April 2005 SC meeting on findings, lessons learned etc. Discussion concluded with BD requesting that this item be added to the agenda for the next RCC Network meeting (1 February 2005). **[Action 2005/011]** The paper on *The NJR Data Effectiveness Audit*, along with key points discussed at the SC meeting, should be circulated to RCCs and added to the agenda of the 1 February 2005 RCC network meeting.	**AEAT**
8	**The NJR – ownership, access to data & associated issues – NJRSC (05) 05** FD introduced this paper firstly by reminding the Committee of the original questions asked by John Timperley, RCC for the South West Peninsula. He had requested that the Committee provide answers as, by doing so, JT felt that many of the concerns expressed by the surgical profession would be allayed.	

	• Who has access to the data? • Who can ask for information from the Registry? • Who interprets the data and collates a report? • What is the mechanism by which the data will be agreed (and checked for validity by the Profession) and released? • Will all data coming from the Registry be seen by the Steering Committee and by the RCCs? A further question 'Who owns the data' had since been added to this list. As requested by the Committee, this paper broke down these high level questions into a more precise set of questions. There was only time for limited discussion, mainly centred around whether feedback should first be obtained from the RCC network before the paper was considered fully by the SC. It was agreed that, since a member of the RCC network had asked the questions, it would be inappropriate for the RCCs to debate this matter first. AM and JvdM felt that some of the lower level questions were not relevant to the original request and queried inclusion of questions where fully formed answers could not yet be given. BD clarified that the paper had gone beyond the original questions asked and that this expansion was of value to the NJR. Further debate resulted in BD determining that SC members should review the current paper and forward their comments to the NJR Centre to allow a revised paper to be submitted to the April SC meeting. Consideration should be given to whether a two-part format might be appropriate. **[Action 2005/ 012A]** SC members to review paper NJRSC (05) 05 – *The NJR – ownership, access to data and associated issues* – and send any comments by email to FD **by Friday 11 March**. **[Action 2005/ 012B]** Taking account of comments received under Action 2005/212A, AEAT to revise paper NJRSC (05) 05 and submit to the April SC meeting.	**AEAT** **AEAT**
9	**AOB** There was insufficient time to discuss the issue of poor compliance – where it is still occurring, actions taken, and further steps required. This will be addressed in the FY2004/05 Q4 Management Report. **[Action 2005/213]** An item relating to poor compliance – where it is still occurring, actions taken, further steps required – will be included in the FY2004/05 Q4 management report.	**AEAT**

Sue Mercer / Fiona Davies

NJR Centre

25 February 2005

APPENDIX 1

Cost of provision of Regional Audit Coordinators (RACs)

Variation Order 18 covers the extension to the contracts of the 4 RACs currently employed by AEA Technology plc. These fixed term contracts have been extended to end on 31 March 2006. The total time extension (for the 4 RACs) is 33 months as the RAC contracts originally ended at different times in the 2005/06 financial year (depending on when their individual contracts started). The total value of VO18 amounts to £308,760.63 including VAT, or £262,775 excluding VAT. Therefore the cost of one RAC per year is £95,555 excluding VAT.

Variation Order 17 covers the recruitment of two new RAC. For the financial year 2005/06 the cost per RAC is £98,091 excluding VAT. This figure is slightly higher due to the higher salary anticipated to be paid to the successful candidates.

This cost includes:

- The salary of the RAC at the current market rate
- Additional National Insurance costs payable by AEA Technology plc
- Company pension costs payable by AEA Technology plc
- An overhead charge to cover business costs associated with employing an individual
- A Car allowance
- Travel and Subsistence costs

The RAC consultancy rate excluding T&S and car allowance is between £410 and £420 per day.

The actual salary that an individual receives and the cost structure of AEA Technology plc is commercial information and therefore further details cannot be given.

It should be noted that a fifth member of the current RAC team was an existing employee of AEA Technology plc and a member of the NJR Centre team from the start of the NJR project. Therefore, their costs are not included above.

APPENDIX 2 PROGRESS ON ACTIONS FROM PREVIOUS MEETINGS

Action no.		Action holder
2004/212A	**Superseded by Action 2005/002** ***(placed at January 2005 SC meeting)*** AEAT to co-ordinate developing an NJR response to the forthcoming Healthcare Commission consultation.	**AEAT/SC**
2004/214B	**Ongoing** AEAT 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. Corrective actions continue to be made and ongoing monitoring of the situation will be required.**	**AEAT**
2004/216	**Ongoing** Following the RSC meeting currently scheduled for 10 November, a paper to be circulated detailing the RSC's intended mode of operation, draft Terms of Reference, and the case for funding (if any levy funding was expected to be allocated to funding appropriate research). A timeline should be included in the paper. **Following the SC meeting on 2 November 2004, discussion between BD, HL (Dept of Health), JvdM and FD indicated that it would be beneficial if the administrative functions of the RSC and its future operations could be undertaken by the NJR Centre. This would free up RSC members' time to concentrate on those elements that require their expertise, including prioritising research ideas, evaluation of applications received and (in the future) assessing research output. The NJR Centre is continuing to determine proposed logistics, including potentially 'ring fencing' an element of levy funds for allocation to approved research purposes. The next RSC meeting is scheduled for 18 March. A progress report will be included in the FY2004/05 Q4 Management Report.**	**JvdM / AEAT**
2004/217	**Ongoing** AEAT to obtain quotes from organisations that could be subcontracted to cover the more routine elements of the interim patient reported outcomes survey. CD and MB to provide names / contact details of potential subcontractors. **See minutes of January 2005 SC meeting, under agenda item 3.**	**AEAT/CD /MB**
2004/218	**Ongoing** HL to explore whether the NJR can be treated as a special financial case, thus allowing levy monies held by the Department at year end to be carried over to the next FY. **Initial reporting back on this action occurred under agenda item 4 (NJR Financial Report) at the January 2005 SC meeting (see minutes).**	**HL**
2004/219	**Completed** AEAT to explore whether any novel funding mechanisms that they have experience of may be appropriate to apply to functioning of the NJR in the future. **AEAT had reported back to the Department of Health.**	**AEAT**
2004/223B	**Ongoing** 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 2005 SC meeting. He would maintain contact with the Trust to ensure that agreed actions were undertaken.**	**BD**

PROGRESS ON ACTIONS FROM PREVIOUS MEETINGS

2004/190	**Superseded by Action 2005/003** ***(placed at January 2005 SC meeting)*** (a) FD to confirm with Hugh Phillips the timescale for publication of *Guidance on Surgical Practice – Criteria, Standards and Evidence*. (b) FD to request copies to circulate to SC members, when the document is published (or in advance if possible). (c) AEAT / SC members to determine whether there is a need for the NJR to produce an additional but complementary statement. **(a) and (b) completed. (c) reframed as Action 2005/003 at the January 2005 SC meeting.**	**AEAT/ SC members**
2004/205	**Ongoing** AEAT 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 2005 SC meeting. See follow-on Actions 2005/012A and 2005/012B, agreed at the January 2005 SC meeting.**	**AEAT/ MPo**