National Joint Registry
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NATIONAL JOINT REGISTRY STEERING COMMITTEE (NJRSC)

MINUTES

Meeting: NJR Steering Committee **Date:** 29th April 2015
Location: Princes Gate Room, RCGP, 30 Euston Square, Euston, London, NW1 2FB

Members Present:	Laurel Powers-Freeling	LPF	Chair
	Martyn Porter	MPo	NJR Medical Director
	Prof Mark Wilkinson	MW	Public Health & Epidemiology Representative
	Mary Cowern	MC	Patient Representative
	Nick Wishart	NW	Orthopaedic Industry / Manufacturer Representative
	Rob Hurd	RH	NHS Management Representative
	Colin Howie	CH	President, BOA
	Michael Green	MG	Orthopaedic Industry / Manufacturer Representative
	Robin Rice	RR	Welsh Government Representative
	Matthew Porteous	MP	Chair, RCC Committee
Attendees:	Elaine Young	EY	Director of Operations-NJR, HQIP
	Richard Armstrong	RA	Programme Director, Northgate
	Mike Swanson	MS	NJR Principal Consultant, Northgate
	Rebecca Beaumont	RB	Senior Communications Officer-NJR,(HQIP)
	Saskia Dean	SD	Executive Assistant-NJR, HQIP
	Khalid Razak	KR	Medicines and Healthcare products Regulatory Agency (MHRA)
	Andy Smallwood	AS	NHS Procurement Representative
	Prof Tim Briggs	TB	Lead, Getting It Right First Time (GIRFT)
	Prof Ashley Blom	AB	Bristol
	Jane Ingham	JI	CEO, HQIP
Apologies:	Keith Tucker	KT	Orthopaedic Surgeon
	Sue Musson	SM	Patient Representative
	Dr Jean-Jacques de Gorter	JJ	Independent Healthcare Sector Representative
	Peter Howard	PH	Orthopaedic Surgeon
	Prof Andrew Price	AP	Orthopaedic Surgeon
	Eve Riley	ER	Research Officer-NJR, HQIP

REF	ITEM	ACTION
1	**Welcome and apologies for absence** LPF opened the meeting and welcomed those present. Apologies were noted. LPF explained that it would have been Keith Tucker's last meeting as an NJRSC member but he could not attend. She expressed thanks for his significant contribution to the NJRSC. EY added that KT would remain involved in NJR activities by representing ODEP/Beyond Compliance at the Implant Performance/Scrutiny Committees and with UDI/Component Database work until the summer. LPF also explained that JJ De Gorter had decided to step down from the NJRSC. EY introduced Jane Ingham, CEO - HQIP, to those members who had not yet met her.	
2	**Minutes of the previous meeting held on January 29th 2015** The minutes of the previous meeting were approved.	
3	**Business Update** 3.1 Private Healthcare Information Network (PHIN) EY reminded the NJRSC that it had been agreed in principle to share a certain level of information (Part 4 of the NJR Annual Report) with PHIN and in return, the NJR would receive information about the independent sector (PHES data). The BOA had liaised between the NJR, specialist societies and PHIN, and although there were concerns about the cost structure, governance and general transparency of PHIN, it had been confirmed that PHIN were legitimately authorised to collect data. JI explained that PHIN had not expressed interest in obtaining data from any other HQIP audits. PHIN had requested that a data sharing agreement be finalised with the NJR and EY sought member's opinions about this given the length of time this issue had been on the agenda. Concerns were raised about the: • funding/charging structure of PHIN and risk of double-charging surgeons/hospitals for data; • possibility of NJR being responsible for new/extra data management, e.g. outlier mechanisms; • data governance if the data was not anonymised - MW explained that the 2 datasets could be anonymised but 3rd party linkage should be considered - he suggested HQIP be considered; • legal implications if the data was being sold/bought, as specific consent would be required - MW suggested the data should be transferred rather than bought/sold. **Action: Develop questions for PHIN to determine what data exactly PHIN want, how PHIN will use the data, how PHIN will be funded and charge, and the various responsibilities associated with the data sharing agreement.** 3.2 Member Induction LPF and EY explained that member induction/training would be planned when the new NJRSC members had been officially appointed. 3.3 Patient Engagement EY explained that Patient Engagement was meant to be a standing agenda item, but had not been included on this agenda as no topic suggestions had been received. Members were encouraged to make suggestions. **Action: Suggest issues/topics for Patient Engagement agenda item.**	**NJR / BOA** **LPF/EY** **All**
4	**HSCIC: NJR Data Access - HES/PROMs** EY explained that NJR had met with HSCIC in February to present the implications of not receiving HES/PROMs data from HSCIC on the NJR Annual Report, compliance figures for the BPT and other NJR activities. They had updated HSCIC on development of the NJR Research Portal, and discussed NJR Research applications and projects. The meeting was positive and HSCIC had agreed to fast-track the NJR's data access application. However, since the meeting, EY had not heard from HSCIC and her messages had gone unanswered. JI explained that other HQIP audits were in the same position, and that the NJR was included in all HQIP's weekly correspondence and negotiations with HSCIC to try to renew data access. The issue had been escalated with NHSE and Bruce Keogh was due to meet Carl Vincent, Director of Finance and	

	interim Director of Information and Analytics, HSCIC, and JI would also meet with HSCIC on May 11th to try to progress matters. LPF added that she had a meeting with Bruce Keogh and would consider discussing the matter with him too. MS added that Northgate had also been working hard to contact HSCIC but that it had become increasingly difficult to reach anyone. EY confirmed that latest news was that the NJR's data request was next to be processed by HSCIC. EY noted that the NJR had contributed to a BOA contribution on the problems of not having access to data from HSCIC to a Health Select Committee evidence session and had been invited to attend a follow up workshop hosted by the Welcome Trust and HSCIC for researchers affected by the delays with data access. She would arrange NJR representation (likely to be one place). **Actions:** • **Maintain communications with HSCIC about data access;** • **Arrange NJR representation at HSCIC data workshop event.**	**EY/LPF/ HQIP NJR**
5	**Outcomes Publication** 5.1 Unit Level Outcome Publication - NJR Dashboards EY confirmed that hospital dashboards went live on March 31st. Publication on NHS Choices would be finalised post election. RA presented the dashboards, using Wrightington as a case study, and highlighting some of the most significant features, which included that: • hip and knee data was shown separately; • thermometer plots displayed new indicators e.g. hospital comparisons with national averages; • hospital revision rates were published in two parts: 1) for all data, 2) for the past 5 years only; • profiles of patients treated at hospitals were now shown to compare to national averages; • information about quality of data provided by hospitals was now published i.e. compliance, patient-consent, NHS numbers, and time taken to enter data. RA expressed thanks to everyone involved in the development of the dashboards, especially MP. Members praised the dashboards, but requested explanatory text related to revision rates to preferably show on the data charts not in a separate section. RA/RB/EY agreed that the dashboards were a work in progress, and that these textual amendments would be made. **Action: Make surgeon titles consistent and include information about compliance for revision rates on dashboards.** TB confirmed the NJR and GIRFT dashboards would dovetail and that GIRFT sub-groups would liaise with stakeholders to ensure this. RH added that GIRFT dashboards would be for Trusts (not patients) and would not be public in the first instance. It was discussed that improving revision reporting would be included and members agreed that this was also a priority of the NJR. It was noted that the Department of Health, GIRFT sponsors, would set up relevant data sharing and governance agreements. TB added that publishing revision rates for infected joint replacements would be a priority to drive infection rates (and related costs) down. Members agreed that both these developments would be positive, as long as information was distributed at individual level. The extent of under-reporting of revision for infection was discussed. RH pointed out that improving revision reporting generally would be part of the GIRFT project. **Action: Liaise with NJR about dashboards in order to avoid duplication** 5.2 Consultant Outcomes Publication (COP) 2015 It was noted that there was an expectation for 2015 that audits included in COP should increase the indicators against which they reported. MPo drew attention to the NJR delivery of unit level outcome data in the form of dashboards in March, which had been a significant achievement, and also current work to implement an NJR Data Quality Strategy and national data validation audit, which should be seen as a priority before any further surgeon level data, in particular revision rates, were published. It was agreed that any further extension of COP had to be relevant to patients and based on good quality data. JI confirmed the NHSE-wide shift towards 'team-based' and 'patient-meaningful' data. MPo explained that he and Peter Kay had met with NHS Medical Director Prof. Sir Bruce Keogh, to discuss these issues, which had also been documented in the NJR response to the HQIP COP guidance. A response from both was awaited.	**N'gate** **GIRFT**

	It was noted that the NJR was considering potential additional indicators to be offered for the 2015 COP (i.e. individual compliance rates) as it was agreed that not complying/entering data was a problem and should be published. CH supported the excellent work the NJR was undertaking with outlier management, both at unit and individual surgeon level, and suggested that as a leader in this field, this should be highlighted to raise awareness. **Actions:** • **Discuss COP 2015 with BK/NHSE at upcoming meeting with him;** • **Seek feedback from NHSE and HQIP on outcome of meeting/COP consultation;** • **Agree COP 2015 indicators;** • **Consider raising profile of NJR work with outlier management.**	**LPF** **MPo** **NJR** **NJR**
6	**NJR Accredited Provider Scheme** EY and RA presented the revised proposal to deliver an NJR Accredited Provider Scheme to link with the launch of the Data Quality Strategy and promote hospitals with good NJR compliance. Eligible Trusts would receive a published logo on their Trust profile. Currently 92/139 Trusts would be eligible based on the BPT compliance threshold of 85%. It was envisaged that this would support other NJR criteria i.e. data quality validation and subscription payment. It was agreed to approve the proposal in principle with revisions. **Agreed/Actions: To approve the proposal in principle but replace the term 'Accredited' with suggested 'Quality NJR Data Provider' and ensure clarity (especially for patients) that the standard related to 'data quality' not 'care quality' . Revised details to be circulated to members before the next NJRSC.**	**NJR/ N'gate**
7	**Upgrade of NJR Component Data Base** <u>7.1 Update on International Collaboration</u> Members noted from MPo an update on on-going international discussions, where collaboration with European registries had been mutually beneficial and was being extended to America and Australia. <u>7.2 Upgrade of NJR Component Data Base</u> RA presented details on progress with the upgrade the NJR Component Data Base, the objective was to categorise implants more specifically - in alignment with international classification systems, in order to improve implant performance monitoring and provide greater granularity of implant results. It would be possible to report on the old classification system and the new in parallel. Northgate and Bristol were working to determine the associated reporting and analysing of data outputs. MHRA confirmed this upgrade would be of significant benefit to regulators. Industry members also supported the upgrade, but felt there would have to be careful international harmonisation, and carried a risk that less-resourced companies would be less able or willing to comply. With regard to expressed concern about on-going costs, RA assured the allocated budget was underwritten as complete, so any additional costs would be taken on by Northgate. **Agreed: To support the proposal with attention paid to: ensuring such granular, 'small' data was meaningful; managing the governance of industry uploading and classifying information.**	**N/gate**
8	**Patient Implant Cards** MS updated on the survey undertaken by Survey Monkey/email where possible (Northgate had 11,500 email addresses) and paper-based questionnaires where not. Associated costs were being finalised.	

9	**NJR Strategic Plan 2015-2018 and Annual Plan 2015-2016** EY presented the Strategic and Annual plans for approval. She explained that indicative budgetary figures were given in the Strategic Plan where available. **Agreed: The Strategic Plan 2015-18 and Annual Plan 2015-16 with following development:** • **review of prioritisation of objectives as per NJR workshop;** • **timelines (including interrelated dependencies) in the Strategic Plan;** • **costs in the Strategic Plan.**	
10	**NJR Communications Plan 2015-2016** RB presented the Communications Plan, highlighting messaging to different stakeholders using effective tools such as regional events, Facebook, twitter and e-bulletins and further plans to develop these. Other work included improvements to website content, a focus on case studies to demonstrate the use of NJR to deliver outcomes, continued collaboration with the BOA and specialist societies, exploring the use of new formats (e.g. e-books), wider dissemination of the Annual Report PPGs and raising awareness of NJR with different audiences i.e. GPs. RH enquired about Trust communication and attention was drawn to further development of the NJR RCC network and plans to recruit Trust 'NJR Clinical Leads'. LPF thanked RB for this overview and the work. **Action: Liaise when drafting communications targeted at different levels within Trusts.**	**RB/RH**
11	**Finance** <u>11.1 2014-2015 Provider Subscription Update</u> EY reported an improved subscription position, but noted a continued problem with non-response from Trusts in London and the North-West. It was felt that non-payment was most likely due to internal administrative delays, especially where Trusts merged/changed, rather than active refusal to pay. Options to deal with non payment were discussed, but it was agreed that some caution was necessary. MP enquired if this could be supported by BPT. EY explained that the DH had been reluctant to alter BPT measures for this year, but NJR would continue to pursue. JI confirmed that NJR payment recovery rates mirrored the rest of the HQIP audit programme, as did the time/administrative resources taken to obtain payments. HQIP were in discussion with NHSE about potential ways to improve recovery rates, but were unable to take stronger measures for the moment. LPF noted that she would raise the issue with BK at their upcoming meeting. **Agreed:** • **TB and MPo to support follow up of non paying Trusts in London and the North-West;** • **Discuss subscription non-payment with BK.** <u>11.2 2015-2016 Provider Subscription Update</u> EY reported Trusts had been notified of their 2015-2016 subscription and 2014/15 non payers reminded that their previous years subscription remained outstanding. Information had also been provided about the new, optional/additional NJR 'EMBED Price Benchmarking Service'. RA presented details of 'EMBED', where Trusts could subscribe to the NJR in return for detailed price benchmarking reports which EY confirmed would provide a new income stream for the NJR. TB explained a post-GIRFT letter regarding disparity in implant pricing was to go to all Trusts and could potentially include reference to NJR Price Benchmarking, as this work was excellent and would make a meaningful difference. Concern was expressed that Trusts might not be in a position to change procurement practice and surgeons may be pressurised about implant use. TB and RH stressed this was essentially about transparency, benchmarking and value for money. <u>11.3 NJR Finance Report Q4</u> EY asked the NJRSC to note the report. <u>11.4 Operational Budget Plan 2015-2016</u>	**MPo/TB** **LPF**

	EY presented the draft 2015/16 Operational Budget Plan. LPF noted a movement of reserve funds, mainly because pending projects were coming on stream in this financial year. She confirmed the plan would continue to be developed and consideration should be given to a 3 year Operational Budget Plan. **Agreed: The Operational Plan for 2015/16 with further development to identify capital and on-going costs, clarify investments being capitalised and present expenditure forecasting for presentation at the next NJRSC meeting.**	**EY/HQIP**
12	**Update from NJRSC Sub-Committees**	
12.1	**NJR Executive Committee (NJREC)** The minutes of the previous meeting were received and noted.	
12.2	**Medical Advisory Committee (MAC)** The minutes of the previous meeting were received and noted. MPo reported that the MAC was fulfilling its role of keeping professional leaders informed and involved with NJR work. This was supported by CH who confirmed increasing professional confidence in the NJR.	
12.3	**Data Quality Group** **i) Meeting** The minutes of the previous meeting were received and noted. **ii) NJR Data Quality [DQ] Strategy** EY confirmed the appointment of Carol Harrison as Project Manager on a fixed term part time basis, to oversee implantation of the DQ validation programme. MPo reported completion of the DQ pilot and production of the 'toolkit' ready for wider implementation. It was noted that RCCs and RCs would be a key NJR resource to assist with the work, but it was also the intention to recruit a network of NJR clinical leads in every Trust to assist with local liaison. It was agreed that the NJR should also include local presentations as part of the communication strategy. JI suggested that the NJR define what success would look like. Members agreed this should include: recruitment of an NJR Clinical Lead in each hospital, engagement of all hospitals in the audit, quantifying the quality of the data, validation of at least one year of data, reduction of under-reporting, removal of systematic errors, and reduction in variation. **Agreed to:** • **Define short, medium & long term goals and 'success' for the DQ Strategy;** • **Develop a series of workshops and visits (national and regional);** • **Provide progress reports about the DQ Strategy roll-out at each NJRSC meeting.**	**DQ Group**
12.4	**Editorial Board:** The minutes of the previous meeting were received and noted.	
12.5	**Research Sub-Committee (RSC):** **i) Meeting** The minutes of the previous meeting were received and noted. MW reported: • Appointment of a new NJR Research Fellow, Tanvir Khan; • Production of a publication on the NJR Research Strategy for submission to the Journal of Trauma and Orthopaedics and possibly Arthritis Care and Arthritis Research UK publications; • Data governance in relationship to HQIP's Data Access Review Group (DARG). JI explained that HQIP was data controller on behalf of NHSE for the whole of NCPOP, and thus needed assurance on data access/sharing. The focus of DARG was data governance and ethics, not clinical/research appropriateness, so broadly speaking DARG would manage information governance whilst the NJR would manage data sharing. MW noted that the NJR RSC wanted	

	to streamline processes to avoid duplication with the DARG and minimise time delay between a project being approved and actually being granted access to the data. JI responded that DARG would work with the NJR to align the project application paperwork, then the NJR RSC could approve or reject applications before DARG made a final decision based on an information governance check. **ii) NJR Annual Data Build, iii) Development of a Research Data Base and Portal** MW explained that Bristol was working on the MDS, which was being transferred from Northgate. The aim was to have one single 'flat' MDS in the future. This would make the processing of handling of research data requests smoother, simpler and safer, which in turn would reduce the risks of information governance. Estimated delivery time was 6 months and the business case was being updated for consideration by the NJREC.	**MW**
12.6	**Regional Clinical Coordinators' Committee** The minutes of the previous meeting were received and noted and MP was welcomed as the new RCC Committee Chair. He explained that RCC membership was under review and further recruitment would be undertaken to re-new and expand regional membership, adding that this and re-defining the role of RCCs to reflect their lead with DQ Strategy work, would strengthen the Networks function and purpose. He also suggested that RCCs with expertise or interest in particular NJR agendas may be considered for other sub-committee membership. **Agreed: To progress development of the RCC Network**	**MP/EY**
12.7	**Outlier Sub-Committee (Surgeon Data)** The minutes of the previous meeting were received and noted.	
12.8	**Implant Performance & Scrutiny Sub-Committees** There had been no meetings since the last NJRSC meeting. Thanks were again expressed to KT who ended his term as Chairman.	
13	**Quarterly Statistic Report Q4 [1st January to 31st March]** The QSR was received and noted.	
14	**Quarterly Management Report Q4 [1st January to 31st March]** The QMR was received and noted. LPF urged members to take the time to look at the QSR and QMR.	
15	**NJR Meeting Schedule 2015** The NJR Meeting Schedule 2015 was received and noted.	
16	**Any Other Business** <u>16.1 Minimum Numbers</u> CH suggested NJR consider publishing numbers of types of procedures surgeons perform, anonymised per unit, to show a unit's practice and service delivery. **Agreed: To consider publishing numbers of types of procedures surgeons perform, anonymised per unit.** <u>16.2 Chair- Appointment</u> LPF announced that she had been offered the position of Chair of Sumitomo Mitsui Bank, but would continue to Chair the NJR.	**NJR**
17	**Next Meeting** Tuesday, 21st July 2015, RCGP, 30 Euston Square, London.	