National Joint Registry
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NATIONAL JOINT REGISTRY STEERING COMMITTEE (NJRSC)

MINUTES - FINAL

Meeting: NJR Steering Committee **Date:** Tuesday 20th October 2009
Location: MWB Venue, 130 Shaftsbury Avenue, London W1D 5EU

Members Present:	Prof Paul Gregg	PG	Acting Chair, Orthopaedic Surgeon
	Mick Borroff	MB	Orthopaedic Device Industry
	Mary Cowern	MC	Patient Representative
	Andy Crosbie	AC	Medicines & Healthcare products Regulatory Agency (MHRA)
	Carolyn Naisby	CN	Practitioner with Special Interest in Orthopaedics
	Martyn Porter	MP	Orthopaedic Surgeon
	Dean Sleigh	DS	Orthopaedic Device Industry
	Keith Tucker	KT	Orthopaedic Surgeon
	Andrew Woodhead	AW	NHS Management Member
Regular Attendees:	Richard Armstrong	RA	NJR Programme Director, Northgate
	Alex Henderson	AH	Committee Administrator, HQIP
	Mike Swanson	MS	NJR Principal Consultant, Northgate
	Yvonne Tse	YT	Development Officer (NJR), HQIP
	Elaine Young	EY	National Development Lead, HQIP
Meeting Invitees:	Peter Howard	PH	Chair, Regional Clinical Coordinators' Network
	Kalid Razak	KR	Medicines & Healthcare products Regulatory Agency (MHRA)
	Robin Rice	RR	Welsh Assembly Government Representative
Guests:	Andrew Sidebottom	ASi	Clinical Lead and Maxillofacial Surgeon
	Hannah Patrick	HP	Consultant Clinical Adviser, National Institute for Clinical Excellence (NICE)
Apologies:	Robin Burgess	RB	Chief Executive, HQIP
	Patricia Cassidy	PC	Independent Healthcare Sector
	Bill Darling	BD	Chair
	Patricia Durkin	PD	Patient Representative
	Charlotte Humphry	CH	NJR Programme Manager, Northgate
	Prof Alex Macgregor	AM	Public Health & Epidemiology
	Andy Smallwood	ASm	NHS Supply Chain

REF	ITEM	Action
1.	**Welcome and Apologies for Absence** PG opened the meeting and welcomed Robin Rice who would be joining the NJRSC meetings as an observer and the Welsh Assembly Government representative. He also welcomed Andrew Sidebottom and Hannah Patrick who were attending as invitees to discuss item 2 of the meeting. Apologies were received and noted.	
2.	**Addition of Temporomandibular Joint Replacement (TJR) to the NJR** Andrew Sidebottom (ASi) and Hannah Patrick (HP) attended the meeting and gave a brief history on Temporomandibular Joint Replacement and why they believed it should be added to the NJR. The following points were mentioned: a. In 2007, the number of operations carried out was approximately 65. By 2015, it was estimated that the number would have increased to 200/300 per annum. b. The outcome of each procedure should be followed up more efficiently. c. It would be beneficial if an audit tool was created which would compare the different joints and their outcomes. d. There would be long-term benefits if the TJR did join the NJR. e. There had been difficulty in following up long-term data. f. NICE stated that they were willing to work on a draft audit with the NJR. g. Currently any TJR procedures had to be authorised by Primary Care Trusts, with this arrangement in place 100% data submission rates could be achieved. h. TMJ was a common problem. 90% of patients were treated with conservative treatment, i.e. rest, splints and physiotherapy, while 10% then went on to have arthroscopic surgery. Of the remaining 1%, about half would then have open joint surgery, and a small proportion would then have a joint replacement. i. The average age of the patients was 44 years old. j. There were 3 joints available for use in the UK, one of which was under scrutiny in the USA. k. There were 2 primary component suppliers in the UK, Biomet and Concept. Biomet were keen to have a database set up, but both suppliers would need to be involved for the benefits to be utilised. l. A database was set up 3 years ago in conjunction with a private company, but the database was not user friendly and was difficult to access so was not good value for money. m. Would like to look at failure rates, patient outcomes and end points in the future. n. A structured way of collecting and monitoring data would enable the number of one operation surgeons to be reduced. AS and HP were asked to leave the meeting while the Committee discussed their proposal. The Committee agreed that in principle, the rationale put forward to join the NJR was good. However, there were concerns about the high cost of the project compared to the low numbers of patients currently undergoing this type of surgery, and whether the NJR was the right place to hold this type of activity. A view was expressed that audit and research could be achieved more efficiently by joining the NJR and that by approving the TJR's proposal; it may encourage other small joint replacements to join. A positive effect of including new joints was that it could generate new ideas and better support for the NJR.	

	It was suggested that the following issues should be further explored: i. Doing a limited dataset with the TJR group ii. Offering analysis via Northgate. EY pointed out that timescales for the inclusion of these joints into the NJR would require careful consideration, given that the NJR strategic plan gave priority during 2009/10 to the incorporation of ankle, elbow and shoulder joints, and this involved a significant workload. **Agreed that:** **1. The NJRSC would support the TJR joining the NJR in principle, but that further investigation into the costs and practicalities were needed.** **2. RA would investigate further with ASi the potential costs of the possible options:** **1. NJR holding the data.** **2. TJR carrying out their own analysis.** **3. NJR would collect and analyse data.** **3. HQIP would respond to ASi and HP confirming that in principle the NJRSC supports TJR joining the NJR, but a decision to include TJR into the NJR would be dependent on further investigation into costs and practicalities of different working arrangements.**	**RA** **HQIP**
3.	**Minutes of the previous meeting** The following changes were to be made to the minutes of the July meeting: a. Item 6, under the list of proposed leads for each sub-committee. For the Development of the NJR sub group, MC will be supported by CN, not PG. Should read: 'MC – Development of the NJR (supported by CN)'. b. Item 11, first paragraph, last word in the last sentence. The acronym 'NJR' should be changed to 'NHS'. Should read: '...no longer an integral part of the NHS.'	**AH**
4.	**Matters Arising (not appearing elsewhere on the Agenda)** **Previous minutes – 6. NJR Strategic Plan 2009 – 2010** a. PG asked AW, PH and MC (who would be supported by CN, not PG as previously stated) if they were prepared to take the lead for their proposed sub-committees. All three agreed. KT had a query regarding the Data Quality sub group and would brief AH outside the meeting. b. MPo confirmed that the contract for the analysis of the 7th Annual Report and the tendering process was not yet completed and a further update would be given at the next meeting. **Previous minutes – 14. AOB** **14.2 Metal on Metal Study** It was noted that the NJR had still not received any report on progress with MoM. AC apologised on behalf of the MHRA and explained that there had been various difficulties, but committed to having a draft report ready for the next NJRSC meeting.	

	KT reported that he had emailed Dr Suzanne Ludgate, MHRA, and John Skinner, Chair of the Metal-on-Metal Hip Group, and received a response from the latter who had praised the NJR's contribution to the analysis. BD had previously raised concern regarding the welfare of patients from the study as well as the size of the problem, and the lack of action. KT explained that although there was a problem with MoM, according to available NJR data, the size of the problem appeared to be relatively low, at around 1%. **4.1. NJR Extension to Northern Ireland (previous minute reference 3.2)** RA reported that this was still ongoing. YT and RA had visited Northern Ireland and since received a letter from the surgeons confirming their expression of interest to be part of the NJR. However, formal confirmation was required from the commissioners in Northern Ireland in order for levy to be applied to their activity, and as such a confirmation letter from the Department of Health, Social Services and Public Safety had been requested but not yet been received. EY reported interest from the Republic of Ireland about joining the NJR after receiving a call registering their interest from their Deputy Medical Director at the Department of Health and Children. RB had agreed to provide further information following a planned visit to Dublin for a conference at the end of October. **4.2. ODEP Data Ownership (previous minute reference 11)** It was confirmed that the ODEP data would continue to be owned by the NHS, but would reside within NICE. Although the data would not ultimately stay with NICE, there were no imminent plans to transfer the ownership to HQIP. **It was agreed by the Committee that:** **1. KT would brief AH regarding his query over the Data Quality sub group.** **2. AC would provide the 'Metal on Metal' report in draft format, if not finalised, for the next NJRSC meeting in January.** **3. EY would get an update from RB regarding the Republic of Ireland joining the NJR.**	**KT & AH** **AC** **EY**
5.	**Regional Clinical Co-ordinators Network** The NJRSC reviewed the minutes of the RCC Network, and noted the high number of apologies for absence. PH acknowledged this, but assured the Committee that there was no lack of enthusiasm from the RCC's and that this had been due to the summer holiday period. KT's suggestion that regular attendance and absence for both the Steering Committee and RCC Network meetings should be noted in future in the Annual Report under the sections relating to each committee was agreed. **Agreed that:** **PH would inform the RCC network that attendance to meetings would be recorded in the next Annual Report, and the Editorial Board would ensure inclusion of this information.**	**PH** **MPo**

6.	**Outliers** **6.1 NJR/BOA Meeting** PG briefed members on the meeting held on the 30th September, between the NJR and the British Orthopaedic Association (BOA), which had been agreed would be held on a regular basis in future. Attendees for the NJR had included himself, BD, MPo, AW, and EY, and the agenda for discussion had been the management of outliers. It was noted, that at the Chairman's request, EY had tabled a copy of the introduction he had made to this topic at the NJR/BOA meeting. A further related paper, detailing the Chairman's proposals for an interim variation to the current outlier process, had been previously circulated to members by BD himself, and had formed the basis of discussion with the BOA. In summary BD had proposed the following changes to the existing process: • Following identification of a potential outlier, Northgate should send details of their performance data to the surgeon concerned and ask for comment/clarification/ explanation within 28 days; • The response, together with the appropriate anonymised data, would be sent by Northgate to two of an enlarged panel of surgeons comprising the three NJRSC surgeon members, and the Chair and members of the RCC Network (it was agreed that at least 1 RCC and 1 NJRSC surgeon should be involved). They would decide within 14 days, either by e-mail, teleconference, or if possible, face to face, whether there was a 'case to answer'. • If the result showed no 'case to answer' the surgeon would be informed immediately. If there was a 'case to answer', the current outlier process would be implemented i.e. call/letter to both the surgeon and their Chief Executive Officer. If the case was considered borderline then an appropriate letter should be sent to the surgeon raising their awareness that they were moving to potential outlier status. PG confirmed that the BOA had supported BDs proposals, and then discussion had ensued about how the reporting and handling of outliers could be further developed in the future. For instance it was agreed that there would be merit in embedding the outlier process within the normal governance structure of every Trust. One suggestion had been to write to Chief Executive's and Medical Directors requesting confirmation of a named individual in their unit who would be responsible for receiving surgeon data for that unit, ensuring completeness of data input, and audit of data, and report to the Trust Chief Executive and/or governance committee. Reference was made to a traffic light system of the Trust rather than the individual surgeons. It was suggested by MPo that Trusts could be assessed on three criteria, 1. Compliance, 2. Data quality, 3. Outcomes. The traffic light system would indicate the performance of the Trusts, green to signal that the hospital was performing well so in control, amber, that there was some concern over performance and red that there was more significant concern or there was a potential outlier situation. Regarding compliance no strict criteria was laid down but it was suggested for example that compliance greater than 90 per cent would be green, compliance 80 to 90 per cent would be amber and below 80 would be red (although these are examples and more work needs to be done to clarify these ranges). In terms of data	

quality, data quality could be assessed according to consent and provision of NHS number. These parameters are necessary to produce linked records. A similar benchmark to that used for compliance was suggested but again the criteria and threshold may be different. In terms of outcome the units could be assessed in a similar way to that individual surgeons are assessed in the outlier process, namely green, the unit is in control, amber the unit is drifted above two standard deviations but is below three standard deviations and red, the unit was identified as a potential outlier with PTIR above three standard deviations of the norm. It was possible that this information once piloted could be put on the website and this may drive up compliance and data quality if units were aware that the data was visible to stakeholders and patients.

Similarly a traffic light system which would categorise individual surgeons was mentioned as follows:

- Green: Surgeon was not heading towards or had not been identified as a potential outlier
- Amber: Surgeon had been identified as heading towards becoming a potential outlier (at that stage, Northgate would write to the surgeon to advise them of their position)
- Red: Surgeon had been identified as a potential outlier.

RA advised the committee that Northgate would be conducting a pilot scheme with another company on the use of statistical process control which would provide real-time monitoring of data to see if it would be appropriate for NJR data. PG suggested that the pilot study was run alongside Jan van der Meulen's proposal to compare results. There was concern over how reliable the data would be for surgeons who only conduct a small number of replacements a week. The Committee were in favour of moving towards CUSUM methodology.

PG reported that the NJR/BOA meeting had been very constructive, and the NJR had agreed to consider the proposals further through the outlier sub group and NJRSC. The NJRSC supported these proposals

6.2 Outlier Sub Group – 14th October 2009.

PG briefed members on the outcome of the outliers sub group held the previous week. Significant discussion had ensued around the proposals arising from the NJR/BOA meeting which the outlier group had supported, and agreed should be recommended to the NJRSC for approval. (Minute 6.1 above refers.) .In addition, PG drew members' attention to some additional issues arising from the outlier group. As follows:

a. <u>Outlier reporting Timetable</u>
   It was noted that currently Northgate produced quarterly outlier reports which the surgeon members of the NJRSC were required to review to establish any 'case to answer'. The associated workload of reviewing the data, together with the difficulty associated with arranging meetings to undertake this work, was such that the group recommended that the reporting schedule change to bi-annual. This would facilitate the surgeons being able to pre plan review meetings in line with Northgate's reporting schedule far easier. It was also felt that reporting twice a year would actually provide more accurate reporting of outlier activity, given that statistically there could often be very little difference in reported activity between quarters.

   The Steering Committee supported this recommendation, and it was agreed that

Northgate be requested to provide reports in March and September, dates to be confirmed. This would then enable the surgeons to schedule the bi-annual meetings in advance to facilitate the review process.

EY's proposal that this should be discussed with BD for his views, prior to implementation, was agreed.

b. Confidence Levels

The sub group raised concerns over the current benchmark calculated by the NJR as the amount of revisions that were being picked up appears to be underestimated by 50%. They had suggested having two funnel plots showing the standard benchmark and a doubled benchmark, which could be taken into account on deciding a case to answer.

c. Low Volume Surgeons

The issue was raised that low volume surgeons were not filtered to show on the funnel plots and there was currently no way of assessing those surgeons. It was agreed that the outliers sub group would investigate that issue.

d. Methodology

The sub group had agreed that the patient time incidence rates would continue to be displayed in funnel plot graphs, and that the methodology used would remain the same.

On behalf of the sub group, PG recommended that future outlier plots should be based on NJR to NJR and NJR to HES linkage. It was noted that the NJR did not currently have permission to use HES data for the purpose of outlier monitoring but an application had been made to do so and the decision was pending. PG also noted that the linkage could not be used in Wales because permission had not been granted to use PEDW data for this purpose. RR to liaise with the unit that produce PEDW data to explore ways of using the PEDW data as part of the outliers monitoring process. It was agreed by the NJRSC that once permission was granted, NJR to HES data would be used.

e. Progress report on dealing with 13 current outliers

PG updated the Committee on progress with the recent outlier review. The current status was noted as follows:

No case to answer: 3 surgeons.

Case to answer: 2 surgeons. (Surgeons and CEOs contacted. Responses awaited.)

Review of surgeon responses by NJRSC surgeons pending: 2 surgeons.

No action required (long term sick and retirement): 2 surgeons.

No response received from surgeon: 4 surgeons.

It was agreed by the NJRSC that Northgate would contact the PA for each surgeon to confirm their postal and email address and to check that the surgeon was at work and not on holiday or sick leave. AW suggested that a timescale should be sent to members giving a clear outline of the process for contacting the surgeons involved.

	The timescale was agreed as follows: • Northgate would call the surgeon's PA and confirm that the surgeon received the letters, and that their contact details were correct • If surgeon had received letters, they would be informed on the telephone that they had 2 weeks from the date of that call to provide the data • If surgeon had not received letters, the letter would be resent and emailed to the surgeon, stating that they had 2 weeks from the date of that email to provide the data • If the data was not provided within 2 weeks, the name and telephone number would be given to one of the NJRSC surgeons who will telephone the surgeon and inform them that they had 2 weeks from the date of that call to provide the data before their Chief Executive would be contacted • If there was still no response, the NJRSC would contact the CE (total of four weeks). It was agreed that the precise process and details would be confirmed outside of the meeting and a simple flowchart to outline the process would then be produced. **6.3 Development of NJR Outlier Process-Conclusion of 6.1 and 6.2 above** PG agreed to finalise a paper that summarised all the proposals/agreement from BD, the NJR/BOA meeting, the outlier sub group, and the NJRSC, and would map out the future development plans for the NJR outlier process, and report back to the NJRSC on this issue. **Agreed that:** **1. AH would send the timescale and process chart to members which would outline the process for dealing with potential outlier surgeons who had not responded to 2 written requests for data.** **2. PG would incorporate key points from the NJR and BOA meeting and the Outliers sub group meeting with BD's 'potential outlier' paper, and would report back to the NJRSC with the recommendations of how to examine low volume surgeons within the outlier position.** **3. EY would speak to BD regarding the four surgeons meeting twice a year to review potential outliers.** **4. YT & MS would explore the option of making the list of non-conforming units available on the NHS Patient Choice website.** **5. RA would propose a timeline for the potential outlier data cut-off date before it gets reviewed by Northgate, sent to HQIP, and then sent to the four NJRSC surgeons for their suggested bi-annual reviews in March and September.** **6. RA would give an update at the next NJRSC meeting on the outcome of a pilot study that Northgate were conducting with another company on the use of statistical process control, which provide real-time monitoring of data, to see if it would be appropriate for NJR data.** **7. PG requested that RA should run the pilot study alongside JvdM's methodology/proposal carried out on the '3M' incident to compare results.** **8. PG asked RR to undertake further investigation into how the NJR can work with PEDW to produce outliers monitoring data.** **9. Outliers sub group would investigate the issue of how to monitor low volume surgeons, and prepare a paper to report back to the Steering Committee at the next meeting.** **10. Regarding potential outliers, Northgate would contact the PA for each surgeon to confirm their postal and email address, and check that the surgeon was at work and not on holiday or sick leave.** **11. Once permission was granted, NJR to HES data would be used.**	**AH** **PG** **EY** **YT & MS** **RA** **RA** **RA** **RR** **PG** **Northgate**

7.	**Editorial Board Sub-Group** MPo thanked everyone for the work they had put into the 6th Annual Report. He then reported back on the highlights from the Editorial sub group meeting held 14th October. It had been agreed that the 7th Annual Report would be produced the same way as the previous reports. He reported that next year the BOA congress would be organised differently to previous years with 5 English speaking countries participating, and that the annual report should be available for this event. Discussion took place regarding the time allocated for planning and reviewing the Annual Report. It was felt very important that the NJR was available for presentation at the BOA Congress and as much detail of the special topics. In the future it may be possible to provide data quarterly downloads although it was realised that this was not practical at the moment. The Committee discussed submitting specialised topics for peer review publication where possible. High impact journals such as the Journal of Bone and Joint Surgery were considered as suitable journals - but could include others depending on the quality of the topics. EY queried whether the contract carried out by the CEU had been met in terms of production of the specialist topics. The Committee discussed how the instructions had been given to the CEU and it was agreed that although the contract had stated that 'if possible' some detail should be made available for presentation at the BOA congress, there had been a degree of flexibility given that it had been recognised that the detail of writing up the topics would probably require further detailed work. The editorial board had discussed progress on the work associated with the specialist topics with the CEU, and had been satisfied that production of the specialist topics was nearing completion and satisfactory. It was however agreed that for future Annual Report specifications NJR expectation regarding a timetable for the specialist topics needed to be very specific. **Agreed that:** **1. A decision on publication would be postponed until the specialised topic papers had been finalised and reviewed by the Committee.** **2. The CEU contract had been met with regard to what had been requested.**	
8.	**Research Sub-Group - Appointment of an NJR Research Development Officer** EY confirmed that an appointment had been made to the NJR Research and Development Officer post, on a part time basis for 3 days a week. A start date had yet to be confirmed.	
9.	**Strategic Plan Gantt Chart** The Committee reviewed a Gantt chart setting out a detailed plan and timescales for taking forward elements of the NJR Strategic Plan. The document would be available from RA for members wishing to review in further detail. **Agreed that:** **1. RA and EY would discuss how the Gantt chart would be developed and reported**	**RA & EY**

	to the Committee for future meetings. **2. RA would produce a progress report/summary to accompany the Gantt chart henceforth.**	**RA**
10.	**NJR Finance Report** The finance report was received and noted.	
11.	**Quarterly Statistics Report Q2 (July – September 2009)** MS outlined the report, and noted that it contained data dating back to 2003. It was agreed that future reports should contain less data, and members suggested that the size of the report could be reduced by focussing on highlights only, and not including historic data. The Committee discussed the issue of non-compliant units not returning data, and noted that the RCs had started looking into this issue. The case was raised of UCLH Trust not having submitted any data despite their patients having given consent. **Agreed that:** **1. YT and CH would discuss the future content of the reports.** **2. UCLH Trust would be followed up by Northgate at a local level.**	**YT & CH** **Northgate**
12.	**Quarterly Management Report Q1 (April – June 2009) & Q2 (July – September 2009)** MS reported that half of the units took more than 30 days to submit their data which resulted in a time consuming process to produce the QMR. A cut off date for data would be set before the next report was due. The Committee discussed the different requests that Northgate received on an ongoing basis, and which requests should incur a charge. It was agreed that no charge would be made for routine data requests that could be easily accessed, but there would be a charge for specific data analysis where the data was not easily accessible. The ultimate requests were referred to HQIP, on a formal application form, for decision. PG suggested that a report should be created that would outline a summary of all the data requests received by the NJR, and that this information should be published in the next Annual Report. EY supported this. **Agreed that:** **1. RA would produce the data request information to show how often the NJR documents were downloaded from the website.** **a. Data requests information would summarise the number of requests received to date, where the requests had come from, who had requested data and what had been requested over the lifetime of the NJR.** **b. Report would be ready for the next NJRSC meeting on 28th January.** **2. RA would investigate how often Clinician Feedback system reports are used by surgeons and units.**	**RA** **RA**
13.	**PROMS** RA presented an update on PROMS. The Committee discussed further funding for	

	PROMS and whether a further questionnaire should be created for patients to fill out. RA had arranged a meeting to see David Nuttall from the DH to discuss the NJR PROMS study with AM in November 2009. **Agreed that:** **1. RA would forward his presentation to NJRSC members.** **2. RA would forward the PROMS paper to NJRSC members when it had become available, towards the end of 2009.** **3. MC would get feedback on the questionnaire from her patient representative group.** **4. PG would attend the next PROMS meeting with David Nuttall.**	**RA** **RA** **MC** **PG**
14.	**Annual Dataset Review (MDSv3.1 Dataset)** PH gave an update on a discussion that the Regional Clinical Co-ordinators had at their previous meeting regarding the dataset. Unanimously, the RCCs had felt that many hemiarthroplasty revisions were as major an undertaking as a total hip replacement, and that it should therefore be entered onto the H2 form, whereas currently it is entered on either form H1 or H2. The RCCs had suggested adding another field with 6 optional choices to the H2 form to identify what was being revised. The Committee discussed the advantages and disadvantages of adding the additional field. It was noted that users had not favoured previous versions with too many fields, but that it would be useful for the data to be added. PH raised two suggestions that Claire Newell had previously made to him. a. Whether the height could be measured and entered into the dataset in metres instead of centimetres, in order to avoid inaccurate weight and height measurements due to the figures accidently being entered into the incorrect field. The Committee agreed to the change. b. Whether thromboprophylaxis could be removed from the default technique in the dataset. The Committee agreed that thromoprophylaxis could be removed from the default technique. There was discussion over adding another box to the form which would highlight an alteration, but it was agreed to hold that decision, further to a response from Mr J Timperly, Consultant Orthopaedic Surgeon. **Surgeon Associate Grades** MS reported that he and Claire Newell had discussed the value of adding an additional grade to the surgery forms, as the only positions to currently be recorded are the Consultant in Charge and the Lead Surgeon, but not the junior surgeons. It was noted that there was originally an additional grade on the form, but that it had been removed over time to simplify the process. It was agreed to leave the two grades as they were on the form, without adding an additional grade. **Agreed that:** **1. RA would investigate the costs involved for updating the Revision Hip form (H2), and possibly the Revision Knee form (K2), to include a selection of 6 tick boxes to identify the type of revision.** **2. The Regional Co-ordinators would check locally which grades the SA's would like to have on the forms, and that the Committee would review at the next meeting.**	**RA** **NJRC**

15.	**Trauma Only Units** RA reported that under the data return section of the Annual Report, the list of non complying units was listed. The list excluded units that were only undertaking trauma activity on the basis that they were likely to be compliant. RA queried whether the NJR should actively pursue the 'trauma only' units for data. **Agreed that:** **1. PH would add this item to the agenda for the next Regional Clinical Co-ordinators Meeting.** **2. As a one off exercise, the RCs would be asked to identify and visit 'trauma only units' and find out firstly, if any of them had completed any hip replacements for hip fracture patients, and secondly, if so whether these had been reported to the NJR. It would also be established from the levy if the unit had purchased any joint replacements. RCs would establish the extent of the problem and report back to PH / RCC Committee.** **3. PH would report back at the Steering Committee meeting in July.'**	**PH** **PH/ RCs** **PH**
16.	**Supplier Data for Outlier & Management Information** MB raised a question from Claire Newell regarding joint suppliers requesting information from NJR concerning the usage of their own products, in the light of the supplier knowing in detail which units and surgeons were using their own products. The Committee recalled discussing this at a previous meeting and there was debate over what the agreed outcome had been. KT had access to the minutes from when the discussion had taken place (23rd April 2008) and read out the following extract under item 5.1, Supplier Information – Brand Usage: 'EY confirmed DH Legal advice, previously circulated to members, which indicated that there were no legal issues with providing implant manufacturers and suppliers with information about the usage of their own prostheses.' **Agreed that:** **1. When hospitals/units request NJR data on specific implant devices, it would be best for the data requests to be sent directly to the supplier concerned, since they have all the clinical evidence for a particular device, including access to the NJR dataset on their own products and will be able to provide a comprehensive review of all the relevant data to the customer.** **2. If a product is flagged as an outlier, unit and surgeons details will be made available routinely to the supplier to allow an investigation.** **3. Where the product is not flagged as an outlier, but the supplier identifies a need to identify a site or surgeon to investigate a potential implant performance issue or off-label usage, the unit/surgeon details will be released on approval of an appropriate data request by HQIP.**	**NJRC** **NJRC** **NJRC/ HQIP**
17.	**Surgeon Associate Grades** This item was covered under item 14.	
18.	**Scottish Request for NJR Components** MS reported that the Scottish Procurement Directorate had requested a copy of the component database from the NJR. MS asked the Steering Committee if the NJR should provide the data and if there should be a charge for doing so.	

	EY highlighted two considering factors. Firstly that Scotland may hopefully join the NJR in the future, and secondly that the NJR had denied the FDA the data they had requested, although their purpose to obtain data had been for research purposes. The Committee felt that as the NJR had spent a lot of resources on developing the database, a charge should be made for future requests. It was agreed in principle that the Scottish Procurement Directorate would receive the data, but would be charged for it. **Agreed that:** **1. MS would produce the cost of managing the NJR Component Database.** **2. Northgate would produce charging options and estimate the work that would be involved. Suggestions had included a licence agreement and pay per view charges.** **3. Northgate would work out the estimated costs for producing and providing the data then would discuss this with YT to work out a reasonable amount to charge.** **4. MS would respond to the Scottish Procurement Directorate.**	 **MS** **Northgate** **MS & YT** **MS**
19.	**Proposed dates for 2010-2011 NJRSC Meetings** In order to enable the different sub-groups to schedule their meeting dates, the following Steering Committee meeting dates were proposed and confirmed: • 29th April 2010, 10.30 am – 4.30 pm • 29th July 2010, 10.30 am – 4.30 pm • 29th October 2010, 10.30 am – 4.30 pm • 24th February 2011, 10.30 am – 4.30 pm It was noted that the scheduling of the Outliers Sub Group meetings would possibly affect the April and October NJRSC dates.	
20.	**Any Other Business** **20.1 Annual Report Feedback** The British Hip Socity (BHS) had not given their feedback on the NJR Annual Report. MPo would follow this up. Robin Allum, previously President of BASK, had sent through a glowing tribute to the NJR Annual Report and the work of the NJR. He asked if the NJR would consider supporting hip and knee audits in the future, subject to funding. **Agreed that:** **1. MPo would chase the BHS for their feedback.** **20.2 Shoulder and Elbows** EY notified the Committee that she had received a letter from Mr Stanley, Consultant Orthopaedic Surgeon, from BESS, confirming their interest in joining the NJR, but had requested a meeting to discuss further issues. This had been arranged and the committee would be kept informed of progress.	 **MPo**

21.	**Date and time for next meeting** Thursday 28th January 2010, 10.30 am – 4.30 pm MWB Venue, Shaftesbury Avenue, London, W1D 5EU	