

Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 11th August 2026

09:00 – 11.00

(Remote meeting via videoconference)

PAG MEMBERS IN ATTENDANCE:	
Role:	
GP Representative from the British Medical Association (BMA)	
GP Representative from the Royal College of General Practitioners (RCGP)	
NHS ENGLAND STAFF IN ATTENDANCE:	
Name:	Role / Area:
Narissa Leyland	PAG Chair
Karen Myers (KM)	PAG Secretariat, Privacy, Transparency and Trust (PTT), Technology, Digital and Data
Vicki Williams (VW)	PAG Secretariat, Privacy, Transparency and Trust (PTT), Technology, Digital and Data
PAG MEMBERS <u>NOT</u> IN ATTENDANCE:	
Role	
GP Representative from the Royal College of General Practitioners (RCGP)	

1	Welcome and Introductions: The PAG Chair welcomed attendees to the meeting.
2	Review of previous PAG minutes: The minutes of the PAG meeting on the 4 th August 2026 were reviewed and were agreed as an accurate record of the meeting.
3	Declaration of interests: There were no declarations of interest.
4. EXTERNAL DATA DISSEMINATION REQUESTS:	
4.1	NIC Number: NIC-810825-X7F0R-v0

	Applicant Organisation: University of Nottingham OpenSAFELY Ref: AOS-2026-1001 Title: 'OptiFIT: Optimising faecal immunochemical testing in early diagnosis of colorectal cancer' Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 See Appendix A	
4.2	NIC Number: NIC-810826-R4R5J-v0 Applicant Organisation: London Borough of Camden OpenSAFELY Ref: AOS-2026-1053 Title: 'OpenJSNA: A shared, reproducible indicator set for Local Authority public health teams' Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 See Appendix B	
4.3	NIC Number: NIC-810827-K0H9H-v0 Applicant Organisation: University of Dundee OpenSAFELY Ref: AOS-2026-1060 Title: 'DOACs vs Warfarin in CKD (A target trial emulation in OS)' Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 See Appendix C	
4.4	NIC Number: NIC-810828-D3K0T-v0 Applicant Organisation: University of Bristol OpenSAFELY Ref: AOS-2026-1062 Title: Title: 'Optimising vaccine evaluation in real time using health records (OVERTURE)' Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 See Appendix D	
5. WIDER PROFESSIONAL INSIGHT		
<i>There were no items discussed</i>		
6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
<i>There were no items discussed</i>		

7. Any Other Business		
7.1	PAG Processes Noting the substantive discussion at PAG on the 22nd September 2026 with regard to the PAG Terms of Reference (ToR) and Ways of Working it was agreed to also include a discussion on the change control mechanisms associated with the PAG feedback form.	Sec
7.2	National Data Opt-Outs (NDOO) i) Following discussion at PAG on 7th July 2026, item 4.2, around NDOOs, Narissa noted whilst the OpenSAFELY Project Application form submitted did not contain the justification why the NDOO should / should not be applied, NHS England still conducts the same assessment to the same standards using the “DARS application form” as a guide. It was agreed that this would feed into the pilot evaluation discussion item on the 22nd September 2026. ii) Following discussion at PAG on 28th July 2026, item 5.1, around whether existing applications that had asked for the NDOO to be applied have ethical support, Narissa confirmed to the Group that only one application submitted did not have ethical support for the application of NDOO and that the applicant had been tasked in amending their proposal to make clear their intention and provide evidence of ethical support. PAG welcomed the update and thanked NHS England for their diligence.	Sec
7.3	Profession advice There was a brief discussion with regard to the profession advice papers currently in train. It was agreed that once finalised, unless part of the confidential sessions, they would be published via the PAG minutes / copy uploaded to the PAG Website, once the RCGP had confirmed contentment around autonomy of PAG to authorise publications without further approval, noting the BMA Representative noted that no additional authorisation was required from the BMA. ACTION for RCGP Representative: to speak to their House and confirm autonomy of PAG to authorise relevant finalised papers for published, without further approvals. The Group agreed that the papers would have a 6-month review cycle, and agreed that all relevant finalised papers would have their first review at the PAG meeting on the 22nd September 2026, where the agreed process could be mapped out and agreed. ACTION for PAG Secretariat: to add the relevant finalised papers to the forward plan for discussion at PAG on the 22nd September, under section 5. ACTION for PAG Secretariat: to provide a draft process map for updating finalised papers.	TO NOTE
		TO NOTE
		RCGP Rep
		Sec
		Sec
Meeting Closure As there was no further business raised, the PAG Chair thanked attendees for their time and closed the meeting.		

Profession Advisory Group (PAG) Feedback Form – OpenSAFELY

Meeting Details		
PAG advice sought by NHSE:	03/08/2026	
Date of PAG advice:	11/08/2026	
Application Details		
NIC Reference:	DARS-NIC-810825-X7F0R-v0 OpenSAFELY Ref: AOS-2026-1001	
Application version Number:	V0	
Applicant Organisation:	University of Nottingham	
Application Title:	OptiFIT: Optimising faecal immunochemical testing in early diagnosis of colorectal cancer	
Attendees		
Representing Organisation	Name	Role
British Medical Association (BMA)		BMA Representative
Royal College of General Practitioners (RCGP)		RCGP Representative
Declarations of Interest		
The RCGP Representative is an Associate of the University of Nottingham, in his role as a Clinical Advisor to PRIMIS. In his role at the RCGP, which includes representing the RCGP at the Pathology Standards Steering Group as an observer, he is part of a larger stakeholder group including NHS England, who have been discussing the algorithms. RCGP has responded to NHS England's recent request for advice. He is not involved in this application, or the related project. The BMA representative has no declarations of interest.		
Advice Required		
OpenSAFELY Application		
The OpenSAFELY Data Analytics Service Pilot Direction 2025 states: The purpose of accessing the data is to establish a secure analytics service using the OpenSAFELY platform, for users approved by or on behalf of NHS England, to run queries on GP and NHS England pseudonymised patient data.		

1a. Does this application meet the requirements of the OpenSAFELY Direction?
Yes, subject to confirmation that the application of the National Data Opt Out arises because of a decision to do so within the ethical approval process for the study. If not, then PAG requires more information to understand the rationale, within the scope of the Data Direction that operates in OpenSAFELY which does not normally require it.
1b. Is this request in line with the following purposes as specified in the OpenSAFELY Requirement Specification? NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 - NHS England Digital
☐ Clinical audit ☐ Service evaluation ☐ Health surveillance ☒ Research ☐ Evaluation of the service ☐ Health & social care policy, planning & commissioning & public health
1c. Advice from the Profession
Supported / Not supported / Not applicable
This study has broad strategic qualities and approaches each of the Quintuple Aims for health care improvement: Population health: by targeting a common life limiting cancer, where the study will consolidate the existing national strategic plans Patient experience: as a life-threatening diagnosis, timely and accurate diagnostic pathways in early suspected cancer are highly impactful. Work such as this which has the potential to improve the calibration of the diagnostic pathway is of benefit to both those with the disease and those who are false positives. The effects extend to everyone around them, as with many serious diseases. Staff experience: suspected cancer calls on many skills – pathway selection, breaking bad news, managing uncertainty etc. Any benefits in test accuracy carry immediate benefits in terms of supporting staff being confident in the uncertainties that they are assessing and communicating. Effective use of resources: rational testing means rational spending, and calibration of the algorithm allows proper cost-effectiveness assessments Advancing health equity: by accessing national data, extrapolation errors may be reduced, resulting in more accurate testing. This study proposes to account for a range of variables which include ethnicity. The study will make use of the breadth of data available in primary care records, where the greater dataset is of clear and direct value to the calibration of the calculations required to optimise this risk score. The authors should be aware that in addition to NICE guidance, each region may produce its own bespoke pathways, which deviate from that in terms of sequencing of blood tests, referrals etc. This may explain regionally observed patterns, and can be investigated, if

necessary, by approaching the regional Integrated Care Boards to request and regional pathways advice.

General Practice will necessarily have a key role in communicating risk score significance. The clinical significance of calibrating the scores based on risk factors including ethnicity will require good transparency over the way that this has been undertaken, to minimise the risk that this approach (which is to advance health equity) is mistaken for negative discrimination.

Profession Advisory Group (PAG) Feedback Form – OpenSAFELY

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Application version Number:	V0	
Applicant Organisation:	London Borough of Camden	
Application Title:	OpenJSNA: A shared, reproducible indicator set for Local Authority public health teams	
Attendees		
Representing Organisation	Name	Role
British Medical Association (BMA)		BMA Representative
Royal College of General Practitioners (RCGP)		RCGP Representative
Declarations of Interest		
There are no declarations of interest		
Advice Required		
OpenSAFELY Application		
The OpenSAFELY Data Analytics Service Pilot Direction 2025 states: The purpose of accessing the data is to establish a secure analytics service using the OpenSAFELY platform, for users approved by or on behalf of NHS England, to run queries on GP and NHS England pseudonymised patient data.		
1a. Does this application meet the requirements of the OpenSAFELY Direction?		
Yes / No		
1b. Is this request in line with the following purposes as specified in the OpenSAFELY Requirement Specification? NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 - NHS England Digital		

- ☐ Clinical audit
- ☐ Service evaluation
- ☒ Health surveillance
- ☐ Research
- ☐ Evaluation of the service
- ☐ Health & social care policy, planning & commissioning & public health

1c. Advice from the Profession

Supported/ ~~Not supported~~/ ~~Not applicable~~

PAG is pleased to support the use of OpenSAFELY by local authorities to access GP data to inform policy decisions.

This study's alignment with the Quintuple Aims for health care improvement is broad, including:

Population health and care: Provision of palliative care is a key strategic need, and in light of the prevailing contracting of care, data to inform policy is valuable to establishing the next stage of national commissioning.

Citizen experience: dying well is a recognisable as affective all citizens, who are guaranteed to be exposed to the experience, along with their family, carers and social groups.

Staff experience: palliative care is challenging, requiring staff to use their training and experience to manage complex emotional challenges, and use their professionalism to continue providing effective care, in the context of their own personal lives. Data which support effective commissioning structures within which those staff work may be impactful.

Effective use of resource: a data driven approach to supplement the JSNAs has the power to directly inform policy and local strategic approaches, adjusted to needs.

Advancing Health Equity: The study intends to identify and expose inequalities in recorded care provision, which may inform policy.

Caution should be exercised in determining coverage of end-of-life-care from primary care data. The removal of the Palliative Care indicators from the GP Quality & Outcomes Framework will result in a shift in the established paradigm, and it may take time for those to be reflected in the data patterns. Many influences will directly affect primary care data such as the availability of community palliative care resources, as well as the digital maturity in communication with those providers. That is to say, primary care data which show care is being provided has a high positive predictive value that that care is being provided. The absence of primary care data may not be a reliable indicator that that care isn't taking place, only that it isn't being recorded in machine-readable coded primary care data.

Consequently, the limitations of the data quality must necessarily be commented when documenting the findings - the study is powered to expose who is recorded as receiving palliative care (but the study may not show who is receiving palliative care before death), and consider the gap between service provision and records, and whether commissioning identifies the prospective requirement for such records to be made.

In this light, we are aware that PC0001 was withdrawn from the GP Quality & Outcomes Framework, and the maintenance of a palliative care register is no longer an incentivised part of primary care service provision. This defunding of the recording of palliative care status has not been replaced by a mechanism for replacing that function.

In 2025/26, the Quality and Outcomes Framework incentive payment for maintaining a palliative care register was retired, meaning general practices (GPs) no longer receive a payment for this activity. However, the use of palliative care registers did not cease, with GPs still able to actively maintain and use their register as part of good clinical practice, including proactive identification, personalised care, and support planning and ongoing reviews. Stephen Kinnock, Labour Party 2026

<https://questions-statements.parliament.uk/written-questions/detail/2026-03-17/121338>

It will become clear over time how the shift in commissioned care affects provision of palliative care. This study may be powered to observe the impact of the computable recording of provision of palliative care within the patient's lifelong primary care record, and commentary may be given on how that impacts on other services, which may rely on those records e.g. the Summary Care Record / GP Connect / regional Shared Care Records.

There are significant issues to consider in developing the coding model for this work, as the data patterns in the domain are primarily influenced by two existing coding models: the QP QOF definitions, and the Palliative and End of Life Care Standard published by PRSB <https://theprsb.org/standards/palliativeandendoflifecare>.

PAG is preparing a document commenting on the risks associated with using the GP QOF definitions. In summary, the choice of codes included for PC0001 was calibrated for payment of maintaining a palliative care register and proactive care, but is therefore selective and excludes many patients with palliative care needs. This means that there is a cohort of patients who were never codified in such a way as to require them to be on the GP QOF register, but are receiving palliative care planning and treatment.

General Practice core training has been to identify and manage palliation as part of a blended approach with curative and active treatment, and the use of any information model which looks for a binary IS/ISNT palliative care does not fit philosophically with the way that we approach palliation. There may be opportunities to identify a much larger cohort of people receiving palliative approaches, if this binary model is abandoned.

Examples include those with orders that they do not wish to be resuscitated, which is not synonymous with palliative care (but can be treated as such) or the role of treatment escalation planning / ceilings of treatment / discussions about preferred place of death, which are all defining components of palliative care, computable and may be sensible to measure and observe as indicates that such management is in place.

The PRSB standard requires careful interpretation – their code lists define the recommendations for prospective data capture, and must not be interpreted as applying to data collection. For example, where PRSB recommends the use of one specific code for each of recording of for and not for CPR, there are many other valid concepts in SCT which also record the same thing. Therefore, any code lists which look for themes from this standard should include ALL of those defined by PRSB, but must necessarily also include others which are used by primary care teams and may not be within the standard.

The coding and information models will require a good level of digital maturity for conclusions to be broadly applicable, and appropriate advice should be sought from primary care informaticians in support of the project.

If the study is able to identify unmet need in terms of end-of-life palliative care provision then its outputs should be used to drive universal palliative care provision across the country rather than just improving the "fairer of targeting of services", a phrase which suggests only a limited improvement is sought.

Caution is advised when talking about reducing avoidable pressure on urgent and emergency care from those in their final year of life. Predicting who might be in this cohort is difficult and just because individuals might be in their final months of life does not mean they should not be seen in hospital or urgent care settings. Each person must be treated as an individual and appropriate care given. Patients must not be seen as a burden to the system - the system should be designed to cater appropriately for those in need. There are computable ways to optimise the denominator, for example, by consider the presence of codes such as 505491000000109 | Preferred place of care is hospital (finding) | in the context of treatment escalation plans – for some patients, admission may be the most appropriate way to manage their care. An emphasis may be best thought of as preventing unplanned, unwanted and unnecessary urgent and emergency care, and acknowledging lack of available data to be able to produce quantified data on this from the available data sources.

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1a. Does this application meet the requirements of the OpenSAFELY Direction?		
Yes		
1b. Is this request in line with the following purposes as specified in the OpenSAFELY Requirement Specification?		

- ☐ Clinical audit
- ☐ Service evaluation
- ☐ Health surveillance
- ☒ Research
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1c. Advice from the Profession

Supported/ ~~Not supported/ Not applicable~~

This study has a defined scope which advances several of the Quintuple Aims for health care improvement, while being supportive of less direct strategic benefits:

Population health: The theme is of prescribing of high-risk drugs in a large cohort of patients, who have potential clinical benefit as well as considerable risk. This work will help to quantify those risks and inform better clinical decision making.

Patient experience: better information supports discussion with patients as to the rational medication choices, and quantification of risks is a cornerstone of good discussions with patients. Medication related harm is a trust issue for the patient, and this work has the potential to help reduce it.

Staff experience: shared decision making of high-risk prescribing is confronting for clinicians because there is no low-risk scenario, and professional judgement which follows prevailing advice does not always result in a good outcome, meaning it is inherently stressful for staff who prescribe, and monitor these treatments. Better information means more confident decision making, and a clearer conscience when things go wrong.

Effective use of resource: good information on risk will help to establish the true costs of treatment and medication-related harms, allowing policy decisions to be made rationally.

Advancing health equity: the authors note that people with advancing CKD are under-represented in many trials, and the use of the broader dataset available in OpenSAFELY may help expose the information necessary to support their care.

The coding model for this work may benefit from some reflections from the profession.

The information model proposed for CKD (2 eGFR values <60 at least 90 days apart) does not align to clinical practice. The diagnostic accuracy of creatinine, and the calculation based on it have been a concern for the profession since the introduction of the original MDRD equation in 2006. While CKD-EPI calculated against creatinine is an advance in the rational attribution of CKD to those with reducing renal function, there are many factors which will influence whether a patient is identified as having CKD, including evidence of end organ damage (such as evidence in urine tests) as well as the context of the readings e.g. dehydration, use of NSAIDs etc. In general practice, it would be highly uncommon to attribute borderline eGFRs to a disease label, and more common to monitor such readings over time for example.

The authors may wish to tailor the information model to the rich availability of data in the primary care record, to consider not just the presence of 2 readings of EGFR, but whether

there is a trend in the patient's creatinine for example, which can be considered with the post-processing abilities in the technology.

The MDRD equation should be treated with caution if it is the only data available, and in particular where the patient does not have white Caucasian ethnicity.

Further, we wish to draw attention to the paradigm shift in the use of the Cockcroft & Gault equation for calculating patient-specific eGFRs using additional variables. This equation has been recommended to primary care for decades but has only recently become available as integrated calculators in the GP IT systems. The authors may therefore be interested in observing the trend of these calculations, which have undergone approx. 120,000% increase in recorded use over the years following since March 2022. The clinical rationale for these calculations is to support the safe prescribing of DOACs.

This study also has the potential to contrast the laboratory recorded eGFR calculations against the Cockcroft & Gault equation, and generate comparative data, while observing the data patterns for the primary objective. The cohort of patients for whom an equation has been calculated overlaps almost exclusively with the patients who have been receiving DOACs, and may be a rich area to explore.

PAG wishes to draw to the attention of the study team that there may be subtle but computable signals with the GP record that suggest a possible GI side effect may have occurred (such as subclinical GI bleeding) but when no specific coding of an identified problem has taken place. Many GPs will view trends in haemoglobin, or Mean Corpuscular Volume (MCV) in patients on warfarin/DOACs, and if reducing and if there is a suspicion of unexplained iron deficiency as well (possibly from a GI bleed), may investigate (e.g. via FIT and/or endoscopies, and/or two-week-wait referrals). They may supply a course of oral iron, especially if there have been fairly recent tests that may have shown no particular pathology. If a pattern were to be shown, it might be possible to develop tooling to provide data driven decision support to the clinician to identify subtle changes before they became more significant.

Profession Advisory Group (PAG) Feedback Form – OpenSAFELY

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Application version Number:	V0	
Applicant Organisation:	University of Bristol	
Application Title:	Optimising vaccine evaluation in real time using health records (OVERTURE)	
Attendees		
Representing Organisation	Name	Role
British Medical Association (BMA)		BMA Representative
Royal College of General Practitioners (RCGP)		RCGP Representative
Declarations of Interest		
The RCGP representative is a Clinical Advisor to PRIMIS at the University of Nottingham. PRIMIS is contracted with the UKHSA for the analysis of primary care data. The RCGP representative also represents the RCGP in its work with the UKHSA and the University of Oxford Research & Surveillance Centre.		
Advice Required		
OpenSAFELY Application		
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1a. Does this application meet the requirements of the OpenSAFELY Direction?		
Yes / No		

1b. Is this request in line with the following purposes as specified in the OpenSAFELY Requirement Specification?

[NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 - NHS England Digital](#)

- ☐ Clinical audit
- ☐ Service evaluation
- ☐ Health surveillance
- ☒ Research
- ☐ Evaluation of the service
- ☐ Health & social care policy, planning & commissioning & public health

1c. Advice from the Profession

Supported/ ~~Not supported~~/ ~~Not applicable~~

The application has a broad alignment to the Quintuple Aims for health care improvement:
Population health and care: In this clinically important area, the ability to generate near real-time estimates of effectiveness and identify groups with reduced protection has the potential to support more responsive vaccination programmes and improve population health outcomes. The effectiveness of OpenSAFELY in doing so is valuable to be considered.

Citizen experience: The paper sets out a series of ways in which patients experience vaccination and the significance of waning immunity for example, which can be informed by this research.

Staff experience: good information supports good decision making and communication in primary care, in this high-volume activity.

Effective use of resource: national data studies such as this have a material chance to impact of public health policy, and the authors document the mechanisms through which the information can be operationalised.

Advancing health equity: There is a strong focus in the paper on exploring variations and their underlying links with factors associated with inequity.

Primary care data for immunisation is known to be complex, and the information patterns that can be used for vaccine effectiveness are an area of considerable digital maturity in UKHSA's modelling. The authors may wish to seek access to those models, rather than developing them from scratch, where such definitions already exist, and in particular because data aligning to them may be more easily interpretable against existing and future publications.

Vaccine delivery is complex, often regionally specific, and the setting of vaccine delivery is necessarily a topic of great interest to the profession. It may be possible to consider what variations may be understood in the context of the different ways in which immunisation can be delivered, particularly in terms of health equity, and patient experience.

For those presenting in general practice who, clinically, may be given a diagnosis of a viral infection, it is unlikely there will supporting laboratory-based evidence for such a diagnosis. Should such a patient be admitted to hospital due to the severity of symptoms where virology samples may subsequently be collected and analysed, a coded diagnosis

may eventually enter the GP record should any discharge letter make clear what the final diagnosis was. At the time of writing, the SGSS is not available in the OpenSAFELY Data Analytics Platform direction, although we note its potential value in this study, were it to be included. Use of such a resource would enable a more complete understanding of diagnoses than relying on a discharge letter and subsequent coding by general practice. PAG considered the benefits of analysing practice-level patterns, however, as with many data areas and in particular because of small-numbers issues for example, identifying practices within the writeup is not advisable. For example, in primary care contracting, some service models do not account for patient choice e.g. vaccine refusal, and instead apply statistical thresholds, where the denominator does not exclude those patients. These sorts of issues can cause the unfair appearance of a practice underperforming for example. We are therefore interested to see practice-level thematic conclusions, but not practice-level identification in the outputs of the study.