

Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 14th July 2026

09:00 – 11:30

(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 7 th July 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-808592-Q9G2W-v0

	Applicant Organisation: London School of Hygiene and Tropical Medicine Application Title: “Understanding the need for conservative kidney care in England” Outcome Points: the Group were supportive of the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025, only if the relevant datasets, in this instance, renal registry data, was in OpenSAFELY. If the renal registry data was not in OpenSAFELY then not all the necessary information was available to make a full assessment. See Appendix A	
4.2	NIC Number: NIC-808593-D0K0P-v0 Applicant Organisation: UK Kidney Association Application Title: “Improving kidney failure risk calculations in ethnically diverse populations” Outcome Points: the Group were supportive of the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025, only if the relevant dataset, in this instance, renal registry data was in OpenSAFELY. If the renal registry data was not in OpenSAFELY then not all the necessary information was available to make a full assessment. See Appendix B	
4.3	NIC Number: NIC-808580-C7R3X 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, PAG has developed a draft specification to assist with identifying the information that would be required from applicants to support any outputs of data at a PCN or GP level. The specification will be shared with applicant post meeting to gather the required information. Where the data granularity could identify a PCN or GP Practice there is a requirement for any release of data must be supported by the GP Profession and NHS England. A clear definition of when the data granularity in a dashboard is high enough to trigger that requirement, in the event of health sector restructuring. ACTION separate to the application: PAG to draft a process map for dashboards for discussion at a future meeting.	PAG
4.4	NIC Number: NIC-802553-F6L6G Applicant Organisation: University of Oxford Application Title: “REDUCE-HF, an electronic health records study of inequalities in heart failure diagnosis in England” 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, PAG has developed a	

	draft specification to assist with identifying the information that would be required from applicants to support any outputs of data at a PCN or GP level. The specification will be shared with applicant post meeting to gather the required information. Where the data granularity could identify a PCN or GP Practice there is a requirement for any release of data must be supported by the GP Profession and NHS England. A clear definition of when the data granularity in a dashboard is high enough to trigger that requirement, in the event of health sector restructuring. ACTION separate to the application: PAG to draft a process map for dashboards for discussion at a future meeting.	PAG
5. WIDER PROFESSIONAL INSIGHT		
5.1	PAG Terms of Reference (ToR) The Group re-reviewed v0.5 and finalised v1.0 and were content, and asked that the 12-week review be pencilled in for September 2026. ACTION: PAG Secretariat to add to PAG Forward Plan for review on the 22nd September 2026	PAG Sec
6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
6.1	Confidential Advice session	
7. Any Other Business		
7.1	NIC-808021-X3K8V-v0 University of Oxford “Trends and Variation” The Group noted that at the meeting on the 23rd June 2026 the PAG representatives had agreed to document missing information required out of committee. The Group noted that this action was still outstanding and that they would provide an update at a future PAG meeting	
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:	06/07/2026
Date of PAG advice:	14/07/2026

Application Details			
NIC Reference:	DARS-NIC-808592-Q9G2W-v0 OpenSAFELY Ref: AOS-2026-1040	Application version Number:	V0
Applicant Organisation:	LSHTM		
Application Title:	Understanding the need for conservative kidney care in England		

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, conditionally (see below)
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
At the time of reviewing the application PAG understands that the UK Renal Registry (UKRR) data is not yet available within the OpenSAFELY Data Analytics service. PAG is aware that it has been available for COVID19-related studies under the COVID19 directions. The following advice is therefore offered on the assumption the UKRR data becomes available to the OpenSAFELY service under its current direction. Should it not become available, PAG is unsure how the study will operated with the available data and would request further information be provided by the authors as to how well the existing datasets within the OpenSAFELY service can answer the study aims. We identify the value of the study proposition, noting that it illustrates the use-case for making UKRR data available in OpenSAFELY extremely well. The clinical question of whether dialysis provides clinically meaningful outcomes for older, multimorbid patients is a focussed, important, and the benefits of the understanding will increase over time with the increasing population of this cohort. The authors do not specify the use of the HES data available through SUS for assessing the burden of hospital admissions, but this may be an omission of summarisation. We note that primary care data surrounding admission and discharge dates is not reliable because creating a contemporaneous record is difficult in practice as the data are not always shared and can be incomplete, there is no clear operational imperative to doing so, and generating data is not prioritised and remunerated contractually. The authors mention twice, both in the project summary and the lay summary, that it is unknown if dialysis helps patients live longer. It reads as if life expectancy is the only question to be considered by this study. Improvements to patients' quality of life should

also be considered and PAG hopes the mentioned clinical trial will look at the wider picture.

This work aligns well with the Quintuple Aims because

- It focusses on answering a population health issue which has been constrained by previous data sources, and the unique datasets in OpenSAFELY can provide answers that are hard to assess from other data sources.
- The dilemma for older, multimorbid patients considering dialysis is hugely impactful for patients and families. Unlike conditions such as cancers and other chronic diseases, there is little to inform the public and professionals involved. Data which inform these conversations will be highly impactful for this focussed cohort of patients
- Clinical counselling of patients in this cohort and the long-term management in primary care can be very difficult for general practice and staff, where the decision on dialysis is of itself a proxy for the patient approaching a phase where palliation may be the most appropriate approach. Where the patient does not have other 'trajectories to death' established, this can be very stressful, and impactful on other decisions such as prescribing of primary and secondary prevention, and the involvement of other services. Any data which can be used to support advice will be very welcome. The context of this is also important – for the first time in around 23 years, General Practice is no longer commissioned under the GP Quality & Outcomes Framework to maintain a Palliative Care register of patients. Therefore, as new frameworks are being explored to identify those most in need and how to serve those needs, the outputs may be supportive of new national policy.
- Dialysis is an expensive intervention, so research guiding its commissioning and deployment rationally should support cost-effectiveness.

The authors plan to include deprivation and ethnicity in the research, allowing the knowledge to potentially advance health equity. This means that the study is highly strategic, while focussing on a narrow scope of patients, and should make excellent use of the platform.

GP data is rich in data which can be used to evaluate those with advanced renal disease, because it contains both relevant observable entities (including height, weight, BMI calculations, and other metrics including waist circumferences) as well as ethnicity data, all of which can influence the interpretation of the specific laboratory calculated values such as the older MDRD equation and the newer CKD-EPI calculations.

The authors may wish to know that that prescribing safety issues have been associated with a paradigm shift in the use of the Cockcroft & Gault formula, as evidenced by the Public Usage Data

For example the (actual weight) variant, rising from 30,000 uses in 2022-2023 to 1.2 million the following year, and 2.4 million times in the year summer 2024 to summer 2025 – an increase of 80,000% in three years in how often it was recorded.

Similarly 3000 to 400,000 for the variant calculated against adjusted body weight (120,000% increase in the number of recorded calculations)

~2000 to ~200,000 for the variant using ideal body weight (90,000% increase).

We therefore wish to draw attention to these variables, which are novel, and used by primary care teams in support of prescribing DOACs, and the data patterns may allow insights which are not normally available, if contrasted with the laboratory calculated values, which do not account for the patient's body mass.

The contractual drivers for general practice have never incentivised the recording of CKD stage beyond Stage 3 onwards or not, and so the authors will also be in an interesting position to consider the data quality observations that this work will expose them to, for questions such as

How strong is the association between CKD staging codes, and observed eGFR calculations?

What is the delay between eGFR crossing defined staging thresholds, and the recording of CKD staging codes?

Are there associations between the recording of CKD staging codes with the measured outcomes of hospital admission or death?

These data quality observations may help inform decision support tools for primary care, where research looking at code use can helpfully influence the GP IT roadmap in which initiatives to improve coding support can be deployed.

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Applicant Organisation:	UK Kidney Association		
Application Title:	Improving kidney failure risk calculations in ethnically diverse populations		

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 former employee of NHS Digital and NHS England, and undertook assurance of the coding model used by the tooling produced by the Qresearch organisation, which included systematic review of the use of ethnicity codes. The assured code lists are published in the public domain by Qresearch. The BMA representative has no interests to declare.

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definitions have never given rise to the implementation requirements for system change, such as would be necessary for effective and consistent recording.

For example, SNOMED CT remains largely constrained to the GP Subset (although the two dominant GP system suppliers are expanding their scope over time), and the breadth of coding has never been realised. There has been no systematic curation of the terminological possibilities against user choice, and the result is highly idiosyncratic recording in primary care, which is notoriously difficult to use in practice.

We therefore caution the authors that a high degree of digital maturity is needed in the coding models used to consider ethnicity, and for meaningful interpretation, either pre or post-processing may be required to tackle the inevitable data conflicts e.g. recording of ethnicity A followed by ethnicity B followed by C, or even returning to A over time. The use-case of any ethnicity lists should therefore be carefully examined if de-novo coding models are not to be developed.

GP data is rich in data which can be used to evaluate those with advanced renal disease, because it contains both relevant observable entities (including height, weight, BMI calculations, and other metrics including waist circumferences) as well as ethnicity data, all of which can influence the interpretation of the specific laboratory calculated values such as the older MDRD equation and the newer CKD-EPI calculations.

The authors may wish to know that that prescribing safety issues have been associated with a paradigm shift in the use of the Cockcroft & Gault formula, as evidenced by the Public Usage Data.

For example the (actual weight) variant, rising from 30,000 uses in 2022-2023 to 1.2 million the following year, and 2.4 million times in the year summer 2024 to summer 2025 – an increase of 80,000% in three years in how often it was recorded.

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We therefore wish to draw attention to these variables, which are novel, and used by primary care teams in support of prescribing DOACs, and the data patterns may allow insights which are not normally available, if contrasted with the laboratory calculated values, which do not account for the patient's body mass.

We note the focus on data quality such as the presence of missing dialysis / transplants.

To operationalise the findings of this research in general practice may require the development of decision support tools that go beyond the purely clinical – for example, if the risk prediction algorithm is not based on an information model which can be informed by the existing data (in the way that the MDRD could never be adjusted for ethnicity at scale because the requesting of laboratory measures could not be coordinated with outbound ethnicity information), then it is less likely to succeed.

The use of the Cockcroft & Gault equation is therefore an indicator that success is possible, provided that there is clinical buy-in, as well as the critical tooling required for its success. For maximum effect, any new risk prediction tools should be coupled with policy

recommendations for the coding / information model support tooling that should be integrated in the GP Supplier Systems.

The Joint GP IT Committee would be happy to be approached on the professional requirements for such tooling in due course.