

Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 18th August 2026

09:00 – 12.15

(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
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 11 th August 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-810830-X7D7J-v0 Applicant Organisation: DHSC OpenSAFELY Ref: AOS-2026-1082

	Application Title: Service evaluation of NHS care pathways for women with gynaecological and menstrual symptoms 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-810834-H9R6L-v0 Applicant Organisation: University of Oxford OpenSAFELY Ref: AOS-2026-1084 Application Title: Monitoring Prescribing Of Type 2 Diabetes Pharmacotherapy In Primary Care In England Outcome Points: 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-810836-P6L1F-v0 Applicant Organisation: Data & Analytics, NHS England OpenSAFELY Ref: AOS-2026-1097 Application Title: Understanding frailty identification, progression and deterioration using primary care data and exploration of interventions and service utilisation Outcome Points: 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-810829-T7Z1W-v0 Applicant Organisation: City of St George's, University of London OpenSAFELY Ref: AOS-2026-1079 Application Title: Safest effective medication options for pregnant women with chronic conditions' Outcome Points: 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 D	
5. WIDER PROFESSIONAL INSIGHT		
<i>There were no items discussed</i>		

6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
6.1	Confidential advice session	
7. Any Other Business		
7.1	Profession Advice Following discussion at PAG on 11th August 2026, item 7.3, the RCGP PAG Representative confirmed that he had spoken to the House, and had autonomy to determine and authorise publications without approval from the RCGP, with discretion to bring back any items to the House if they warranted a further discussion. It was agreed to discuss this autonomy as part of wider discussion around the PAG Terms of Reference (ToR) on the 22nd September 2026. It was noted that two PAG ‘profession advice’ documents were now finalised for onward dissemination: • <i>Profession Advice – Moving from Legacy Systems to OpenSAFELY for GP Analytics (confidential) v1.0 final</i> • <i>Profession Advice – Clinical Trials v1.0 final</i> ACTION for PAG Secretariat: to finalise the two ‘profession advice’ documents, circulate and publish, where appropriate, on the PAG Webpage.	TO NOTE Sec Sec
7.2	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 out of committee.	PAG
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:	10/08/2026	
Date of PAG advice:	18/08/2026	
Application Details		
NIC Reference:	DARS-NIC-810830-X7D7J-v0 OpenSAFELY Ref: AOS-2026-1082	
Application version Number:	V0	
Applicant Organisation:	DHSC	
Application Title:	Service evaluation of NHS care pathways for women with gynaecological and menstrual symptoms	
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 was the digital clinical lead for an CCG/ICB for approx. 13 years, and supported commissioning gynaecological pathways and their implementation. He is a Clinical Advisor at PRIMIS (University of Nottingham) who provide a contract for service to NHS England for the development and maintenance of national code lists. 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		

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

Supporting statement:

This application has strong alignment with the Quintuple Aims for health and care.

Population health and care: Strong alignment. Women's health is a major strategic priority and the work seeks to describe real-world NHS pathways, delays, investigations and treatment journeys. It has direct relevance to service improvement and pathway redesign.

Citizen experience: Strong alignment. The stated rationale is repeated presentations, fragmented care and long delays to diagnosis which are all impactful in the patient experience. Better understanding of pathways has a plausible route to improving timeliness and coordination.

Staff experience: Moderate alignment. Better pathway intelligence may help clinicians understand where patients become delayed or lost within the system, but workforce experience is not directly evaluated. There are opportunities for this to be strengthened, and advice is offered below.

Effective use of resource: Strong alignment. Explicitly concerned with where care is delivered across primary and secondary care, use of investigations and procedures, and identifying unwarranted variation that may inform commissioning and service planning.

Advancing health equity: Strong alignment. Stratification by deprivation, ethnicity, geography and comorbidity is built into the design and may expose variation in access, investigations and timelines.

We advise caution in interpretation of GP data, when considering the issue of 'time to diagnosis' in women's health problems. In some conditions, making a precise diagnosis supported by objective evidence is critical to the process, and a clinically meaningful outcome.

For example, the national guidance and clinical training is that for patients with many common gynaecological symptoms such as painful periods, irregular bleeding etc is that the focus of management should be on treatment, not on diagnosis. Where a patient does not have red flags, and treatment is adequate, GPs may suspect a particular diagnosis, but there is no requirement for this to be

explicitly stated, and there are dangers of over-medicalising symptoms which can be managed with simple treatments. It would not be appropriate to focus on a subsection of those with gynaecological symptoms who end up with a specific diagnosis, and infer that there was a 'delay' in diagnosis, where the patient has had a problem-management based approach, with appropriate investigation and treatment, but who later is given a diagnostic label.

Gynaecological cancer is a good example of where measurement of time delay between symptom presentation and diagnosis is a clinically meaningful metric, and may indicate issues with a pathway or clinical care.

A patient who is ultimately diagnosed with endometriosis by diagnostic laparoscopy, who has had years of painful periods which were managed effectively for many years before a loss of symptom control lead to diagnosis does not necessarily indicate a pathway issue, or one of clinical care.

This should be clearly reflected in the narrative, and 'time to diagnosis' should be applied to the temporal observations with care.

Gynaecological problems will often have problem-orientated records which are linked with symptoms, not diagnoses, but identifying symptom patterns from GP data is often challenging. For direct care purposes, there is little to no point in investing effort in using SNOMED concepts to record symptoms, and they are likely to be found only in the free-text of consultations. Where symptoms codes are found, care should be taken to differentiate between whether the symptom has been linked as a "Problem" header which may mean the code appears repeatedly as a reflection of the review of overall gynaecological complaints, and does not necessarily indicate that the symptom continues contemporaneously. Where a symptom code is recorded and NOT a "Problem" header, it can be reasonably inferred that the symptom was present on that day, or recently (high positive predictive value). The absence of symptom codes does not in any way indicate the absence of a symptoms (low sensitivity).

The authors will detect a series of data quality issues in this study, which have the potential to be written up and influence policy.

We wish to highlight a specific national issue – the influence of cost-saving bias in compromising overall strategic goals, in the commissioning of ultrasound.

The primary goal of commissioning diagnostic ultrasound in the community has always been to reduce cost. It is also strategic in patient experience because it often allows care closer to the home, in less medicalised settings, and may help advance health equity if providers are more accessible.

The effect on data quality however is substantial, because community providers rarely have the level of technology to be able to send structured data to primary care, by which we mean that the results are typically sent to GP surgeries as a PDF document attachment. This is in contrast to hospital radiology departments, where they will send the entire report digitally, which will include a (procedure) code to identify the result. When a structured report is filed into a GP system, it renders the entire free-text of the ultrasound result as a code-associated free-text entry.

The consequences are significant. Community ultrasound reports may or may not be filed against an appropriate code. When they are, the text remains inside the

attached PDF file, which is not searchable. This has the effect that when trying to review care, a clinician must first identify that there is a document, and then access the document (typically in a separate piece of software) instead of using the built-in results mechanisms. This is an example of suboptimal data quality – loss of accuracy in the record through manual processes to codify the data, and accessibility. Furthermore, this also means that shared care record systems which typically include only codes and their associated free-text may inform a non-GP provider of the fact of the ultrasound, but the report itself is inaccessible – only a properly formatted structured message will carry the information. This results in frustration for staff, and either time spent accessing those records, or worse, failure to access those records because the effort required is deemed too high.

This study may have the potential to expose quantitative data on whether ultrasound reports were received as structured messages, or as attached documents, and quantify this issue, including whether there is evidence that providers are now sending structured data or not.

We recommend that consideration is given to whether a national requirement for the commissioning of community ultrasound should be for messages to be sent as true structured data, to enable better data quality, and support pathways of care.

The authors should also be aware that there are data quality issues in cervical cytology as recorded in primary care records, because of the constraints imposed by the ongoing use by the NHS of the obsolete PMIP/EDIFACT data transfer system, which constrains the coded results to a single code i.e. cervical cytology result. The valuable structure to the messages is lost between the sending systems (labs), and it is converted to code-associated-free-text. This means that the precise and rich data from cytology results which could empower clinical care (through decision support, audit etc) and research is limited. Work is underway at NHS England to replace the technology, but the Joint GP IT Committee has repeatedly called for escalation on the pace of progress.

To support better care, and more reliable research to inform policy, this issue may benefit from being identified as a data quality hole in the information available, and policy guidance to support the timely replacement of the obsolete system.

The Joint GP IT Committee remains committed to advocating for a national data quality improvement programme to report on these issues, and to support work towards creating a positive feedback loop between policy, practice, and service evaluation / research.

We note the laudable aim of creating re-usable code lists, and support the intention. Please be aware that the selection of codes to understand primary care data in this study will require considerable digital maturity for the study to be valid, and for the code lists created to be re-usable by others. For the code lists to be “*clinically informed*” may not provide the level of maturity required – many research teams benefit from code lists being professionally driven i.e. primary care clinical informaticians, particularly if there is an intention for them to be re-used.

Profession Advisory Group (PAG)

Feedback Form – OpenSAFELY

Meeting Details		
PAG advice sought by NHSE:	10/08/2026	
Date of PAG advice:	18/08/2026	
Application Details		
NIC Reference:	DARS-NIC-810834-H9R6L-v0 OpenSAFELY Ref: AOS-2026-1084	
Application version Number:	V0	
Applicant Organisation:	University of Oxford	
Application Title:	Monitoring Prescribing Of Type 2 Diabetes Pharmacotherapy In Primary 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		
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

Supporting statement:

PAG is pleased to support this study, which builds on the work the National Diabetes Audit that the Joint GP IT Committee supports.

The study demonstrably aligns to the Quintuple Aims for health & care improvement:

Population health and care: Strong alignment. The condition and how its care is delivered is highly impactful. Monitoring uptake of NICE guidance and identifying unwarranted variation has a direct route to improving outcomes.

Patient experience: Moderate to strong alignment. Appropriate and timely diagnosis and treatment are important aspects of the patient experience in diabetes care. The study focuses on access to recommended therapies and delays within pathways, though experience is inferred rather than directly measured.

Staff experience: This is out of scope for the study, with benefits being indirect.

Effective use of resource: Strong alignment. There is clear potential relevance to medicines optimisation, commissioning and value-based prescribing.

Advancing health equity: Very strong alignment. Equity appears to be a central objective of the project, with planned analysis of variation by ethnicity, deprivation, geography, age and sex, alongside examination of differential adoption of NICE recommendations.

We note that this chronic condition benefits from over 20 years of prioritisation in commissioning, through the GP Quality & Outcomes Framework, in which the prospective identification and codification of cases has been incentivised, leading to robust systems including real-time computer assisted decision support, as well as population analytics including regional population health management tools, which all promote the identification of the condition.

Further, the granularity of the data are supported by further incentivisation of prospective record entry in support of detail relating to the condition. All of these factors lead to the ability to study the condition using pseudonymised data which are likely to be advanced in terms of being Complete, Accurate, Relevant, Accessible and Timely i.e. data quality.

The authors may be in a position to explore the impact of different commissioning models, and the positioning of personalised care. For example, the setting of patient-specific targets – whether there are associations between the recording of

those values and the outcomes, and whether the creation of an individualised care element itself indicate about the patient as a proxy for whatever goes into bespoke management.

We identify the role of nursing colleagues in general practice, where there has been a substantial shift over the past 20 years between GP-led care, which is often now delivered by nurse practitioners who have increasing influence on care decisions including prescribing, in collaboration with prescribing doctors.

When analysing coded findings that indicate outcomes related to medication e.g. medication not tolerated, medication not indicated, we encourage careful review of when those concepts became 'selectable' in the GP system suppliers' interfaces. For example 2385961000000109 | Adverse reaction to glucagon-like peptide 1 receptor agonist (disorder) | was first introduced to SNOMED UK in February 2025, and GP system suppliers do not necessarily allow their users to enter those data. This means that when examining denominators for treatment (which may exclude patients with adverse reactions from particular definitions), it may be challenging to compare like-for-like with different cohorts of patients over time.

If the authors identify any absence of codable concepts for recording meaningful findings such as "treatment refused" codes, then policy recommendations may enable the appropriate requesting of such concepts for addition to SNOMED UK.

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Application Details		
NIC Reference:	DARS-NIC-810836-P6L1F-v0 OpenSAFELY Ref: AOS-2026-1097	
Application version Number:	V0	
Applicant Organisation:	NHSE, Data & Analytics	
Application Title:	Understanding frailty identification, progression and deterioration using primary care data and exploration of interventions and service utilisation.	
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		
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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

Supported

Supporting statement:

PAG is pleased to support this policy development study, which has breadth in how it approaches the Quintuple Aims for Health & Care improvement

Population health and care: Strong alignment. Frailty is a major determinant of health outcomes, healthcare utilisation and quality of life in older adults.

Patient experience: The benefits for direct experience relate to better service delivery

Staff experience: Moderate alignment. Frailty care has only relatively recently been systematised nationally, and building this into evidence based recommendations which will improve confidence for staff, indirectly.

Effective use of resource: Strong alignment. The study explicitly examines service utilisation, interventions and outcomes, and is intended to inform policy, service monitoring and operational delivery through the Frailty and Dementia Modern Service Framework.

Advancing health equity: Strong alignment. The study includes analysis of variation in identification, service use and outcomes by socio-demographic characteristics and geography, with a stated objective of understanding inequalities.

We observe that the context of the study, which included the introduction of the eFI score into general practice initially through the enhanced service, and later through core GMS contract requirements.

This study has the opportunity to identify several interesting issues – when the eFI score was introduced, some surgeries added batch calculations for the population, and others did not. Some surgeries chose to rapidly add frailty level coding based on the score, and others did not. Advice followed to practices that this should not be done as a batch function, and that each patient should have individual assessment, but this was an issue in the communication of the commissioning intention, which was a suboptimal change management, and highlights the challenges with using primary algorithmic identification as opposed to primary clinical.

During the pandemic, the integration of the Clinical Frailty Index (Rockwood Score) into decision making in relation to ventilators for the frail population caused a rapid 'ripple' in the use of the score, which extended into non-intensive care settings, and became used by emergency departments when prioritising admission,

paramedics when making decisions to convey patients to hospital or not, and all the way through to general practice, where GPs began to code the score. In the Oxfordshire shared care record, the item was added to ensure that GP scores were accessible to hospital teams for example. Caution should be exercised when interpreting the code scores, because of the Alternative Maps for Observable Entities used during the READ->SNOMED migration, but the data from 2018 onwards should contain these records.

Nevertheless, the data show a paradigm shift – there is a rapid and accelerating growth in the use of the Rockwood Score, which is being recorded preferentially instead of the eFI score.

The measured indicators are entirely valid, being based in the contractual framework, and should represent accurate information.

The study has the potential to look at conflicting information to identify data quality issues – how many patients have inconsistent attribution of frailty that is wildly inconsistent with their scores? How often are patients recorded as severely frail for long periods of time but then recover?

What is the difference when different professionals record frailty? With the same parameters, do different professions judge frailty more reliably? Does continuity of care impact on the accuracy of the frailty determination? These questions are valuable for planning delivery.

In terms of health policy, this is an opportunity to review the accelerative increase in the use of the Rockwood Score, and consider why records in general practice are showing those increases. At present, there is no national requirement for GP supplier systems to promote the use of the score, and existing tooling still favours the use of Mild/Moderate/Severe frailty, which aligns easily to the eFI score.

NHS England may wish to ask its terminologists to demote the Preferred Term in SNOMED of the Rockwood Score, either aligning to its common name, or the Clinical Frailty Scale, but we observe that the positioning of the synonym “Canadian Study of Health and Ageing” to be unhelpful in its position as the default term for the score.

Finally, it is very difficult to predict life expectancy on an individual level, particularly many months in advance, and hence trying to form policy to help those “entering their last year of life” may be better phrased to be less specific to the timescale, or to use the language of the Gold Standards Framework to indicate that it is those who ‘may be’ entering the last year of life.

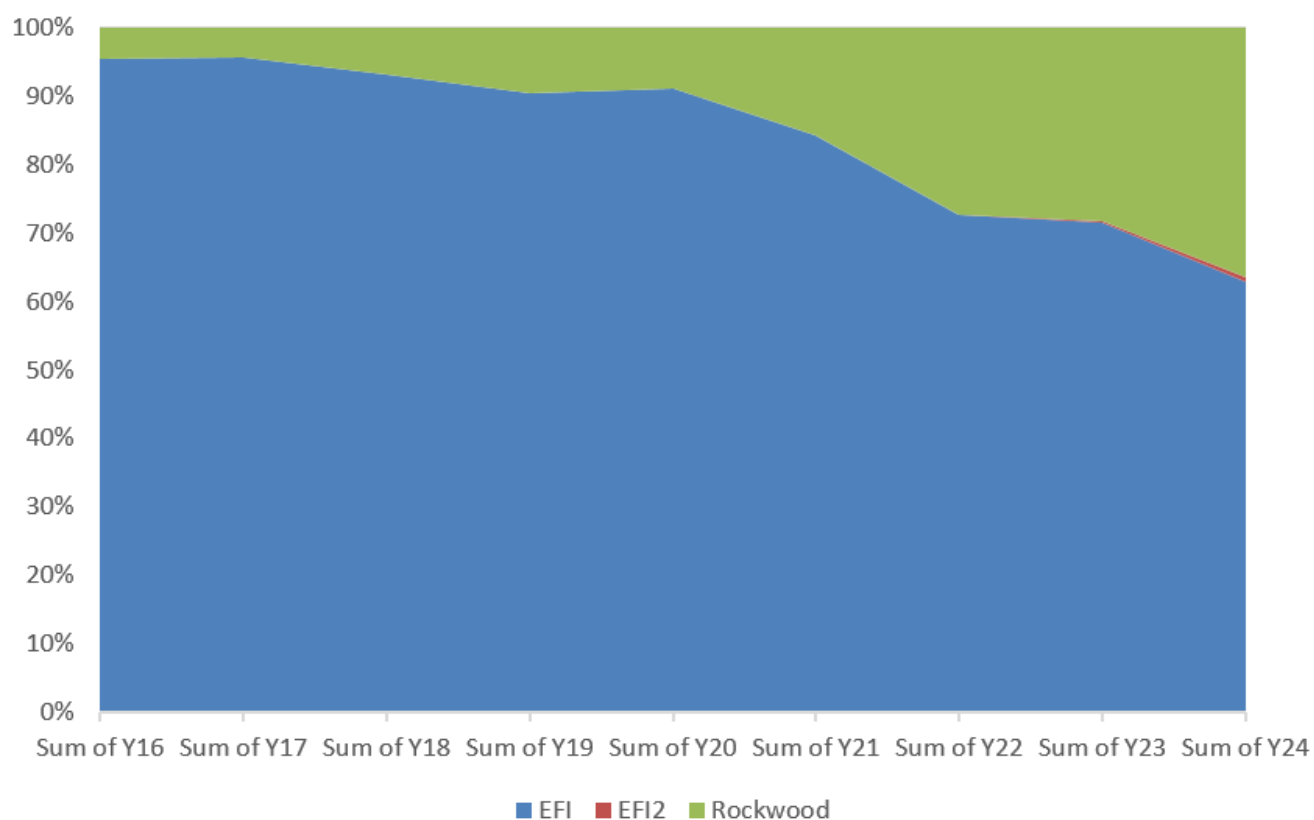


Figure 1 100% stacked area chart showing rough analysis of public usage data for general practice coding in SNOMED, showing how the percentage of all codes indicating a frailty score that are being recorded has gone from 5% 10 years ago to 35% today, a sevenfold increase

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Application version Number:	V0	
Applicant Organisation:	City St George's, University of London	
Application Title:	Safest effective medication options for pregnant women with chronic conditions.	
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		
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, 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~~

Supporting statement:

PAG is pleased to support this interesting study, which has great potential. We observe good alignment with the Quintuple Aims for Health & Care:

Population health and care: Strong alignment. Every single person alive has been a fetus, and generating better evidence on comparative medication safety has a direct route to improving maternal and pregnancy outcomes.

Patient experience: Very strong alignment. The focus on supporting informed treatment decisions and balancing risks of treatment against risks of untreated disease is highly relevant to patient-centred care.

Staff experience: Very strong alignment. Clinicians frequently face difficult prescribing decisions in pregnancy with limited evidence available. Better comparative safety information may support shared decision-making and greater confidence in treatment recommendations. The intention to create a closed-loop feedback system in which conclusions drawn from GP data being presented to GPs and patients via BUMPS is particularly appealing.

Effective use of resource: This is not within scope for the study, although any recommendations may improve the rationality of treatment.

Advancing health equity: Moderate alignment. The study will adjust for ethnicity, deprivation and other demographic factors, and improved evidence may benefit patient groups who are often excluded from clinical trials

PAG is aware of the work underway to validate the OpenPREGnosis system, and see this as a natural extension of it.

We observe the context of the study, which is of existing mechanisms for Yellow Card Reporting, and the optional reporting of maternal exposure to UKTIS. The former is recordable in primary care using 185100004 | Adverse drug reaction notification (procedure) | but we note that the total count of codes recorded per year in public usage data is low. Nevertheless, where the concept is observed in the record of a pregnant patient, it does reflect an important event – it may be possible to report on this and offer observations on patterns that are found.

The authors demonstrate good insight into the challenges that we face as prescribers in general practice.

The authors make an interesting proposition of converting their medication definitions into ATC code. The integration of DM&D into SNOMED remains challenging, and the value of converting medication lists may be limited by the applicability of the content, where VMP/AMP/AMPP level specification may not be as universally valuable. Depending on which technology is used to develop the specification, VTM level specification may be the most portable, or ingredient-level / prescribing if a machine-readable model is used.

Caution should be exercised in using “*existing codelists and optimisation*” to ensure that the precise use-case and do-not-use cases of the code lists is understood, which may not be available. As this work may be foundational and any developed information / coding models may be of broader value to the research community, advice from professional primary care informaticians (as opposed to clinicians) may be helpful in ensuring high levels of maturity in the specification.

This work stimulates further consideration of the awkwardness of recording all information relating to a fetus in the notes of the birthing parent, and the authors touch on the potential benefits of being able to interrogate GP data to understand the connection between maternal exposure to the long-term outcomes for a live birth outcome. The Joint GP IT Committee has periodically considered the potential advantages of having an object-orientated record for the fetus that is connected with the maternal record, but which has a separated identity and could provide a bridging record for such work, potentially becoming a component of the record of any live-birth. Committee has been receptive to the notion, while understanding care is needed to respect legal frameworks etc.

We will be interested to see these constraints identified as part of the study, as they have the potential to build the strategic case for considering such measures, and this may be timely as the Single Patient Record programme considers its use-cases and what the professional requirements are for it to advance beyond existing record systems.