

Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 7th July 2026

09:00 – 10.30 and 14.00 – 15.50

(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)	
UNIVERSITY OF OXFORD STAFF IN ATTENDANCE (ITEM 6.3)	
Dr. Alex Walker	Senior Epidemiologist, Bennett Institute for Applied Data Science, Nuffield Dept of Primary Care Health Sciences, University of Oxford (Presenter: item 6.3)

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 30 th June 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-808587-C6Y6J-v0 Applicant Organisation: NHS England Application Title: “Descriptive evaluation of palliative care identification in general practice in England using routinely recorded SNOMED CT–coded data from GP practices linked to secondary care data” 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-808590-T5B3K-v0 Applicant Organisation: University of Bristol Application Title: “Tackling inequalities in cardiovascular prevention” Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025 Please see Appendix B. Separate to the application: The Group asked NHS England to provide an update on the change control mechanisms for the PAG feedback form, for example the section on National Data Opt-Outs.	NL
4.3	NIC Number: NIC-802553-F6L6G-v0 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 the application was to be discussed on the 14th July 2026	
5. WIDER PROFESSIONAL INSIGHT		
There were no items discussed		
6. CONFIDENTIAL ADVICE / BRIEFING SESSION		
6.1	Confidential briefing session	
6.2	Confidential advice session	
6.3	Confidential briefing session	
7. Any Other Business		

7.1	PAG Processes
------------	----------------------

	There was a brief discussion around the PAG meeting processes including the sharing of the calendar of attendance for the full financial year at next week's PAG meeting; how ratified minutes / PAG feedback are shared with the wider NHS England Teams and the Advisory Group for Data (AGD); and how any changes to the PAG meeting agenda will be updated via an annotated agenda.
--	--

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:	29/06/2026
Date of PAG advice:	07/07/2026

Application Details			
NIC Reference:	DARS-NIC-808587-C6Y6J-v0OpenSAFELY Ref: AOS-2026-1071	Application version Number:	V0
Applicant Organisation:	NHS England		
Application Title:	Descriptive evaluation of palliative care identification in general practice in England using routinely recorded SNOMED CT-coded data from GP practices linked to secondary care data.		

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 / No
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 is opportune, because of the impact of the removal of the national indicator PC001 from the GP Quality & Outcomes Framework, “The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age” which was removed from the QOF in the year 2025-26, which had been present for approximately 20 years, and incentivised active engagement in forming palliative care registers, and the systematic approach to multi-agency palliative care processes out of hospital. The study has the potential to work towards finding a new, data driven approach to case identification of those who might benefit from palliative care, which may help to bridge the gap. The purpose of the study is primarily aligned to the management of population health and in support of the Modern Service Framework for Palliative Care and End-of-Life Care, with a strong emphasis on advancing health equity by exposing the relevant data. In terms of alignment with the IHI’s Quintuple Aims, it has the potential to support better patient and carer experience if it helps contribute to the knowledge of the service requirements. There is no direct connection to the wellbeing of the staff providing the services, or the cost-analytics of national service provision. Those issues are challenging to assess using data driven approaches, because much of the information is not recorded. The authors may wish to consider whether patient-centric outcomes which are measurable should be considered such as preferred place of death, which may be recorded etc. as patient experience is a key strategic concern which can be informed by recorded data.

We observe that significant variations should be expected across the country as to the identification of this cohort, and we will be interested to see whether the authors observe those variations increasing over time, and their temporal association with the withdrawal of the GP QOF.

In general practice, the decision to add a 'QOF code' with the resulting addition of the patient to the 'palliative care register' has been clinician specific, practice specific, and influenced by regional policy, which includes whether or not there is a preference for using the GOLD Standards Framework, or other tooling, such as the Amber Care Pathway or the Supportive and Palliative Care Indicators Tool [SPICT]. If it were possible to identify which areas were and were not using these tools, then it could give valuable insights.

PAG notes that presence of a simple 'register' of patients for palliation was always somewhat crude, and was associated with confusion about the difference in prospective palliation and end of life care. Although the distinction is recordable in GP systems, the coded distinction of end-of-life care registers in addition to palliative care registers is not standard.

We note that although the GSF has specific pre-coordinated SNOMED codes which may record where that tooling is being used, Amber Care and SPICT do not. This means the authors may be able to identify pockets of GSF from a data driven approach, provided those codes are examined.

PAG advises caution in the planned approach which specifies using "published SNOMED CT and ICD-10 code" for data extraction. Please find attached some draft guidance on this issue. We specifically wish to draw attention to the issues around the GP QOF selection of coding, which, if used, would identify only a small subset of patients, with a high positive predictive value of requiring palliative care, but at the calibrated expense of having a high 'sensitivity' for case finding.

Care should be taken when examining any published dataset, to understand whether there is a clearly defined use-case and do-not-use-case. Many datasets do not have readily available metadata.

For example, the use-case for the PRSB end of life care standard should be understood in the context of prospective record keeping (and therefore data entry) and is therefore highly selective. PAG is aware of concern where those coding and information models have been misunderstood and used for data extraction, which should be considered as a do-not-use-case for those code lists.

The authors may wish to expand on published lists, and include inactive concepts, and whether proxy codes should be considered, such as the presence of coded discussions around preferred place of death, resuscitation status, the presence of treatment escalation planning etc to identify activity suggestive of palliative care requirements, as they may have very high positive predictive values.

Prescribing of palliative care specific drug treatments in primary care will include just-in-case prescribing, as well as end of life treatments. As our software is for prescribing purposes not administration, the precise dose instructions of drugs

administered is not available in primary care records. Medicines Administration Records (and other synonyms) tend to be maintained in word processed documents, which limits data driven approaches to understanding the use of these drugs in end of life. If available, the dosing instructions of these drugs may often contain valuable insights into their intended use. It may also be possible to draw inferences from the number of times end of life medicines have been prescribed as to what the understanding of the patient's condition was at that time. Such medicines, though prescribed, may not need to be used. We note that although the Medical Certification for Cause of Death (MCCD) regulations changed in 2024, SNOMED CT does not contain the granularity of coding that we would like to have, and the implementation of SNOMED in primary care has never allowed the use of post-coordinated expressions. The palliation of children and young people is heavily dependent on non-primary care service provision i.e. secondary care and third sector. This means we would expect such patients to be coded onto the palliative care register (previously) but the level of data obtainable from primary care may be low, and their drug treatments would not normally be through primary care.

Profession Advisory Group (PAG) Feedback Form - OpenSAFELY

Meeting Details	
PAG advice sought by NHSE:	29/06/2026
Date of PAG advice:	07/07/2026

Application Details			
NIC Reference:	DARS-NIC-808590-T5B3K-v0 OpenSAFELY Ref: AOS-2026-1024	Application version Number:	V0
Applicant Organisation:	University of Bristol		
Application Title:	Tackling inequalities in cardiovascular prevention.		

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
Cardiovascular risk management is a core topic for the profession, and a matter of significant national importance, and we acknowledge the opportunity to advance health equity by exposing the relevant data. In primary care, we face several challenges in delivering interventions, which may be helpful to the authors in understanding the data, and writing up the conclusions. The delivery of primary prevention is affected by regional factors including the commissioning of NHS Health Checks which were previously delivered through GP surgeries, but more typically now through services commissioned by local authorities, as well as the NHS Digital Health Check service which is in pilot. Our prescribing is heavily influenced by the use of regional formularies with specific drugs and doses, which are often actively promoted using real-time prescribing support tools which request changes to a prescription if we select an off-formulary drug. The authors may wish to be aware that there is a significant national issue with the use of the obsolete QRISK2 integrated calculators in our GP clinical systems. There are complex regulatory concerns which have meant that the GP system suppliers have not enabled built-in QRISK3 calculators. This has had the effect that GPs are clinically advised by NICE to use QRISK3, but the only non-proprietary calculator is the web-based version provided by Endeavour Predict CIC, which is not a medical device. There is current work underway between NHS England, the profession, and the GP system suppliers to create a central API through which the calculation can be run, but the profession has written to NHS England to express concern as to how long it is taking for this to take place.

With this in mind, the authors can sensibly consider the overlap of the data specifications, and whether this study can expose the availability of coded data such that would support QRISK3 and 4 calculations, to help build the knowledge base for the impact of tooling. This is a significant issue for the workforce in primary care.

In terms of targets to reach should treatment be started for primary prevention, GPs will frequently try to reduce the non-HDL cholesterol by 40% once a decision to treat is made. It is not easily visible within clinical systems what the individual-level target is, and on which value, and from which point in history, this target may have been derived. One output of this study may be to suggest improvements in how clinical systems operate, such as tooling to enable more transparent exposure of relevant observable information within the context of relevant diagnoses and guidelines to support care, where multiple overlapping guidelines can be difficult to access, and data variables not all accessible in one place when making prescribing decisions.

For secondary prevention it is more complex to understand if a patient is appropriately treated or not given the numerous guidelines in existence and the reporting of “normal ranges” for cholesterol within pathology system. Different areas may flag different advice and this may have an effect on prescribing decisions (for example, if there is text present within a pathology report that indicates the normal ranges are applicable to patients only in need of secondary prevention).

We note the ambition to socialise the code lists (phenotypes) developed within this study, but there are considerable obstacles to the re-use of the study specifications in the real world after the study.

The UK has no central repository of code lists, and no standards for development and maintenance in socialised lists. This places considerable burden on anyone developing these phenotypes to self-appraise the maturity of the product, and document it in a communicable way. Examples of requirements are for advanced tooling to support the consistent incorporation of relevant inactive concepts, and editorial policies on which if any proxy codes are allowable. After publication, such code lists would require feedback loops in order to grow in digital maturity as well as the requirement for maintenance cycles so that the performance is not degraded by the updates within the terminology.

To prepare these lists for such use, as much metadata as possible should be recorded during the development of these code lists, including authorship, tooling, editorial policies, the use case and do-not-use cases etc. Their curation in national work may require formal commissioning of development and maintenance if they are to be used beyond the study.

We are interested to note that the authors have indicated that they wish to apply the National Data Opt Out to this application. The current application form reviewed by PAG does not include a rationale, which is not a concern, but of interest to us.

The authors should expect considerable regional variation in prescribing, attributable to regional prescribing formularies and prescription switching tools which prompt the use of formulary medication prescribing.

With statin prescribing, data interpretation can be challenging because of the lack of enforced dose syntax, for example Atorvastatin 20mg – take one and a half tablets each evening, which is not directly machine readable, and can create gaps in data quality between implied and actual statin intensity.

We note that the regionalisation of the NHS in terms of enhanced service provision results in idiosyncratic provision of care, which this study is powered to explore. The delivery of item-of-service care such as injectable lipid-lowering treatment which is not part of the core GMS contract, means that regional prioritisation and timelines create differences between when a prescribing formulary permits the issuing of a prescription, and when a surgery is offered a contractual basis to administer it. Where the contract is not accepted by a practice, those treatments may not be given in primary care.

In addition, each region has the prerogative to commission services outside of the practice e.g. a hub to deliver services, and although it is technically possible for data such as prescriptions-issued-elsewhere to be entered into the primary care record, if there is no financial / contractual incentive to do so, then there may be gaps in the data that suggest a patient has not had the treatment, when they have. These factors will undermine the Sensitivity of looking for these data.

We note that there is currently no procedural code which pre-coordinates a procedure of the administration of Inclisiran, meaning that there may be patients who have a valid procedural entry such as descendants of 59108006 | Injection procedure) | which are post-coordinated with the freetext being the drug name. The constraints on free text mean that these data will be invisible.