

Profession Advisory Group (PAG) – Meeting Minutes

Tuesday, 8th September 2026

09:00 – 12:00

(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
Terry Service (TW)	PAG Deputy Chair
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 18 th August 2026 were reviewed out of committee by the Group and were agreed as an accurate record of the meeting by the PAG Chair, on behalf of the Group.
3	Declaration of interests: There were no declarations of interest.
4. EXTERNAL DATA DISSEMINATION REQUESTS:	
4.1	NIC Number: NIC-810837-H0B4G-v0

	Applicant Organisation: King's College London OpenSAFELY Ref: AOS-2026-1006 Application Title: Enhance National Quality Improvement Programmes Outcome Points: The Group noted that not all the necessary information was available to make a full assessment in relation to the National Data Opt-out, 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-810838-G0G0J-v0 Applicant Organisation: University of Oxford OpenSAFELY Ref: AOS-2026-1014 Application Title: Risk of venous thromboembolism in admitted for treatment of mental health conditions 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-810839-P5X7Z-v0 Applicant Organisation: University of Bristol OpenSAFELY Ref: AOS-2026-1036 Application Title: Collaborative HIV Research Of Multimorbidity In OpenSAFELY (CHROMIOS) Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025, however advised that in order to provide more thorough feedback on this application, further advice would be sought out of committee. ACTION separate to the application: PAG to discuss at a future meeting, potential guidance on how OpenSAFELY can be utilised for sensitive / legally restrictive data codes, to further support research on under researched areas. See Appendix C	
4.4	NIC Number: NIC-810840-T0B4Z-v0 Applicant Organisation: LSHTM OpenSAFELY Ref: AOS-2026-1049 Application Title: PRISM: Population Risk: Infections, Socioeconomic deprivation and Minority ethnic groups Outcome Points: the Group supported the application which was in line with the NHS OpenSAFELY Data Analytics Service Pilot Directions 2025.	

	See Appendix D	
5. WIDER PROFESSIONAL INSIGHT		
There were no items discussed		
6. CONFIDENTIAL BRIEFING SESSION		
6.1	Confidential briefing session	
7. Any Other Business		
7.1	There were no items discussed	
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:	28/08/2026	
Date of PAG advice:	08/09/2026	
Application Details		
NIC Reference:	DARS-NIC-810837-H0B4G-v0 OpenSAFELY Ref: AOS-2026-1006	
Application version Number:	V0	
Applicant Organisation:	King's College London	
Application Title:	Enhance National Quality Improvement Programmes	
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, subject to clarification on applicants' indication that they wish to apply the National Data Opt Out		
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 subject to clarification on the applicant's wish to apply the National Data Opt Out

Supporting statement:

This application has focussed alignment to 4 of the Quintuple Aims for Health Care Improvement as set out by the IHI.

Population health and care: Good alignment. The focus is to explore beyond rheumatology and evaluate OpenSAFELY as a platform for broader quality improvement work. It is therefore a strategic foundational piece of work with a clear pathway for extension.

Patient experience: Good alignment. Timely diagnosis, access to specialist assessment, time to treatment and prevention of avoidable complications are patient-centred outcomes.

Effective use of resource: Strong alignment. A core objective is replacement of manual data collection processes with automated analysis of routinely collected data. The study explicitly aims to reduce the burden and cost of national quality improvement programmes while supporting commissioning and service improvement activities, while improving collection overall.

Advancing health equity: Strong alignment. The authors aim to improve case ascertainment in under-served populations, examine demographic variation in care quality and outcomes, and identify inequalities that may be poorly represented in existing audit programmes.

A review of the QI programmes including finds that they have not yet brought into scope one of the Quintuple Aims however: Staff experience.

Quality improvement outcomes depend entirely on NHS staff, and historical strategies have focussed on purely clinical outcomes, patient experience and cost effectiveness to the exclusion of considering the impact of strategy on the workforce. This was recognised by the IHI, who document the importance of considering and balancing those impacts.

The BMA constitutionally adopted the Quadruple Aims, at around the same time that NHS Wales did so. This means the medical profession expects that strategy will consider those delivering care systematically, and apply active consideration to the impact on the workforce. The Quintuple Aim, which adds advancing health equity is more recent, but is a logical extension.

This study is in line with the QI programmes and we approve of the intentions in the application, but we wish to reflect that the existing indicators do not seem to

actively consider the impact on staff, and measure outcomes which are relevant to ensuring balance. This may be a strategic hole which could be addressed. PAG is happy to offer advice if clarity is needed on how this aim could be measured.

We considered the challenge you face in using the available data to calculate your outcomes, and have some observations.

Musculoskeletal pathways have always been a high-cost high-volume part of regional commissioning, and during the CCG era, many if not all regions adopted tiered commissioning, in which 'hubs' or 'tier 2' services were used. This has profound effects on the data patterns.

There is little incentive in primary care to codify suspected diagnoses precisely in the early stages of a pathway, and even less incentive to codify symptoms. General Practice will assess undifferentiated symptoms and signs, form provisional diagnoses, and refer for investigation or an opinion without there necessarily being any 'breadcrumbs' which you will find to establish the onset of a presentation.

This means that taking a disease-focussed approach to the pathway is highly selective for the small number of patients who end up with a precise diagnostic code, and there is a risk that it may not be representative of the quality of the regional management of the patient.

Without having a clear data picture of the onset of symptoms, calculations on time to treatment will be difficult. This is complicated by the broad lack of the transfer of structured data between commissioned providers of 'hubs' where you should expect that their letters are returned to surgeries in PDF format (sometimes paper) and the codification is subject to the idiosyncrasies of GP surgeries and whether they chose to record diagnostic labels and or findings, for direct care purposes. There is often no intrinsic significant value in doing so.

Time to treatment will also be somewhat complicated to derive. GP data will at times include digital records of medication which was prescribed elsewhere, and has been added manually to the record e.g. an injectable treatment given by hospital. This is not done according to any national standards or requirements, so is excellent for direct care when present, but laborious and often will not be present.

These data quality issue should be considered carefully both in the study and its write-up. This study demonstrates missed opportunities with the recording of the data necessary for QI work. It can also highlight interventions such as the possibility of a national data quality improvement programme in which standards are agreed of how data should be recorded in general practice such that they are more 'research ready', as well as the tooling necessary to implement those standards, and the contractual framework for such data custodianship. It should also prompt for there to be clear technical requirements for commissioned frameworks – for example, a call for commissioned providers of tier 2 services to

transmit structured data for their outcomes into the primary care record, for example using NHS England's Direct Care API – GP Connect: Update Record.

The likely data limitations also mean that caution should be exercised in the dashboarding intentions. Our inference is that the planned dashboards are hospital-focussed. Please note that the Direction for these data indicates that if dashboarding will identify general practice organisations down to PCN level or lower, it must be done so in consultation with us, so if this is an intention please consult further with PAG before proceeding.

On a technical note, the pre 2018 coding in Optum will have been in READ/CTV3 and so the digital maturity of the coding model will require understanding of which legacy concepts were mapped to SNOMED terms which have subsequently been inactivated. This may require proprietary software.

We note that you have chosen to apply the National Data Opt Out. The policy and legal direction do not require the NDOO to be applied. Although ethics committees may recommend it be applied for research, we agree that your study is a service evaluation piece. Please will you clarify the reasons for the planned application of the NDOO, as we would like you to be able to take full advantage of OpenSAFELY if there are no firm reasons why the opt out must be upheld.

Profession Advisory Group (PAG)

Feedback Form – OpenSAFELY

Meeting Details		
PAG advice sought by NHSE:	28/08/2026	
Date of PAG advice:	08/09/2026	
Application Details		
NIC Reference:	DARS-NIC-810838-G0G0J-v0 OpenSAFELY Ref: AOS-2026-1014	
Application version Number:	V0	
Applicant Organisation:	University of Oxford	
Application Title:	Risk of VT in admitted for treatment of MH conditions	
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 subject to confirmation that the application of the NDOO is because of ethical committee decision

Supporting statement:

This paper has broad strategic appeal. It aligns to 4 of the Quintuple Aims for Health Care Improvement as defined by the Institute for Healthcare Improvement:

Population health and care: Good alignment. VTE is a serious and potentially preventable cause of morbidity and mortality. It is preventable, and this study can meaningfully contribute to the risk assessment and management of the relevant cohort.

Patient experience: This is not a primary focus of the study.

Staff experience: Good alignment. The development of a risk prediction tool has the potential to support clinical decision-making in an area where risk assessment is not currently routine. Benefit to staff is likely to arise through greater confidence and consistency in thromboprophylaxis decisions.

Effective use of resource: Moderate alignment. Preventing avoidable VTE events may reduce subsequent healthcare utilisation and complications. Resource benefits are not the primary focus of the study but are a plausible downstream consequence of improved risk management.

Advancing health equity: Very Strong alignment. The proposal is founded on a potential disparity between physical healthcare provided in acute hospitals and mental health settings. Understanding whether people admitted for mental health care experience unmet VTE prevention needs aligns strongly with reducing inequalities in healthcare delivery.

VTE is a clinically important diagnosis, and we would expect to find it coded in primary care records, although it can be very difficult to use a data driven approach to understanding the episodicity of any VTE event. Specifically, where a patient for example has 710167004 | Recurrent deep vein thrombosis (disorder) |, it may be impossible to differentiate between an event reviewing the long term issue and its problems, from the acute event of an acute DVT. There are no systematic constraints which would encourage any particular model of problem-orientated notes. This will weaken the interpretability of data used in this way.

We were interested to note that the delay between admission and recognition of a VTE event might result in the connection of the event being hard to identify, making a statistical analysis on this scale an appealing proposition.

A drugs-to-diagnosis approach might be supplementary to differentiate events in those with recurrent DVT, for example if they are on long term treatment before the presence of a code appears. We would expect the authors to observe the paradigm shift from Warfarin to DOACs during the time period being studied, from the effects of the COVID19 pandemic.

We reflected on the multifactorial reasons why patients admitted with mental health problems might be at elevated risk, and instinctively felt that VTE concerns were one of the many reasons why encouraging physical mobility and exercise in admitted patients could reasonably be promoted.

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NIC Reference:	DARS-NIC-810839-P5X7Z-v0 OpenSAFELY Ref: AOS-2026-1036	
Application version Number:	V0	
Applicant Organisation:	University of Bristol	
Application Title:	Collaborative HIV Research Of Multimorbidity In OpenSAFELY (CHROMIOS)	
Attendees		
Representing Organisation	Name	Role
British Medical Association (BMA)		BMA Representative
Royal College of General Practitioners (RCGP)		RCGP Representative
Declarations of Interest		
Details of declarations of interest: The RCGP representative is a former employee of NHS Digital, and was involved in reviews of the RCGP Sensitive Codes List and the Legally Restricted Code Lists. They are also a Clinical Advisor to PRIMIS at the University of Nottingham, who are commissioned by NHS England for the maintenance of Reference Sets for NHS England, which includes reference set 999004381000000103 General practice summary data sharing exclusion for sexually transmitted disease simple reference set . 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 NDOO to this project is on the basis of the ethical assessment

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 subject to confirmation that the application of the NDOO to this project is on the basis of the ethical assessment

Supporting statement:

This study has broad strategic alignment to the Quintuple Aims from the Institute of Health Care Improvement:

Population health and care: Strong alignment. The study seeks to address evidence gaps that are increasingly important as people with HIV live longer and develop more chronic disease, and presents an important emergency cohort, about which we understand the evidence base is necessarily emergent.

Patient experience: Strong alignment. The proposal is notable for its explicit focus on acceptability of HIV research, stigma, confidentiality concerns and involvement of community representatives in determining research priorities. The transition of care between specialist HIV services and primary care is directly relevant to patient experience.

Staff experience: As the authors indicate, the balance of care is shifting towards primary care, a setting less familiar with the condition and its guidance. Therefore up to date science will be particularly beneficial to the professionals involved on both sides of transfers of care.

Effective use of resource: This is approached indirectly, because understanding the patterns of care and unmet needs has the potential to inform policy and funding streams.

Advancing health equity: Very strong alignment. Health inequalities, stigma, confidentiality concerns, under-representation and differential access to care appear central to the proposal. The study explicitly seeks to identify potential

biases in the dataset and involves HIV community representatives throughout the research process.

This is an excellent study to make use of the OpenSAFELY platform, which is unique in being able to access the full breadth of the data available for patients with HIV, and is worth commenting on in detail, because of underlying issues in the application of different frameworks designed to protect data, but which are appropriate for careful consideration.

Issue 1 – the Legally Restricted Code Lists

The history of these lists must be considered in the context of

<https://standards.nhs.uk/published-standards/sensitive-data> ISB 1572

Sensitive Data. Although this standard is no longer active under the Health & Care Act 2012 as amended by Health & Social Care Act 2022, and the datasets which it was designed to protect (which include HIV data) no longer exist, the laws around some components of the lists (Human Fertilisation and Embryology Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008) and the Gender Recognition Act 2004 (as amended by The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) Order 2005).) risk being conflated with the exclusion of data related to sexually transmitted infections and termination of pregnancy, which do not have specific laws surrounding them to the best of the PAG's knowledge.

The ongoing use case for the LRCLs is complex, and they do not come with clear do-not-use-cases, clinical ownership or a product to which they are attached.

Issue 2 – the NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000

This legal direction was revoked in 2023, on the grounds that the majority of trusts which were bound by the direction no longer exist, and the bulk of STI data are stored in other services. This was accompanied by clear confirmation that STI data are bound by general laws (the GDPR, the Data Protection Act and any subsequent laws), and marked the removal of the only special laws which identified HIV data as being different legally.

Issue 2 – the General practice summary data sharing exclusion for sexually transmitted disease simple reference set |

Around 2007, when the Summary Care Record was designed, RCGP was commissioned to consider the issue of whether certain codes were sufficiently sensitive that they should not be shared via the platform, even for direct care purposes. The initial "RCGP Sensitive Codes Lists" are no longer a product of the Royal College, and are governed by NHS England as a component of its live service. They continue to be maintained on a technical level with professional input from a commissioned clinical informatics service, but without a clinical 'owner' for a policy approach to its contents.

The 'reference set' of codes, the "General practice summary data sharing exclusion for sexually transmitted disease simple reference set" is one component of the Summary Care Records 'exclusion dataset'.

The effect of the Exclusion Dataset is that many regional data platforms have adopted it as a safety precaution, without necessarily forming a specific policy on its role in their platform. This includes regional shared care records (for direct care) who often share data feeds with regional research / secondary use systems. The effect is that regional clinicians will be unable to see the HIV status of the patients they are treating, and legitimate service evaluation / research will be impossible.

That was not the intention of the Exclusion Dataset, and the RCGP has no separately published policies relating to these data.

The chain of cause and effect is that HIV research and other secondary uses on GP data have not been possible. This is under active discussion in the RCGP Health Informatics Group, being mindful of the approaching Single Patient Record programme. At the time of writing, PAG is advised by NHS England that the SPR is expected to use the GP Connect data feed for GP data (which has the Exclusion Dataset built into it).

OpenSAFELY's positioning within these issues

OpenSAFELY's unique ability to enable use of GP data at source, with its additional privacy constraints as commented on by the authors make it a very strong system to use for research in this area, and the Summary Care Record Exclusion Dataset has not been applied to the dataset.

At present, unlike other datasets, OpenSAFELY does not restrict access to coded information relating to sexually transmitted diseases.

This positions OpenSAFELY as being a potentially very important platform to work with GP data in this area.

Other comments

The authors should be aware that SNOMED CT became deployed in General Practice in April 2018, so if in due course older data are brought into scope, careful consideration should be given to the specification of Inactive codes in SNOMED CT to ensure that data are not lost if they were mapped to codes which are now inactive.

PAG is aware of the national drive to have opt-out testing for HIV in emergency departments, and notes that the pathways to screening and testing are changing.

Finally, PAG observes that NHSE are currently working towards the replacement of the obsolete QRISK2 integrated calculators in GP clinical systems, with QRISK3. The authors may be interested to consider whether how the recording of HIV has or has not been associated with the recording of a QRISK3 score as opposed to QRISK2. The Joint GP IT Committee has previously expressed concerns that certain populations have been disadvantaged by the lack of integrated calculators, so research evidence exploring this may be of interest to the profession.

Appendix D

Profession Advisory Group (PAG) Feedback Form – OpenSAFELY

Meeting Details		
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Applicant Organisation:	LSHTM	
Application Title:	PRISM: Population Risk: Infections, Socioeconomic deprivation and Minority ethnic groups.	
Attendees		
Representing Organisation	Name	Role
British Medical Association (BMA)		BMA Representative
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Declarations of Interest		
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Advice Required		
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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:

This study aligns well to the Quintuple Aims as set out by the Institute of Health Care Improvement:

Population health and care: Strong alignment with prevention and population health management, with a specific focus on known cohorts experiencing inequity.

Patient experience: Good alignment - the outcomes being studied are patient-centric.

Staff experience: While out of scope, staff are aware of health inequity, and it is a global concern for the health care professions. Evidence based guidelines which help advance health equity are inherently important to the ethical integrity of the service.

Effective use of resource: Strong alignment. The project explicitly aims to identify vaccination and prevention strategies that reduce illness and healthcare utilisation, supporting the NHS objective of shifting from sickness to prevention and improving targeting of interventions.

Advancing health equity: Very strong alignment. This is a central objective of the study. The project is specifically focused on understanding inequalities associated with ethnicity and socioeconomic deprivation, identifying their drivers, and evaluating interventions which may reduce those disparities.

We observe that the different patterns of health-seeking behaviour are highly impactful in the access to care in this area, and may be a difficult factor to quantify when looking at the influence of different contributors to the observations this study will make.

We note the absence of the SGSS data in the current framework, and observe that the pathway to codification of organism testing results e.g. virology in GP data may be idiosyncratic – while virology may be recorded in the records through practices engaged in the RCGP Research & Surveillance Centre work, there is no consistent

mechanism by which structured data for results requested via non-primary care services will result in codification in GP surgeries.