Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 28th July 2026

09:00 – 11.20

(Remote meeting via videoconference)

PAG MEMBERS IN ATTENDANCE:	
Role:	
GP Representative from the British Medical Association (BMA) (in attendance for items 1 to 6.1 (part) and 7.1i)	
GP Representative from the Royal College of General Practitioners (RCGP)	
NHS ENGLAND STAFF IN ATTENDANCE:	
Name:	**Role / Area:**
Narissa Leyland (NL)	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 21st 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-810118-F0H1M-v0	

	Applicant Organisation: University of Liverpool **OpenSAFELY Ref:** AOS-2026-1070 **Title:** "Understanding safe, effective medicine use in the NHS" **Outcome Points:** the Group noted that not all the necessary information was available to make a full assessment in relation to the authors intention to apply the NDOO to this study, but were clear that if the ethics approval stated that the NDOO was applied, the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025. If a different reason for the application of the NDOO, then the rationale should be provided for consideration by PAG. See Appendix A	
4.2	**NIC Number:** NIC-810119-Z7W0S-v0 **Applicant Organisation:** PrescQIPP CIC **OpenSAFELY Ref:** AOS-2026-1076 **Title:** "NHS England Medicines Safety Improvement Programme Evaluation" **Outcome Points:** the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 The Group noted that the application should be compliant with OpenSAFELY policies and procedures. **ACTION separate to the application:** the Group agreed that it would be advantageous to pull together a list of the applications to date that had requested the National Renal Registry, which could support onboarding of new datasets to the OpenSAFELY in the future, and upload a copy to PAG SharePoint. See Appendix B	NL / Sec
5. WIDER PROFESSIONAL INSIGHT		
5.1	**National Data Opt-outs (NDOO)** Whilst considering item 4.1, the PAG were clear that they could not conceive of a scenario where they would not support the application of the NDOO, unless it was an obvious error by the applicant when completing their OpenSAFELY application. **ACTION:** to check the existing applications that had asked for the NDOO to be applied and did they have ethical support. If not, then a further discussion at PAG was required.	TO NOTE NL
6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
6.1	**Confidential advice session**	
7. Any Other Business		
7.1 **i)**	**PAG Processes** Quoracy of PAG and alignment with the PAG Terms of Reference (ToR) was briefly discussed for example if the RCGP representative was not available and the process around seeking a professional representative from the House.	

ii)	It was agreed that the PAG Forward Plan would be discussed at a future meeting.	

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:	20/07/2026		
Date of PAG advice:	28/07/2026		
Application Details			
NIC Reference:	DARS-NIC-810118-F0H1M-v0 OpenSAFELY Ref: AOS-2026-1070	**Application version Number:**	V0
Applicant Organisation:	University of Liverpool		
Application Title:	Understanding safe, effective medicine use in the NHS		

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 Oxford, who have a contract for services with the British Society for Heart Failure (BSfH), for the development of information models to support their 25 in 25 programme. https://www.bsh.org.uk/25in25 . The RCGP representative is responsible at PRIMIS for maintaining the data models for the PINCER programme, and is a co-author of the information models in the BSfHF programme.

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
This study has strategic appeal in line with the following of the quintuple aims for health care improvement: Population health – by generating insights into the implementation of national guidelines Effective use of resources – the treatments being studied have already been evaluated for cost-effectiveness by NICE. Understanding patterns of implementation may help understand how guidance should be issued, and add understanding to the effectiveness of its decisions. Advancing health equity – by focusing on and exposing geographical variations in prescribing. The authors may wish to consider ethnicity as another variable. Staff and patient experience are not in scope for the work planned. We note that there is an intention to create reproducible phenotypes (which are normally referred to as code lists in informatics circles), which is a laudible social aim. PAG acknowledges the potential benefits of doing so, and notes that the BSfHF have published the information model they commissioned, which is available for request from their website. The adoption or adaptation of the BSfHF models may be considered. All code lists can be considered on a scale of digital maturity such as the Code List Maturity Index, and the use of advanced tooling, integration with public usage data, are all multiplicative with the skill and experience of the authors and operational processes such as peer review. We note that the real-world impact of research phenotypes is often dependent on maintenance cycles (to accommodate the planned changes in SNOMED CT) and that in the absence of maintenance and deployment mechanisms, the value of even mature code lists reduces progressively over time without maintenance, and feedback systems. There are specific issues in the codability of data relevant to heart failure, the distribution of available data, which are relevant to the study. Please be aware that the existing

national reference sets used for the GP contract are not calibrated to the use case proposed, and would require significant adaptation.

Understanding and documenting drug treatment benefits from gathering recorded clinical findings which may appear in coded records for example where a patient has explicitly dissented to a treatment, has an allergy or adverse drug reaction history, or a clinical judgement that indicates that the treatment is not clinically necessary / appropriate. The pace at which SNOMED UK has caught up with the recordability of the newer treatments for heart failure means that until recently, many of these findings could not be recorded – there were no Concepts. Although the required codes have now become available, it is not a matter of public record whether those have become available for entry in GP Supplier Systems.

Additionally, the authors may wish to consider whether or not the clinical judgement that a treatment regime has been titrated to the maximum tolerated treatment level, for the different regimes. These are sometimes recordable, and help to add nuance to the statistical observations. We note that prescribing budgets are a regional issue, which have been managed by consecutive regional health authorities such as the Clinical Commissioning Groups and now Integrated Care Boards. Those bodies exert key influence on GP surgeries such as

1 – Low Priority Statements, where a treatment is restricted to Individual Funding Requests

2 – Prescribing Formularies, which determine whether a region has decided that a treatment should be initiated in primary or secondary care, and shared care arrangements. These influence prescribing

3 – Regional prescribing guidelines, which advise GPs when to prescribe treatments

4 – Software-based prescribing support tools, which operate in a modular capacity to interrupt prescribing, and offer alternatives to the prescriber

5 – Prescribing Schemes, which can be incentivised, which target prescribing patterns.

We therefore feel there are considerable known influences on regional prescribing patterns. PAG is keen that factors such as these, which we perceive to heavily influence prescribing, are explored when documenting prescribing patterns, where the autonomy of the prescriber may be better understood in light of this.

Appendix B

Profession Advisory Group (PAG) Feedback Form - OpenSAFELY

Meeting Details			
PAG advice sought by NHSE:	20/07/2026		
Date of PAG advice:	28/07/2026		
Application Details			
NIC Reference:	DARS-NIC-810119-Z7W0S-v0 OpenSAFELY Ref: AOS-2026-1076	**Application version Number:**	V0
Applicant Organisation:	PrescQIPP CIC		
Application Title:	NHS England Medicines Safety Improvement Programme Evaluation		

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 at PRIMIS, and responsible for maintaining the data modelling for the PINCER (Pharmacist-led Information technology intervention for reducing Clinically important Errors) programme.

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 ehrQL's "event-level data extract" request is consistent with the existing policy and national data direction

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 work is broadly strategic, and approaches each of the quintuple aims for healthcare improvement:

Population health – reducing medicines-related harm is important

Patient experience – effective reduction in harmful prescribing is of direct benefit to the experience of accessing health care treatment for patients and their carers

Staff experience – medication-related harm is a constant concern for healthcare professionals. The concern to prescribe well is associated with professional stress, and the ethical and medico-legal liability from unidentified prescribing harms is one of the constant pressures under which staff operate. Systems which help us identify and reduce medication-related harms are therefore very welcome.

Effective use of system resources – medication-related harm is expensive to put right, and there are cost savings in reducing risky prescribing, and from preventing harmful events.

Advancing health equity – the authors identify deprivation as a focus. The authors may wish to consider accessing the primary care ethnicity data which are available.

We acknowledge and agree with the authors observation that this work would benefit from integrated data from the Renal Register. At the time of writing, these data are not available in the OpenSAFELY Data Analytics Service, which continues to work towards making such sources available.

There are several difficulties the authors may face in interpreting the dosing regimes, because of the lack of national GP supplier system standardisation in machine-readable dose syntax. For example, where 20mg capsules of the drug Omeprazole are less than half the price of 40mg capsules, standard practice in the NHS is to prescribe the drug with the following dose instructions

"take 2 capsules once daily in the morning"

GP systems may allow this free text to be linked with a machine-readable record that allows it to be interpreted as quantity per day = 2 but many prescriptions are issued in free text, without properly programmed equivalent definitions. Those definitions are created the first time a free-text prescription is issued, and are subject to user error. Once created,

they are often not corrected for errors, and they are organisation specific. This means that interpretability may be difficult, even where machine-readable metadata are available, as the prescription free-text is not available in OpenSAFELY.

We note that NHS England continues its work on a national Dose Syntax programme of work which is on the GP IT Roadmap for implementation in GP Supplier Systems.

We have some concerns on whether the review of a harm is a recorded event in primary care. There are no systems known to us which standardise the recording of specific medication-related harms, or reviews relating to them, so the authors may find it difficult to obtain these from the coded record.

This is also true of the recordability of additional contextual data to understand the justification of prescribing decisions, for example, where a patient taking valproate does not require contraception. This may not be consistently recorded as a coded entry and instead may form part of the free text substance of a review. We note the high variability in the use of 169445007 | Contraception not needed (finding) | in public usage data for example, which are significant, and indicate policy / procedural differences.

Converting prescribing data patterns for this field is challenging, and we note that combining data with interventions has an evidence base e.g. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61817-5/fulltext

When reviewing the paper, we considered the overlapping systems that are in place for managing prescribing safety, which may not present a coherent and strategic approach. The systems include but are not limited to the built-in prescribing safety support e.g. GP Supplier System interfaces and specific functions, proprietary software such as prescribing decision support tooling commissioned by the regional health authority, and additional toolkits which are deployed. Each of these can cause conflict between the others.

We therefore observe that in documenting the findings of research such as this, there may be policy recommendations that could be taken such as identifying the need for standardised systems for prescribing safety, with single definition approaches to the machine-readable models to maximise consistency.