Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 21st July 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
Vicki Williams (VW)	PAG Secretariat, Privacy, Transparency and Trust (PTT), Technology, Digital and Data
PAG MEMBERS NOT 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 14th July 2026 were reviewed and, after minor amendments, 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-808600-B4C8V-v0	

	Applicant Organisation: University of Bristol **OpenSAFELY Ref:** AOS-2026-1005 **Title:** "DEPILL-CKD_ DEPrescribing In peopLe Living with advanced Chronic Kidney Disease – understanding patterns and outcomes" **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-808601-D2G5B-v0 **Applicant Organisation:** University of Oxford **OpenSAFELY Ref:** AOS-2026-1059 **Title:** "CIPHER_ Cardiovascular Inequalities in Primary care – an electronic Health records study focusing on Equitable management of cardiovascular Risk in England" **Outcome Points:** the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025. See Appendix B	
5. WIDER PROFESSIONAL INSIGHT		
	There were no items discussed	
6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
	There were no items discussed	
7. Any Other Business		
7.1	**PAG Processes**	
i)	The PAG calendar of attendance for the financial year was shared with PAG and it was agreed to be uploaded to the Group's SharePoint for information.	Sec
ii)	The PAG forward plan was shared with the Group and it was agreed to be uploaded to the PAG SharePoint for information.	Sec
iii)	A PAG process map was briefly discussed and it was agreed to add to the PAG forward plan for a future discussion.	Sec
iv)	The OpenSafely PAG form was discussed briefly and it was agreed to add to the PAG forward plan for a future discussion so that feedback on the form could feed into the pilot evaluation.	Sec
v)	Quoracy of PAG and alignment with the PAG Terms of Reference (ToR) was briefly discussed for example if the BMA representative was not available and the process around seeking a professional representative from the House, alongside the relevant PAG processes which underpin the Group.	Sec

vi)	It was agreed that the PAG ToR and ways of working would be substantive discussion item at PAG on the 22nd September 2026. It was agreed that the PAG Secretariat would set up a template for 'professional advice from the Houses' to support Applicants with guidance ahead of them writing and submitting applications, and to add to the PAG forward plan for a future discussion. It was also agreed this item would have an annual review	Sec

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:	14/07/2026
Date of PAG advice:	21/07/2026

Application Details			
NIC Reference:	DARS-NIC-808600-B4C8V-v0 OpenSAFELY Ref: AOS-2026-1005	**Application version Number:**	V0
Applicant Organisation:	University of Bristol		
Application Title:	DEPILL-CKD_ DEPrescribing In peopLe Living with advanced Chronic Kidney Disease – understanding patterns and outcomes		

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

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

We recognise the clinical problem, and the lived experience of managing patients in this cohort, where evidence-based guidelines that were developed in constrained contexts (e.g. use this drug for this condition) without overlap in understanding is associated with polypharmacy, both by 'drift' as the patient develops multiple problems, by the selective identification of individual prescribing decisions out with a holistic patient review, and the ageing context. We recognise that in this cohort, even a structured medication review can leave us struggling to weigh these things in the balance to arrive at the patient specific decisions which are necessary. We also note that the challenge of taking a blended approach to prevention vs palliation is often influenced by the people around the patient including family, friends and carers, who all need to be on-board with de-prescribing decisions, or the patient is often re-started on the drugs by someone who did not understand the careful decision making that went into the deprescribing.

Although the author specifies the use of creatinine measurements, we would recommend the use of eGFR in preference to creatinine, because of the closer interpretability in primary care records. Historical data from 2006 onwards should include eGFR calculations derived from the MDRD equation, but that the majority of laboratory reporting is now using the CKD-EPI equations. We also wish to point out that there has been a 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 the study date of 1st March 2022. The clinical rationale for the 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.

We encourage frank acknowledgement with the PPIE exercises that the original MDRD equation's deployment in the UK was suboptimal because the technology is not yet available to reliably collect and communicate ethnicity from requesting GP IT systems at the point of requesting kidney function tests. This resulted in the recording of MDRD results for all patients using the assumption of non-African-American ethnicity, and will have affected accuracy in the identification and monitoring of renal conditions.

Please find attached a document exploring the coding of ethnicity.

We were interested in the author's goal to explore protected characteristics, which we infer to be the 9 characteristics from the Equality Act 2010.

The following can be reliably extracted from OpenSAFELY

- Age, disability, pregnancy and maternity, sex and gender

The following may be present, but the data will be incomplete

- Marriage and civil partnership, race, religion or beliefs, and sexual orientation

The following are topics within the Legally Restricted Code Lists, and the authors should discuss with NHS England whether those data are available in OpenSAFELY, if there is an intent to use the information:

- Gender Reassignment

This study approaches the Quintuple Aims for health care improvement nicely:

The population health benefits of reducing harmful prescribing are identified and quantified, and the potential for data to improve this is high.

Reducing prescribing burden and medication-related harm is an inherently patient-centric goal, and rational decisions have the potential to improve the experience for patients and their carers

The prescribing dilemma for these patients is real, stressful, time consuming and involves discomfort as to both liability and the perception of liability through de-prescribing, so evidence to support these decisions and communicate them would be very welcomed by the workforce.

The cessation of unnecessary medication and the reduction of medication-related harms would automatically be cost saving, and is a realistic goal of this study.

The recording of ethnicity and involvement described in PPIE gives the study a good scope to explore the role of ethnicity in determining these harms, and exposing any opportunities to advance health equity.

The study has the potential to set the scope for a future interventional study. As the prescribing decisions observed were made in a context which is not machine-readable (i.e. the reasons why medication was stopped will not be documented), caution in guidance should be exercised until interventional studies can explore prospective decision making.

Attachment to be appended to future PAG minutes: Professional advice on coding model design in OpenSAFELY

Appendix B

Profession Advisory Group (PAG) Feedback Form - OpenSAFELY

Meeting Details	
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Date of PAG advice:	21/07/2026

Application Details			
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Applicant Organisation:	University of Oxford		
Application Title:	CIPHER_ Cardiovascular Inequalities in Primary care – an electronic Health records study focusing on Equitable management of cardiovascular Risk in England		

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

Declarations of Interest
RCGP Representative is a Clinical Advisor to PRIMIS at the University of Nottingham, and has worked with Professor Sheppard, the study applicant's PhD Supervisor previously in that role. BMA Representative has no declarations of interest.

Advice Required

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

1c. Advice from the Profession

We acknowledge the clinical importance of cardiovascular risk prevention, and the existing understanding that there are significant opportunities for advancing health equity in this space.

The focus on the NHS Health Check programme is highly topical, because of the publication in recent years of the NHS Health Check Standard by the Professional Record Standards Bureau https://theprsb.org/standards/nhshealthcheckstandard and the current DHSC digital health checks programme https://digitalhealth.blog.gov.uk/2025/06/03/dhsc-health-checks-complete-your-nhs-health-check-alpha-assessment/

Our lived experience is that the NHS Health Checks programme over the years has generated mixed feelings in the profession. The programme was originally deployed in primary care, where it was felt to be part of providing holistic care to the patient, and feedback from clinicians was that the management of care after the event of an NHS HC was optimal because of the closed loop between the identification of need for risk screening, through to the eventual decisions and long-term care of the patient.

We are aware of frustration expressed by primary care arising from the shift in commissioning away from primary care to alternative services providing the checks. Issues have arising from communication from other providers, and concern is expressed about the fragmentation of the holistic approach that General Practice aims to achieve and can offer when such programmes are delivered through General Practice.

The profession is therefore interested as to whether the study will expose the differences in outcome between the different service models, and whether these observations can be made and documented to better inform the discussion.

We note the involvement of PPI from the homeless and prison populations, but that the patient records in OpenSAFELY are likely to be incomplete. In broad terms, the historical provision of primary care to the homeless is often boundaried from conventional general practice, in large part due to the funding streams, which tend to come from local authorities rather than through NHS commissioning. The result can be that primary care records may not be within the core GP system suppliers. The absence of systems such as GP2GP for example, can result in a digital-> paper transformation of the record if the provider of primary care is not using a GP2GP compatible record transfer system, and likewise on re-registration with a normal GMS/PMS practice, the record may remain non-machine-readable.

This is also an issue affecting prison populations, whose GP record systems often do not interoperate with NHS GP systems. In view of these factors, the authors may find it very difficult to identify these populations from the pseudonymised records, and where they do, their data may not be accessible.

We would be interested to see which data are available, and note that the data issues themselves are part of a vicious cycle that drives inequity for these populations.

Please find attached a document describing the issues you may expect to face in relation to the available published code lists, and the pitfalls of re-using QOF code lists, or existing code lists that have been used for other projects.

In particular, it is worth drawing your attention to the public availability of the Qresearch cardiovascular orientated code lists, which underwent assurance by NHS Digital in recent years, demonstrating considerable maturity. As NICE recommend the use of the QRISK3 algorithm, careful re-use of those definitions may allow easier interpretability with the QRISK2 and QRISK3 calculations

We also caution of the difficulties in record keeping in ethnicity in primary care, which is hampered by the lack of machine-level national standards for recording of ethnicity in the setting, and the absence of coding decision support that might be necessary to prevent data corruption e.g. recording of conflicting ethnicities without resolution.

Again, this is an area where the validation of the Qresearch ethnicity definitions may be of use, as they were specifically tailored to cardiovascular risk calculation.

This work approaches the following of the Quintuple Aims for health care improvement:

Population health – it is an important group of health conditions, and any insights leading to change therefore scale with the breadth of the topic

Patient experience – by identifying the pathways are associated with the best outcomes, recommendations from this work may facilitate better experiences for those accessing care

Staff experience – if this study exposes important differences between the outcomes of pathways, including where those pathways are delivered, it will allow rational commissioning that makes best use of NHS staff.

Managing NHS resource effectively – evaluation of pathway impact has the potential to improve where resource should best be spent, and how to direct it at those in most need.

Advancing health equity – this aim is the very core of the study.

The OpenSAFELY platform has enormous potential for this sort of study because of the scale that it can provide in terms of population health data, and it is good to see applications that will make use of this power.

Finally, we wish to draw the attention of the authors to the mismatch between the clinical requirements for lipid lower drug prescribing and the available tooling. For example, many lipid-lowering guidelines advocate for percentage reductions in the levels of the targeted lipids. In primary care however, the clinical decision support tooling required to make such determinations is limited to a clinicians' willingness to engage in tabular or graphical trends over time. We do not have available core programming to help compute sensible parameters, to determine treatment success or failure.

If a study such as this (with the ability for data processing) is able to expose clinically meaningful data patterns that could be influenced by such calculations, then the Joint GP IT Committee would be supportive of requests for the GP IT Roadmap to include requirements for GP Supplier Systems to develop additional tooling to support a computational approach to this issue.

Attachment to be appended to future PAG minutes: Professional advice on coding model design in OpenSAFELY