National Joint Registry
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NJRSC (O4) 19

NATIONAL JOINT REGISTRY STEERING COMMITTEE

MINUTES

Meeting: Steering Committee meeting Date: Thursday 15 July 2004

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

Present:	Paul Gregg	PG	Acting Chair in Bill Darling's absence
	Ken Bateman	KB	Smith & Nephew Healthcare Ltd, ABHI (representing the orthopaedic device industry)
	Jan van der Meulen	JM	Royal College of Surgeons (representing the surgical profession)
	Alex MacGregor	AM	University of East Anglia (representing public health and epidemiology)
	Christine Miles	CM	Royal Orthopaedic Hospital (representing NHS Trust management)
	Martyn Porter	MPo	British Hip Society
	Chris Dark	CD	BUPA Hospitals (representing the independent sector)
	Colin Thomson	CT	All Wales Community Health Councils (patient group representative)
	Andy Crosbie	AC	Medicines and Healthcare products Regulatory Agency (MHRA)
	Martin Jones	MJ	Arthritis Care (patient group representative)
	David Forsythe	DF	Stryker UK Ltd (representing the orthopaedic device industry)
	Tim Wilton	TW	British Association for Surgery of the Knee
	Fiona Davies	FD	AEA Technology (contractor)

The following AEA Technology staff were also present:

David Carter	DC	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:	Bill Darling	BD	Chair
	Mick Borroff (deputy attended)	MB	Depuy International Ltd, ABHI (representing the orthopaedic device industry)
	Andy Smallwood	AS	NHS Purchasing and Supply Agency
	Stephen Chamberlain	SCh	National Assembly for Wales

Item	Welcome and Introductions	Action by
1	PG, acting as Chairman in Bill Darling's absence, welcomed all attendees to the meeting, and in particular Martin Jones the new representative from Arthritis Care. PG announced that it was with regret that Hugh Phillips' resignation had been received. However, the Steering Committee congratulated him on his appointment to the Presidency of the Royal College of Surgeons. PG suggested that the Committee should write to Hugh Phillips thanking him for the time and effort he had given to his Steering Committee role as well as for his considerable input to the initial scoping of a national joint registry for England and Wales. **[Action 2004/187]** AEAT to arrange for a letter to be sent to Hugh Phillips on behalf of the Steering Committee thanking him for all his efforts and wishing him well in his Presidency of the RCS. **[Action 2004/188]** AEAT to contact David Adams to initiate the process of the BOA selecting a replacement representative.	**AEAT** **AEAT**
2a	**Progress on actions** Appendix 2 incorporates updates and progress on actions. The following actions were discussed. (Note: New actions arising are indicated in bold type.) Action 2004/169: FD advised that the action to produce a guide for SHAs to assist them in their evaluation of submitted Clinical Governance Development Plans would be dealt with at item 3. Action 2004/173: This action, relating to apportionment of NJR funds would be considered at item 12. FD raised the subject of the forthcoming initial meeting of the NJR Research Subcommittee on 27 July 2004. She asked that consideration be given to a member of NJR Centre staff providing secretariat functions to the meeting. This was agreed. **[Action 2004/189]** David Carter to act as an observer and minute taker at NJR Research Subcommittee meetings. [Post-meeting note: Debbie Warren – the NJR Centre Deputy programme manager took on this role at the July meeting.] Action 2004/182: With regard to the "Criteria Standards and Evidence document" (CSE) that the RCS are developing, Hugh Phillips had advised that there is an RCS Senate meeting in w/c 19 July at which this document would be considered. PG asked the Committee whether they felt the CSE document should be sufficient to encourage surgeon compliance with the NJR and therefore that a further statement from the BOA / RCS would not be necessary.	**DC**

	MPo felt that the CSE document paired with a statement from the BOA / RCS would better help compliance. TW advised that it would be better to wait until the CSE document was completed and available. Then, if it was considered insufficient to encourage compliance with the NJR, provision of an additional statement should be considered. PG closed the discussion by saying that the Steering Committee would revisit this matter following the publication of the CSE document. **[Action 2004/190]** (a) FD to confirm with Hugh Phillips the timescale for publication of the CSE document. (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.	**AEAT / SC members**
2b	**Approval of minutes – NJRSC (04) 09** The Committee approved the minutes of the April 2004 SC meeting with no amendments. They would be placed on the NJR website.	
3	**Quarterly Management Report – NJRSC (04) 10** DC introduced this paper and asked if there weere any questions. As no questions were raised, DC went on to advise that Appendix B of the Quarterly Management Report was a copy of a letter recently sent from Regional Clinical Co-ordinators to Chief Executives (copied to Clinical Directors) at all NHS Trusts, Independent Hospitals and Treatment Centres. The letter provided them with a summary of data that had been submitted to the NJR by their hospitals between 1 April 2003 and 31 May 2004. KB asked if there had been many replies to this mailout. DC responded that to date there had been 4 or 5 replies to RCCs, RACs and himself, all of which were of a positive nature. FD advised that there had been one or two hospitals that questioned the accuracy of the figures provided. Again, this was a positive development as it led to hospitals comparing their internally held data against that submitted to the NJR, with the intention of rectifying any discrepancies. AC asked if the letter had gone to all trusts and if there was any method of ensuring that all Treatment Centres (TCs) and hospitals were included in the NJR. DC replied that the National Implementation Team has to notify the NJR of new TCs. PG suggested writing to the team on a quarterly basis for confirmation that all notifications were up-to-date. DC agreed. With regard to ensuring that all relevant hospitals were captured and included in the NJR system, it was decided that the NJR could write to the Healthcare Commission for information. This could be supplemented by requesting that prosthesis suppliers advise when new TCs or hospitals start purchasing hip and knee implant components.	

	[Action 2004/191] (a) AEAT to send a list of TCs to the National Implementation Team every 3 months, asking them to verify which are operational, and whether there are any to add, and any to remove. (b) AEAT to facilitate writing to the Healthcare Commission notifying them of the NJR and its requirements and requesting that they inspect against NJR requirements and notify the NJR when they do so. (c) AEAT to request that prosthesis suppliers notify the NJR Centre when a new hospital / TC starts purchasing hip and knee components. DC further advised that Appendix C of the Quarterly Management Report was a copy of a letter sent to Clinical Governance leads at Strategic Health Authorities and Welsh Health Boards regarding NJR inclusion in Clinical Governance Development Plans. DC continued that SHAs should pass these details to their trusts. CM advised that she had not received any comment from her SHA. MPo told the meeting that the NJR had an opportunity to produce an article for inclusion in the British Orthopaedic News (BON) regarding compliance. PG indicated that BON was published twice yearly. It was a good place to include articles about the NJR as it is read by many surgeons. **[Action 2004/192]** AEAT to prepare an article for inclusion in the next issue of BON (deadline 30 July). MPo and TW to be consulted about the topics to be covered.	**AEAT** **AEAT**
4	**NJR Finance Report** A Finance Report had not been submitted to the meeting as Paul Woods, the original Department of Health representative on the NJR Steering Committee, had new responsibilities within the Department. PG advised that Bill Darling had spoken to Lord Warner regarding Paul Woods' replacement but had been advised that currently there was no nomination for this role. PG expressed the view of the meeting that the situation was unsatisfactory and needed to be resolved as a matter of urgency. MPo queried how full operation of the levy system could continue to operate satisfactorily in the absence of a Department representative. DC advised that a colleague of Paul Woods had temporary delegated powers to ensure that NJR monies continued to be collected and reported, as well as to make the required payments to the NJR contractor. CM advised that there would be significant increases in levels of THR and TKR procedures to be completed in FY 2005/06 to meet reduced waiting time targets. This could impact on the level of the levy to be set. **[Action 2004/193]** "Determining the levy for FY 2005/06" to be added to the October SC meeting agenda.	**AEAT**

5	**NJR Statistics Report (Reporting Period: 29 March 2004 to 27 June 2004) – NJRSC (04) 12** ***Headline statistics*** CN introduced this paper by firstly advising that 88% of all hospitals had entered at least one operation onto the NJR system and that 72% were returning MDSv2 data. As Data Quality Manager, CN manages the team of Regional Audit Co-ordinators; currently they are concentrating their time and effort on helping hospitals to clear the backlog of MDSv1 information (both paper proformas and records that are in the MDSv1 edit stack) and transfer over to use of MDSv2 by the 15 August 2004 deadline. CN also advised that overall about 59% of all THR and TKR procedures carried out since 1 April 2003 were registered (calculated against numbers of levies collected), although this figure had risen to 77% for the last 4 weeks of the reporting period. TW noted that this higher figure of 77% could be due to the fact that hospitals were clearing the backlogs of MDSv1, but PG continued that the registry was moving in the right direction. ***Compliance and the annual report*** In terms of further encouraging compliance, FD pointed out that hospitals would be listed in the 1st Annual Report as follows: (1) Hospitals that had submitted data – by 31 March 2004 - for operations carried out between 1 April and 31 December 2003 inclusive (2) Those hospitals not included in (1) but that were compliant by 30 June 2004 (3) Those hospitals not compliant by 30 June 2004 ***Trauma surgery*** A discussion then followed on whether consideration should be given to including Trauma cases within the scope of the NJR. FD clarified that the NJR had originally been set up to include only elective surgery, although trauma (though not trauma surgery per se, as performed in A&E situations) could be selected as an indication for primary total hip or knee procedures or revision procedures. The choice of trauma options that can be selected as indications has been widened in MDSv2. TW felt that total joint replacement due to trauma should be fully included in the NJR remit, whereas MPo believed that priority should be given to elective surgery at present, although trauma cases could perhaps be recorded in the future. TW pointed out that trauma surgery used NJR-levyable components. DF mentioned that trauma products such as cable and mesh are uploaded onto the NJR system. [Post-meeting, IC verified that some suppliers had chosen to upload at least some of their trauma products onto the NJR system, although this was not a requirement of the NJR. This was largely due to it being easier to upload complete product ranges rather than selecting sub-sets. If a hospital contacts the NJR Centre to register trauma products as missing components they are reminded that trauma product data is not required and the request is cancelled. Including trauma products would in fact	

	more than double the size of the component database.] It was agreed that information available to hospitals should be checked to ensure that it is clear to users entering data what procedures and components should / should not be included in the NJR. PG continued by saying that it was necessary to re-emphasise that A&E trauma surgery was not recorded on the NJR at present and suggested that this was communicated through the website and newsletter articles. There are concerns that there is some level of misunderstanding and possible entry of non-NJR data. PG said that the NJR needed to consult with RCCs to obtain their views on whether, in the longer term, there was a case for A&E trauma surgery to be included in the NJR. **[Action 2004/194]** (a) AEAT to liaise with RCCs and members of the SC regarding whether current information - relating to the NJR and the situation with respect to trauma – is clear enough, available and well promoted. (b) A discussion item should be added to the agenda for the next RCC meeting relating to whether RCCs feel there is a case for A&E trauma surgery to be included in the NJR. (The outcome of this discussion would be fed back to the next SC meeting.) ***Data backlogs*** CN advised that 100 hospitals were not yet submitting data to MDSv2 , although it was believed that many hospitals were making their priority the clearing of any backlog of MDSv1 submissions ahead of 15 August. CN added that another issue that the SC needed to be aware of was the fact that 65% of the outstanding records in the edit stack had patient consent – this equates to 2000 operations that patients expected to be registered on the NJR. Obviously this figure does not include the many paper proformas stored in hospitals from which no data has yet been entered into the NJR – an unknown number of these will have patient consent. PG said that if the operations which had patient consent were not fully entered into the NJR, then the NJR had failed to deliver. He questioned whether assistance could be given with the input of outstanding information. FD responded that the SC could agree to apportion NJR funds for this purpose but that such action would cause resentment in the majority of hospitals that had already achieved this through their own considerable efforts. CT echoed the sentiment that, as patients had been given the choice whether or not their full operation details (ie including strong identifiers) should be registered on the NJR, they would be very disappointed if they were to find that no details at all were recorded. ***Future format of SC Statistics report*** CN asked for agreement that statistics in future should be provided for the previous 52 week period rather than since 1 April 2003, as this would give a clearer picture of the current situation. **[Action 2004/195]** SC Statistics Report to introduce a 52 week running total from the October 2004 report onwards. ***Surgeon default techniques*** MPo believed that a high percentage (approximately 85%) of the records	**AEAT** **AEAT**

	in the edit stack were there due to problems with surgeons not entering their default techniques. He asked if administrative staff could be allowed to enter these techniques into the NJR system. He also asked what would happen to records remaining in the MDSv1 edit stack when hospital access to MDSv1 closed on 15 August 2004. In relation to the MDSv1 edit stack, IC said that technically there was no problem in keeping this open beyond 15 August, although the ability to enter new MDSv1 records would be closed on that day. The meeting agreed that this approach should be taken and clearly communicated to hospitals. (Following 15 August 2004, any hospitals that hold details for operations carried out between 1 April 2003 and 31 May 2004 inclusive, recorded only on MDSv1 proformas, and that wish to submit the data to the NJR will be required to apply for permission via the NJR Helpline. Decisions will be made on a case-by-case basis.) **[Action 2004/196]** MDSv1 edit stack to be kept open beyond 15 August but the ability to enter new MDS v1 records to be closed, as previously agreed, on 15 August 2004. IC advised that, with IT development, it would be technically possible for Hospital Data Managers (HDM) to enter default techniques on behalf of surgeons. FD emphasized the importance of surgeons taking "ownership" of their default techniques. Thus, they would be required to sign and date a printed version of the default techniques entered into the NJR system on their behalf, to verify the accuracy of the data. This would need to be kept on file in a similar manner to patient consent forms, and made available as required for future audit. Because of the urgency of tackling the edit stacks, addressing alternative ways of getting default techniques into the NJR system should be a priority task. MPo added that it would be the responsibility of the surgeon to advise the HDM of any necessary amendments to their default techniques. In addition, surgeons would be contacted on an annual basis to review their NJR registered default surgical techniques and either verify that they remained correct or update them. As MDSv2 was introduced in April 2004, the first review would be undertaken in Spring 2005. **[Action 2004/197]** AEAT to develop outlines for one (or perhaps more) approach to enabling HDMs to enter surgeons' default techniques, cost the approach(es) and determine timeframe(s). To be submitted for approval when ready (i.e do not wait until October SC meeting).	**AEAT** **AEAT**
6	**IT Update, including the case for Implementing a Public Key Infrastructure System (PKI) on the NJR – NJRSC (04) 13** ***IT update*** IC said that work had been carried out to improve CSV downloads of surgeons' own data so that the system is more "user friendly". Work is ongoing on developing the bar code reading facility, although the Committee were advised that what appears to be a straightforward project is quite complex. The overall timeframe is affected by factors such as each supplier having a different standard of bar coding, and	

	needing to be set up one after the other on the NJR system rather than in parallel. Work on developing bulk upload is continuing. Users who have shown interest in bulk upload have been emailed requesting information regarding the technology they are currently using. Following replies from this mailout, the NJR will create a test environment for bulk upload. MPo asked if the information had to be sent direct to the NJR from a hospital database or through a 3rd party supplier such as Bluespier. IC replied that the NJR system would accept either option. CM added that within the next 7 years all hospital IT systems should be compatible as a result of developments under the National Programme for IT (NPfIT). ***PKI paper*** IC stressed that the paper circulated was not definitive. It was designed to provide a supporting case for asking the Committee for permission to continue with further investigation into this facility. A feature of PKI is that it would enable surgeons to download their procedures including patient detail. IC added that he had spoken to companies that could provide PKI and was of the opinion that the facility would cost somewhere in the region of £100-200k to implement, with annual maintenance costs of perhaps 10-15% of this value. These figures should only be regarded as ballpark estimates at present. TW commented that surgeons would welcome this facility whatever the cost. JvdM added that he felt there was a less expensive alternative to PKI, although data security levels would probably be lower. He referred to the system used for the National Prospective Tonsillectomy Audit. AM mentioned that other alternatives should be considered as well, eg surgeons emailing requests to the NJR Centre and being provided with CDs of the requested data. FD pointed out that the NJR was required to meet a range of security and confidentiality criteria as well as abiding by the requirements of the Data Protection Act. However, the NJR Centre would welcome assistance from SC members in looking at other possible options to PKI. **[Action 2004/198]** AEAT to carry out a scoping study on implementing a PKI security system on the NJR, including costings. Cheaper potential alternatives should also be considered, including the system used on the tonsillectomy audit, and surgeons emailing the NJR Centre and being sent CDs of their own data.	**AEAT**
7	**NJR First Annual Report – Progress Update – NJRSC (04) 14** PG introduced this paper by summarising that the 1st Annual Report would be launched by Lord Hunt at the BOA Congress on 15 September 2004. SC members would receive written invitations to a BOA banquet on the previous evening as well as to the launch on the morning of 15 September.	

	Regional roadshows FD advised that there would be an Editorial Board meeting following the SC meeting. She asked for SC views on the possibility of arranging a series of perhaps 3 or 4 regional roadshows following the launch of the report, with contributions from RCCs and RACs. The purpose would be partly to provide information to NJR stakeholders but also to listen to their views on what they would like to obtain from the NJR in the immediate future and in the longer term. MPo suggested that arranging events at a local (i.e. SHA level) might be preferable and involving a broader range of attendees – surgeons, hospital data entry staff, audit staff, patients, representatives from SHAs etc. Such events could be held on an annual basis, and have sufficient flexibility to be tailored to differing local and regional needs. PG confirmed that this matter should be debated by the RCCs at their next meeting, as their influence and contributions would be key to the success of such initiatives. **[Action 2004/199]** AEAT to add to the agenda for the October RCC meeting discussion on the suggestion of having SHA level events on an annual basis – involving patients, hospitals, SHAs etc. ***Welsh participation*** CT commented that at a recent Welsh regional meeting he had attended he had been disappointed at the lack of enthusiasm for the NJR shown by surgeons in Wales. The prevailing view seemed to be that the NJR was more for England rather than Wales. PG asked the Committee for views on what could be done to improve the Welsh contribution to the NJR. He pointed out that concerns had been expressed at the recent RCC network meeting and he had raised the issue at BOA Council. FD mentioned that RACs and the NJR Centre had put considerable effort into encouraging compliance in Wales – including training and visits – but with few positive results. The NJR Centre suggested that one option might be to appoint a new RAC to cover all of Wales, in place of the existing arrangement where two RACs each cover part of Wales as well as an extensive English region.	**AEAT**
8	**NJR Compliance, Data Quality and Completeness – A Review – NJRSC (04) 15** CN introduced this paper by advising that the first three RACs had started work in February 2004, with two further RACs taking on this role more recently. PG said that that feedback from the recent RCC meeting (which four of the RACs attended) was complimentary and results in terms of compliance rates, clearing edit stacks, conversion to MDSv2 demonstrated the benefits of employing RACs. Tackling patient consent issues takes considerable effort but as more examples of good practice are identified and shared they are making headway. There are many examples of RACs and RCCs working together to good effect. CN advised that the RACs' role would increasingly encompass audit activities. MPo stated that this was essential, while JM said there needed to be some element of crosschecking NJR-entered data against that in	

	patients' notes. From the point of view of the next (2nd) annual report, it was critical that consent rates were increased, correct and complete patient details entered (where patients gave their consent), and that strenuous efforts were made to improve the initial capture rate of (accurate) NHS numbers. Also, that routine quality checking of NJR entered data be initiated.	
9	**The NJR – Developing an "Early Warning" System** Due to time pressures, this item was initially held over to the afternoon session but subsequently it was agreed that it should be held over to the October SC meeting.	
10	**Hip: Owner's Manual – NJRSC (04) 17** DC introduced this paper by firstly circulating a copy of the Hip: Owner's Manual in its current incomplete format. PG advised that there was no further funding available from the NHSIA. The SC were being asked whether they agreed in principle to the NJR taking over the development, funding, implementation and management of the manual. But firstly, PG wanted to know whether the SC considered that the manual would benefit the NJR in terms of improving patient consent rates and compliance. The consensus was that the NJR Centre should carry out the proposed further evaluation and produce costings. AC commented that the NJR already had details of the patients' implants that need to be included in the manual. MPo added that the manual could include additional information about the NJR. CD pointed out that it would not be acceptable for the manual to be provided on a costed basis to the independent sector but free to the NHS – both the independent sector and the NHS pay the levy. The SC agreed that there should not be a cost differential between the user sectors. **[Action 2004/200]** AEAT to provide a detailed evaluation and full costings on the Hip Owner's Manual for the October SC meeting. This should include being able to demonstrate that the NJR taking on the manual would improve consent and compliance.	**AEAT**
11	**Any Other Business** **a. Decision on current participation in the European Arthroplasty Register (EAR)** PG asked for views as to whether the NJR should join the EAR at present. As no comments were raised, PG asked if anyone was in favour of joining EAR. TW said that it would be a mistake to have no connection at all with the EAR as it could be beneficial for patients if data was available on a Europe-wide basis. JM added that rather than England and Wales recording data in isolation, to work together in Europe would provide a better comparison of results. However, the majority view was that the NJR should remain firmly focussed at present on getting things right in England and Wales. PG concluded the discussion by saying that the NJR should not currently join the EAR but should keep in touch with developments and review the situation in 2005. It was likely that the NJR would wish to participate in	

	the EAR in the future . **[Action 2004/201]** AEAT to draft a letter to be sent to EAR on behalf of the Steering Committee indicating that the NJR will not be joining at present but would like to be kept informed of progress. **b. 10th European Forum on Quality Improvement in Health Care** This is an annual conference for European healthcare managers and clinicians that CM has attended in previous years. In April 2005, it will be coming to London. From her experience, CM thought it worthwhile for the NJR to put forward an abstract for a scientific poster as this would facilitate obtaining Scandinavian views on implementation of registries in their countries that would be of benefit to the NJR. It was agreed that CM and David Dunlop (RAC) working with AEAT could best produce an appropriate submission. **[Action 2004/202]** AEAT to work with CM and DD on preparing an appropriate NJR submission to the European Forum on Quality Improvement in Health Care (deadline for abstracts -1 October). **c. NJR compliance in Wales** The subject of poor compliance in Wales was raised again and possible courses of action discussed. It was agreed that initially a meeting should be arranged involving SCh, BD, PG and DC. The purpose would be: to ensure that there is a full, common understanding of the situation in Wales; and agree what steps need to be taken. **Action 2004/203]** AEAT to arrange a meeting involving SCh, BD, PG and DC to ensure that there is a full, common understanding of the situation in Wales; and agree what steps need to be taken. **d. Meeting start and finish times** PG pointed out that this meeting's full agenda, along with the likelihood of future meetings having relatively full agendas, meant that future meetings should be scheduled to include an afternoon session. **Note: From the next Steering Committee meeting, NJR Steering Committee meetings will normally be scheduled to start at 10.30 and close by 15.30, with a break for a buffet lunch.** **e. Date of next meeting** *** ***Please note:*** The date of the next Steering Committee meeting has had to be changed. It will take place on **Tuesday 2 November 2004**. ***	**AEAT** **AEAT/CM/DD** **AEAT**
12	**The National Joint Registry – A Strategy for Development – NJRSC (04) 18** DC introduced this paper by saying that its purpose was to propose a strategy for development of the National Joint Registry (NJR) Programme over the short to medium term (1-3 years) and longer term (5-10 years). PG asked SC members to also consider in parallel the list of potential uses of NJR funds (see Appendix 1). He added that the committee needed to revisit the role of the NJR and believed that priority should be	

	given to improving data collection, possibly expanding the size of the RAC team and pursuing use of a patient feedback questionnaire. AC felt that one priority should be developing a PKI system if giving surgeons improved access to their data was likely to raise compliance levels. The consensus view was that apportioning funds to improving data collection and use of a patient feedback questionnaire should be supported. There were differing views on development of a PKI system but this would be revisited in October when further evaluation of PKI systems had been completed. JM stated that the NJR needed to know the reasons why hospitals have problems with data collection. CN responded that a key element of the RAC role was identifying the specific problems in individual hospitals and then addressing them. By pooling their experiences and liaising closely with the NJR Centre and RCCs, the main generic problems have been identified and central action taken to resolve them. TW commented that surgeons need to know the benefits for them in participating in the NJR. These messages are still not getting through to some groups of surgeons. AM said that he was concerned about the potential costs of improving data collection. The committee needed to very clearly justify expenditure on improving data collection. They also needed to determine where the cut-off point would be at which the NJR could be considered to be working and therefore efforts aimed at increasing compliance further would not be required. TW advised that the Trent Registry had 95% compliance. PG agreed that the NJR needed to raise compliance and asked those present what level of compliance they considered should be aimed for. MPo expressed the view that, following examination of the Norwegian Registry, he felt that the NJR needed to be 90% compliant. Following further discussion it was agreed that the compliance level to be aimed for should be: • 95% of hospitals entering data • 90% of patient information input from those hospitals • 95% data accuracy It was also agreed in principle that a timescale should be attached to the above targets. There would need to be work around defining what data quality means in terms of NJR data, how data quality is to be achieved and how it is to be proved, **[Action 2004/204]** AEAT to work with MPo in developing a paper on the levels of compliance, quality and accuracy that are required for the NJR, making use of Furness' work in Norway. PG advised that John Timperley, RCC for the South West Peninsula, had requested that the Steering Committee provide answers to the following questions. By doing so, JT felt that many of the concerns expressed by the surgical profession would be allayed.	**AEAT/MPo**

	• 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? FD pointed out that addressing these and related questions would form an important part of the process of determining reporting requirements for the various stakeholder groups and how they were to be satisfied. Further discussion led to the decision that these high level questions needed to be broken down into a more precise set of questions to which draft responses should be prepared for consideration. **[Action 2004/205]** 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. Returning to the proposed strategy for development, the meeting was in broad agreement with its contents. A number of proposed actions were already underway or being actively considered. In response to a query from MPi, the committee agreed that the MDS should remain frozen for 2 years as changes on a shorter timescale were likely to prove disruptive and lead to decreasing, rather than increasing, compliance. It was agreed that AEAT should take the proposed next step of developing a draft strategy road map and link activities to the cost base. This should be circulated to SC members for comment and their input to allow it to be developed further ahead of the October SC meeting. **[Action 2004/206]** AEAT to draft the strategy road map, including costing key elements, circulate for SC input and develop further in advance of the October SC meeting. Ahead of development of the road map, all SC members were invited to reconsider the contents of the Strategy paper in the light of discussions at the SC meeting and provide the NJR Centre with any further comments by 4 August 2004. **[Action 2004/207]** SC members to email the NJR Centre (David Carter) with any further comments on the Strategy paper. Deadline date – 4 August 2004.	**AEAT/MPo** **AEAT** **All**
	See Appendix 3 for summary of actions allocated at July Steering Committee meeting.	

Sue Mercer
Project Administrator, NJR Centre

6 August 2004

APPENDIX 1

POTENTIAL APPORTIONMENT OF NJR FUNDS

Action 2004/173 – Suggestions have been received from SC members and RCCs on future apportionment of NJR funds.

Summary details are provided below.

Responses received from Jan van der Meulen, Alex MacGregor, Martyn Porter, David Dunlop, John Newman and John Timperley have been added to suggestions given at the April SC meeting and May RCC network meeting. Two items being covered in the July 2004 SC agenda – Public Key Interface and the Hip Owner's Manual – have also been included.

Table 1: Potential future apportionment of NJR funds

• **Use surplus funds to lower the size of the levy in the following year**
• **Funding research** o Perhaps including funding of a PhD post o Fund research aimed at increasing quality and completeness of data. (Need to understand why certain hospitals perform well and provide complete data and others do not to develop appropriate strategy.) o Make specific funds available to allow commissioning of specific research that is relevant for the NJR, overseen by the Research Subcommittee. (Use to fund a dedicated research group or competitive bids.)
• **Improved data collection** o Providing support in hospitals which have insufficient resources available to comply with the NJR (in terms of data clerk effort, availability of PC etc) *Other responses opposed this as it penalises hospitals that have established their own systems.* o Use University students to clear backlog of data entry – cost effective and efficient (especially if sons / daughters of surgeons / hospital staff)
• **Improvements to the NJR system output** o Adding the facility to download an operating note o Implementing a PKI security system, to allow the NJR to be used by surgeons as an online tool and resource library
• **Customisable data collection** o Allow collection of local outcome data on standardised forms so that can put local systems in place to track own dislocations, DVTs, Pes etc
• **Expanding the size of the RAC team** o More support from a larger number of RACs would improve the numbers and quality of data submitted o (Resources allowing) assign an RAC to each RCC, to allow each SHA to be fully analysed and audited in the manner previously suggested by M Porter

• **More for patients** o Consider taking over the development, funding, implementation and management of the Hip Owner's Manual (NHSIA funding has ceased) o Subject to the Hip Owner's Manual proving to be a successful addition to the NJR portfolio, consider development of a Knee Owner's Manual.
• **Patient Feedback Questionnaire** o Development, validation and application of a suitable process • 100% coverage at 1 and 5 years. Send results to Trusts or surgeons. (*Currently at least one Trust is trying to organise follow-ups which would duplicate NJR PFQ process. Give responsibility the NJR to ensure that standard data obtained.*)
• **Extend the NJR to other joints** o One view is that it is too early to extend the scope – the existing system for Hips and Knees needs to become better established first.

Fiona Davies

14 July 2004

APPENDIX 2 PROGRESS ON ACTIONS FROM APRIL 2004 SC MEETING & EARLIER

Action no.	Progress	Action holder
2004/169	**Ongoing** AEAT/CM to produce a draft guide for SHAs to assist them in their evaluation of submitted Clinical Governance Development Plan. The draft is to be produced by 31 May, circulated to SC members for comment, revised as appropriate and approved for distribution by 18 June. **Sent to Clinical Governance lead in each SHA / Welsh health region, copied to all SC members, RCCs and RACs.**	**AEAT/CM**
2003/142 (Revised)	**Delayed** JvdM to produce a paper for the July SC meeting, detailing the Research Subcommittee's proposed constitution and summarising key points of their first meeting. Paper to be provided to FD at the NJR Centre by 30 June. **Postponed until October 2004 SC meeting as Research Subcommittee has its first meeting in July (after the July SC meeting).**	**JvdM**
2004/170	**Completed** AEAT to add "Compliance with the NJR, data quality and completeness" to the agenda for the next RCC network meeting (19 May) and the next SC meeting (15 July). **Agenda item (8) on July SC meeting.**	**AEAT**
2004/171	**Completed** Amend the January 2004 SC meeting minutes as agreed and place final version on the NJR website. By 26 April 2004.	**AEAT**
2004/172	**Completed** PW to e-mail ISD to ensure that the independent sector are included in communications regarding hip and knee replacement data collection in Scotland. [Note: ISD is the Information and Statistics Division of the Common Services Agency, NHSScotland. They carry out the analyses and produce the reports for the Scottish Arthroplasty Project.] **FD actioned on behalf of PW by emailing Sandra Falconer, Scottish Executive.**	**AEAT**
2004/173	**Completed** SC members to inform the NJR Centre by 11 June of their suggestions for how future NJR funds could be best apportioned, with supporting rationale, so that AEAT can produce a discussion paper with possible priorities, for the July SC meeting. **Suggestions collated and forwarded to SC Chair and Vice chair.**	**All SC members**
2004/174	**Completed** AEAT to prepare a paper for the July SC meeting reporting on data quality issues including nil returning hospitals and hospitals with low levels of case ascertainment. **Integrated into Action 2004/170.**	**AEAT**
2004/175	**Completed** AEAT to produce a paper for the July SC meeting that evaluates the RAC role. **Integrated into Action 2004/170.**	**AEAT**

2004/176	**Completed** AEAT to request that all RCCs contact their allocated hospitals to obtain: (c) contact details for a lead consultant, administrator and manager responsible for obtaining and retaining NJR compliance (c) indicator information (details to be agreed between NJR Centre and Mpo) (c) Idetails of what the hospitals have done to improve compliance This information request should be copied to Medical Directors. The detailed approach will be agreed at the RCC meeting on 19 May 2004. **Turned into revised Action 2004/176A in light of discussions at May 2004 RCC network meeting. The letter to hospitals is being included as an Appendix in the FY2004/05 Q1 management report. (See July SC meeting agenda item (3).)**	**AEAT / All RCCs**
2004/177	**Ongoing** AEAT to request that all RCCs submit summary reports on their activity to 31 March 2004. **RCCs to be reminded by PG that these reports are required.**	**AEAT**
2004/178	**Ongoing** AEAT to obtain Swedish (and other) registry comparison compliance figures ahead of the July SC meeting. This should be for a comparable stage of development, i.e. 1 year after going live. **DC to speak to this under agenda item (8) at the July SC meeting.**	**AEAT**
2004/179	**Completed** PG to arrange for a member of the BOA Patient Liaison Group to join the Patient Feedback Advisory Group. (Name and contact details to be forwarded to David Carter.) **Relevant contact is Anthony Vivian.**	**PG**
2004/180	**Completed** PG asked that a list of nil return hospitals be sent to RCCs after having been updated with the SC members' corrections. **Each RCC received details for their SHA / Welsh Health region.**	**AEAT**
2004/181	**Completed** AEAT to produce a paper on developing a PKI (Public Key Interface) system (including costs) for the July SC meeting. **Agenda item (6) at the July SC meeting.**	**AEAT**
2004/182	**Ongoing** FD to contact Hugh Phillips to obtain an update on development of the "Criteria Standards and Evidence" document that can also be circulated to SC members. **Reply awaited to FD email.**	**FD**
2004/183	**Completed** NJR Centre Communications Manager to make contact with Grey Giddins, Chairman of the British Society for Surgery of the Hand (BSSH) to offer them appropriate support. **Contact established. GG will submit an article for the September NJR newsletter.**	**AEAT**

2004/184	**Ongoing** JvdM to liaise with the various NJR stakeholder groups to determine what 'early warning' functionality is required for the NJR, what triggers each aspect should set off, resulting actions, and which bodies take prime ownership of each type of scenario involved. JvdM to produce a related paper for the July SC meeting. Individuals to be consulted are: AC, AS, MB, PG, CD and DC. Draft paper to be delivered to the NJR Centre by 30 June 2004. **No paper received.**	**JvdM**
2004/185	**Cancelled** AEAT to produce a paper for the July SC meeting regarding putting procedures in place for helping what NJR data appears to indicate are poorer performing surgeons. Production of the paper should involve consulting BD, PG, HP, PW and JvdM. **DC discussions with PG and BD led to this action being cancelled, with any required activity at this stage being subsumed in Actions 2004/182 and 2004/184.**	**AEAT**
2004/186	**Ongoing** The Steering Committee to make an initial decision on whether or not to participate in the European Arthroplasty Register (EAR) at the July SC meeting. **Under AOB in July SC meeting.**	**All SC members**
2003 / 134	**Ongoing** JM to provide SH with an article on NJR research in time for the next issue of the newsletter (end of February 2004). **Research subcommittee has not yet met. JM to be requested to provide an article for the September 2004 newsletter.**	**JvdM**
2004 / 159	**Ongoing** Progress in obtaining compliance from current nil return hospitals to be reviewed at the April SC meeting. **Being revisited in July 2004 SC meeting under agenda item (8).**	**All**

APPENDIX 3 SUMMARY OF ACTIONS FROM JULY 2004 SC MEETING

Action no.		SC Action holder
2004/187	AEAT to arrange for a letter to be sent to Hugh Phillips on behalf of the Steering Committee thanking him for all his efforts and wishing him well in his Presidency of the RCS.	**AEAT**
2004/188	AEAT to contact David Adams to initiate the process of the BOA selecting a replacement representative.	**AEAT**
2004/189	David Carter to act as an observer and minute taker for the NJR Research Subcommittee.	**DC**
2004/190	(a) FD to confirm with Hugh Phillips the timescale for publication of the CSE document. (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.	**AEAT/ SC members**
2004/191	(a) AEAT to send a list of TCs to the National Implementation Team every 3 months, asking them to verify which are operational, and whether there are any to add, and any to remove. (b) AEAT to facilitate writing to the Healthcare Commission notifying them of the NJR and its requirements and requesting that they inspect against NJR requirements and notify the NJR when they do so. (c) AEAT to request that prosthesis suppliers notify the NJR Centre when a new hospital / TC starts purchasing hip and knee components.	**AEAT**
2004/192	AEAT to prepare an article for inclusion in the next issue of BON (deadline 30 July). MPo and TW to be consulted about the topics to be covered.	**AEAT**
2004/193	"Determining the levy for FY 2005/06" top be added to the October SC meeting agenda.	**AEAT**
2004/194	(a) AT to liaise with RCCs and members of the SC regarding whether current information - relating to the NJR and the situation with respect to trauma – is clear enough, available and well promoted. (b) A discussion item should be added to the agenda for the next RCC meeting relating to whether RCCs feel there is a case for A&E trauma surgery to be included in the NJR. (The outcome of this discussion would be fed back to the next SC meeting.)	**AEAT**
2004/195	SC Statistics Report to introduce a 52 week running total from October 2004 report onwards.	**AEAT**
2004/196	MDSv1 edit stack to be kept open beyond 15 August but	**AEAT**

	the ability to enter new MDS v1 records to be closed as previously agreed on 15 August 2004.	
2004/197	AEAT to develop outlines for one (or perhaps more) approach to enabling HDMs to enter surgeons' default techniques, cost the approach(es) and determine timeframe(s). To be submitted for approval when ready (i.e. do not wait until October SC meeting.)	**AEAT**
2004/198	AEAT to carry out a scoping study on implementing a PKI security system on the NJR, including costings. Cheaper alternatives, eg system used on tonsillectomy audit, and emailing the NJR Centre and being sent CDs of their own data.	**AEAT**
2004/199	AEAT to add to the agenda for the October RCC meeting discussion on the suggestion of having SHA level events on an annual basis – involving patients, hospitals, SHAs etc.	**AEAT**
2004/200	AEAT to provide a detailed evaluation and full costings on the Hip Owner's Manual for the October SC meeting. This should include being able to demonstrate that the NJR taking on the manual would improve consent and compliance.	**AEAT**
2004/201	AEAT to draft a letter to be sent to EAR on behalf of the Steering Committee indicating that the NJR will not be joining at present but would like to be kept informed of progress.	**AEAT**
2004/202	AEAT to work with CM and DD on preparing an appropriate NJR submission to the European Forum on Quality Improvement in Health Care (deadline for abstracts – 1 October.)	**AEAT/CM/DD**
2004/203	AEAT to arrange a meeting involving SCh, BD, PG and DC to ensure that there is a full, common understanding of the situation in Wales; and agree what steps need to be taken.	**AEAT**
2004/204	AEAT to work with MPo in developing a paper on the levels of compliance, quality and accuracy that are required for the NJR, making use of Furness' work in Norway.	**AEAT /MPo**
2004/205	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.	**AEAT/ MPo**
2004/206	AEAT to draft the strategy road map, including costing key elements, circulate for SC input and develop further in advance of the October SC meeting.	**AEAT**
2004/207	SC members to email the NJR Centre (David Carter) with any further comments on the Strategy paper. Deadline date – 4 August 2004.	**All**