Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 30th June 2026

09:00 – 11:15

(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

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 23rd June 2026 were reviewed and were agreed as an accurate record of the meeting.
3	**Declaration of interests:** In respect of NIC-808571-P5B0J, the RCGP Representative is a clinical advisor to PRIMIS at the University of Nottingham and currently engaged in providing informatic support to the University of Sheffield, in relation to a software medical device trial in collaboration with the Motor Neuron Disease Association and funded by LifeARC. The trail is approaching its final stages of data collection. University of Nottingham is NOT a research stakeholder but providing informatic support only. In respect of NIC-808580-C7R3X, the RCGP Representative is a clinical advisor at PRIMIS, a business operational unit at the University of Nottingham. PRIMIS deliver the PINCER (Pharmacist-led Information technology iNtervention for the reduction of Clinically important ERrors) approach which was previously deployed via the SHAs etc. the RCGP Representative maintains the information and coding model for the PINCER indicators, at PRIMIS.
4. EXTERNAL DATA DISSEMINATION REQUESTS:	
4.1	**NIC Number:** NIC-808571-P5B0J-v0

	Applicant Organisation: University of Bristol **Application Title:** "Estimating neurodegenerative disease burden, underdiagnosis and quality of care in England using linked electronic health records" **Outcome Points:** the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 Please see Appendix A.	
4.2	**NIC Number:** NIC-808580-C7R3X-v0 **Applicant Organisation:** University of Oxford **Application Title:** "The PITSTOP Study: Using routine data to reduce Potentially Inappropriate Primary Care Testing" **Outcome Points:** the Group noted that this application was still under evaluation as not all the necessary information was available to make a full assessment. The PAG Representatives agreed to produce a 'dashboard specification' to further support this and other similar applications presented to PAG for review. It was agreed that the 'dashboard specification' would be presented / discussed at the PAG meeting on the 14th July 2026. In addition, the Group agreed that NIC-808580-C7R3X would be discussed again at the PAG meeting on the 14th July 2026, once the 'dashboard specification had been produced. **ACTION for PAG Representatives**: To produce a 'dashboard specification' prior to the PAG meeting on the 14th July 2026. **ACTION for PAG Secretariat:** To add 'dashboard specification' and **'**NIC-808580-C7R3X' to the PAG meeting agenda on the 14th July 2026. Please see Appendix B.	PAG Reps PAG Sec
5. WIDER PROFESSIONAL INSIGHT		
There were no items discussed		
6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
6.1	Confidential briefing session	
7. Any Other Business		
7.1	**NIC-802553-F6L6G University of Bristol** The Group noted that following the advice provided at the PAG meeting on the 9th June 2026 on NIC-802553-F6L6G, an additional query had been raised by the Group in respect of the machine learning aspect of the application and whether this is compatible with the OpenSAFELY Permitted Methods Policy. The Group noted that as part of the work being undertaken on 'dashboard specification' (please see item 4.2) a further discussion would take place on this application at the PAG meeting on the 14th July 2026.	

	ACTION for PAG Secretariat: To add 'NIC-802553-F6L6G' to the PAG meeting agenda on the 14th July 2026.
7.2	**National Data Opt-outs (NDOO)** Notwithstanding the information within the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 in respect of NDOO, the Group agreed to produce a paper outlining the potential risk of identifiability of individuals, for example, as data is minimised. **ACTION for PAG:** To produce a paper outlining the potential risk of identifiability of individuals in respect of NDOO.
7.3	**Published Code List** The Group discussed the implications of using existing published code lists when undertaking research in OpenSAFELY, and agreed to produce a standard feedback document that could be shared with applicants on this subject. **ACTION for PAG:** To produce a standard feedback document on the implications of using existing published code lists when undertaking research in OpenSAFELY.
Meeting Closure As there was no further business raised, the PAG Chair thanked attendees for their time and closed the meeting.	

Appendix A

Profession Advisory Group (PAG) Feedback Form - OpenSAFELY

Meeting Details	
PAG advice sought by NHSE:	22/06/2026
Date of PAG advice:	30/06/2026

Application Details			
NIC Reference:	DARS-NIC-808571-P5B0J-v0 OpenSAFELY Ref: AOS-2026-1019	**Application version Number:**	V0
Applicant Organisation:	University of Bristol		
Application Title:	Estimating neurodegenerative disease burden, underdiagnosis and quality of care in England using linked electronic health records		

Attendees		
Representing Organisation	**Name**	**Role**
British Medical Association (BMA)	Mark Coley	BMA Representative
Royal College of General Practitioners (RCGP)	Tom Nichols	RCGP Representative

Declarations of Interest

RCGP Rep is a clinical advisor to PRIMIS at the University of Nottingham and currently engaged in providing informatic support to the University of Sheffield, in relation to a software medical device trial in collaboration with the Motor Neuron Disease Association and funded by LifeARC. The trail is approaching its final stages of data collection. University of Nottingham is NOT a research stakeholder but providing informatic support only.

MC 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

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

There is a formatting issue in the application, which means we cannot be 100% certain whether or not ethical approval has been granted:

We identify no specific ethical issues with this application.

Primary care records are rich in clinical codes and prescribing of the type relevant to the study, with some exceptions.

Time-out-of-hospital is an attractive clinically meaningfully variable, but the landmarks are not consistently recorded in primary care. For example, where an inpatient unit has not created a discharge summary (at times, the percentage of discharge summaries generated can be as low as 50% even from digitally advanced hospital trusts), and codification of the admission and discharge dates will not be coded precisely in primary care records, as those are not variables required to be machine readable – a clinician would refer to the document normally, not the coded record, if wanting to interpret. The

hospital-sourced data held in OpenSAFELY may be able to adequately provide for this measure.

The authors should expect to encounter dilemmas when determining the coding model for identifying diagnostic terms. Caution to understand the precise use-case for any given coding model should be exercised, prior to relying on any particular code list. For example, some of the conditions are part of national enhanced services, such as dementia etc, but the code lists used by the GP Quality & Outcomes Framework (GPES datasets) are deliberately focussed on service delivery, and they come with a warning that they should never be used for clinical care. There are conditions which specialists would want to consider, which have been actively excluded from the QOF dataset. Further, in neurodegenerative disease, the 'churn' of older data concepts which have now been deactivated is considerable. This means that many patients will have older syndromal conditions which were recorded either in Read v2, or with SNOMED CT concepts which have now been inactivated. Any code lists used to identify these codes necessarily required advanced understanding of how to apply the SCT Query Table, in order to look at historical relationships, as well as public usage data, to understand which Inactive SNOMED concepts should be included.

Consideration should be given to whether to expand datasets beyond coding models, to look for proxy information which may indicate uncoded neurodegenerative disease, such as multiple entries of dementia annual reviews etc, or 'prescribing without diagnosis' indicates such as dementia treatments with no diagnosis.

The authors may wish to contact the Motor Neuron Disease Association to understand what level of maturity is available in their coding models.

Care would also be needed when looking at any geographic spread of conditions particularly, with regard to proxy measures for deprivation (such as postcode), as care homes (Dementia Care Homes and Specialist Nursing Homes for Mental Health) that care for those with dementia may be strategically positioned in areas where land prices are less expensive and there is a nearby workforce.

We are interested in the role of antiplatelets in the cohort of patients with vascular dementia only without other indications. The current CKS guideline does not comment on this issue, and we can find no other routine authoritative guideline which instructs us.

We note a Cochrane Review on the issue: Antithrombotic therapy to prevent cognitive decline in people with small vessel disease on neuroimaging but without dementia https://doi.org/10.1002/14651858.CD012269.pub2. We believe that where in the past primary prevention with Aspirin was the clinical norm for many patients, and secondary prevention was given under the

precautionary principle, there may be patients who remain on antiplatelets who have vascular dementia without another indication for antiplatelets. We wonder whether this would be an interesting, GP-centric metric to uncover with a mind to supporting future guidelines which may or may not instruct GPs to prescribe for this indication.

This study approaches many of the Quintuple Aims for health care system improvement

Population Health – these conditions are important to the public, with rising rates in the population, with considerable social impact. Therefore, data have potential to guide policy and scientific understanding.

Patient Experience – by supporting the identification of underdiagnosis, and analysing adherence to NICE quality indicators, gaps in care may be identified which could lead to correction. "Time of out hospital" is an extremely patient-centric metric, if it can be analysed reliably from primary care records, or, with data linkage.

Making effective use of resources – these conditions can be high cost, and early diagnosis can make a material difference, so insights may yield gains in reducing avoidable wasted resource

Staff experience – it may not have an immediate direct on front-line clinicians.

Advancing health equity – a core strength is that inequalities are being analysed including demographic and geographic differences and is therefore powered to support knowledge gains in this area.

Appendix B

Profession Advisory Group (PAG) Feedback Form - OpenSAFELY

Meeting Details	
PAG advice sought by NHSE:	22/06/2026
Date of PAG advice:	30/06/2026

Application Details			
NIC Reference:	DARS-NIC-808580-C7R3X-v0 OpenSAFELY Ref: AOS-2026-1038	**Application version Number:**	V0
Applicant Organisation:	University of Oxford		
Application Title:	The PITSTOP Study: Using routine data to reduce Potentially Inappropriate Primary Care Testing		

Attendees		
Representing Organisation	**Name**	**Role**
British Medical Association (BMA)	Mark Coley	BMA Representative
Royal College of General Practitioners (RCGP)	Tom Nichols	RCGP Representative

Declarations of Interest
TN is a clinical advisor at PRIMIS, a business operational unit at the University of Nottingham. PRIMIS deliver the PINCER (Pharmacist-led Information technology iNtervention for the reduction of Clinically important ERrors) approach which was previously deployed via the SHAs etc. TN maintains the information and coding model for the PINCER indicators, at PRIMIS. **MC 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?
Under Review – dashboarding consideration
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
This study has the potential to be highly strategic, and with a broad-based approach to the Quintuple Aims for health care improvement. **Population Health – undertesting and overtesting have a considerable impact on patients, and both are directly harmful. Knowledge in this domain and rationalisation of care is automatically helpful.** **Patient experience – the authors set out a series of clinically meaningful harmful outcomes which could be improved with operational understanding. Testing the right patients at the right time is very valuable for engaging patients** **Managing resources effectively – any improvement in under or overtesting has the potential to optimise resource usage, as well as avoiding expensive preventable complications associated with LTCs and their treatment. There is good evidence that a data-driven approach in this domain is effective, when accompanied by appropriate support.** **Staff experience – undertesting is associated with considerable head-space for staff, and anxiety related to getting the tests done, in order to prevent iatrogenic harm. Overtesting is associated with unnecessary time and energy at a time when there are considerable workforce and problems with working conditions. The harms associated with iatrogenic complications are incredibly stressful for primary care staff, and so having good data systems**

to correctly identify those needing intervention is inherently calming and good for clinicians.

Advancing health equity – the authors set out a series of approaches to making sure that the data are stratified to expose inequity, and help shape fair and appropriate access and care provision.

On variations:

The study will likely expose considerable variations in observed data. The time period for the data include historic data, from before the introduction of SNOMED CT, and will therefore face the challenges of both understanding the differences between how laboratory data were coded in READ, and the difficulty in the separation of the codes related to lab readings in READ, and the Alternative Mapping for Observables which resulted in the separation of the Values from those codes, to separate codes. There are additional challenges in understanding the Inactivation of many key observables in the specific indicators described, which will mean that mature code lists will need to be developed or re-used which are able to respond to the public usage data as well as advanced understanding of how to apply the Query Tables in SNOMED CT to make sure that non-ambiguous mappings of the codes are integrated. NB the re-use of any existing code lists should be accompanied by the cautious examination of the metadata including use-case and do-not-use-cases for the concept lists. For example, where the GP Quality & Outcomes Framework specifies lab codes for contemporaneous use, those code lists may not be appropriate for service delivery analysis of historical data, particular with the legacy issues.

Dashboarding down to practice / PCN level is allowable in OpenSAFELY but requires special consideration from the profession, because of the risks of data quality issues being misunderstood and causing the appearance of a gap in care where it may not be the case. We therefore seek further information on the detail of the dashboarding, and strategic intention.

Providing meaningful data to GP surgeries can be extremely effective, but the change management principles required to deliver effective intervention require more than good data. The authors' overall aims appear to be strategic, but the practical difficulties may prove challenging. In general terms, practices typically benefit from the support of regional prescribing advisors who will work with the primary care teams to optimise prescribing. The target for the dashboards should also be considered – how to bridge between the user base of practice-based pharmacists, and other clinicians working in GP and nursing roles.