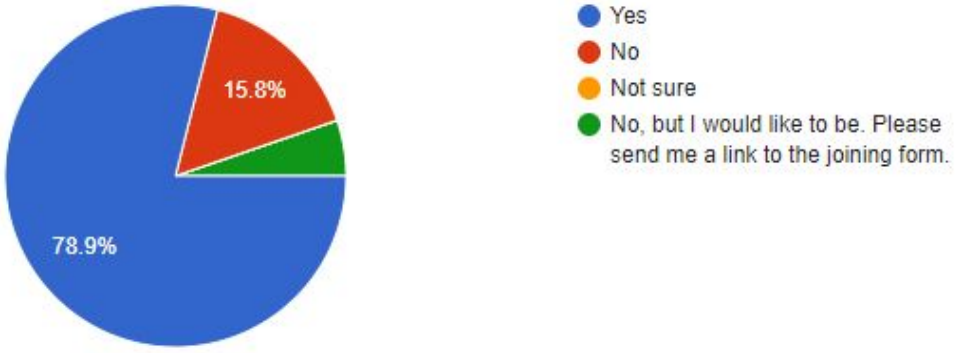
INTEROPen

CareConnect STU3 Curation Feedback (19 responses)

One respondent did not take part in any Curation calls - feedback removed
Order of respondent's answers changed for each questions
Occasional modification to de-identify individuals who asked for this

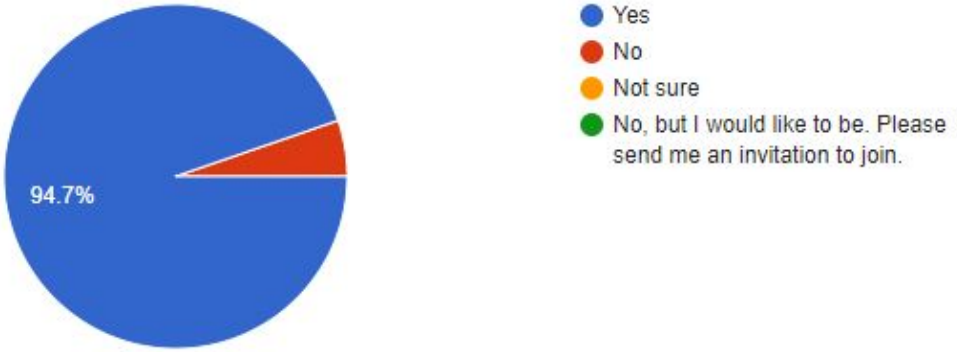
Are you a member of INTEROPen?

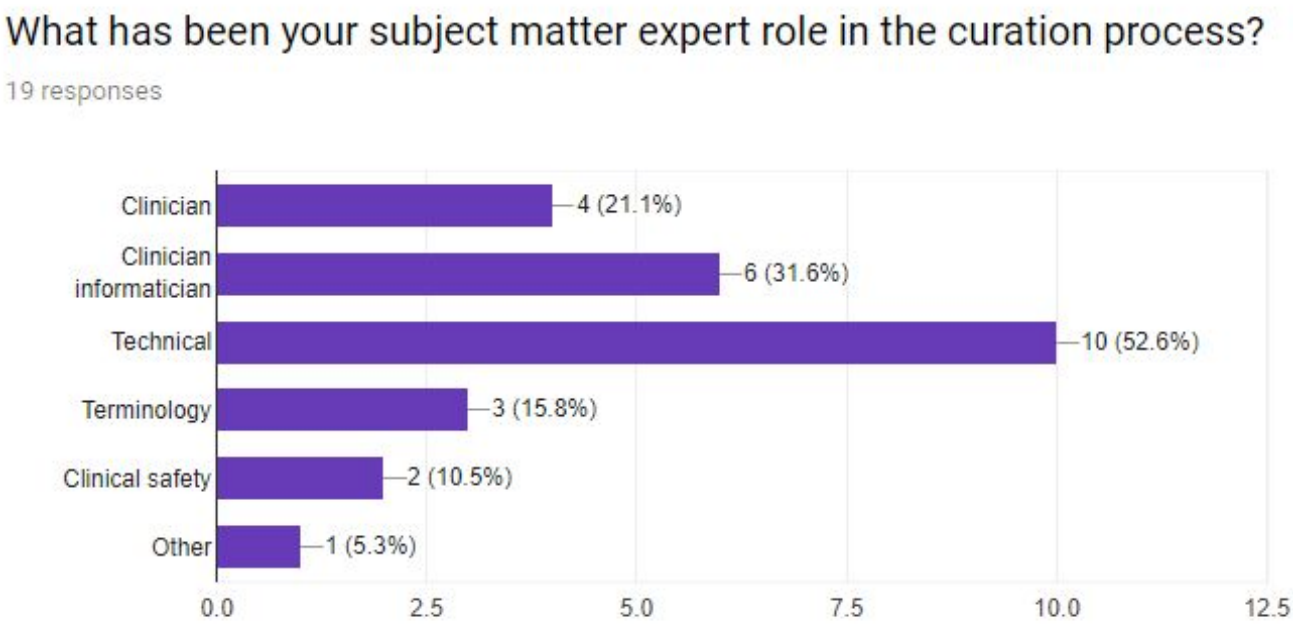
19 responses



Are you on Ryver?

19 responses



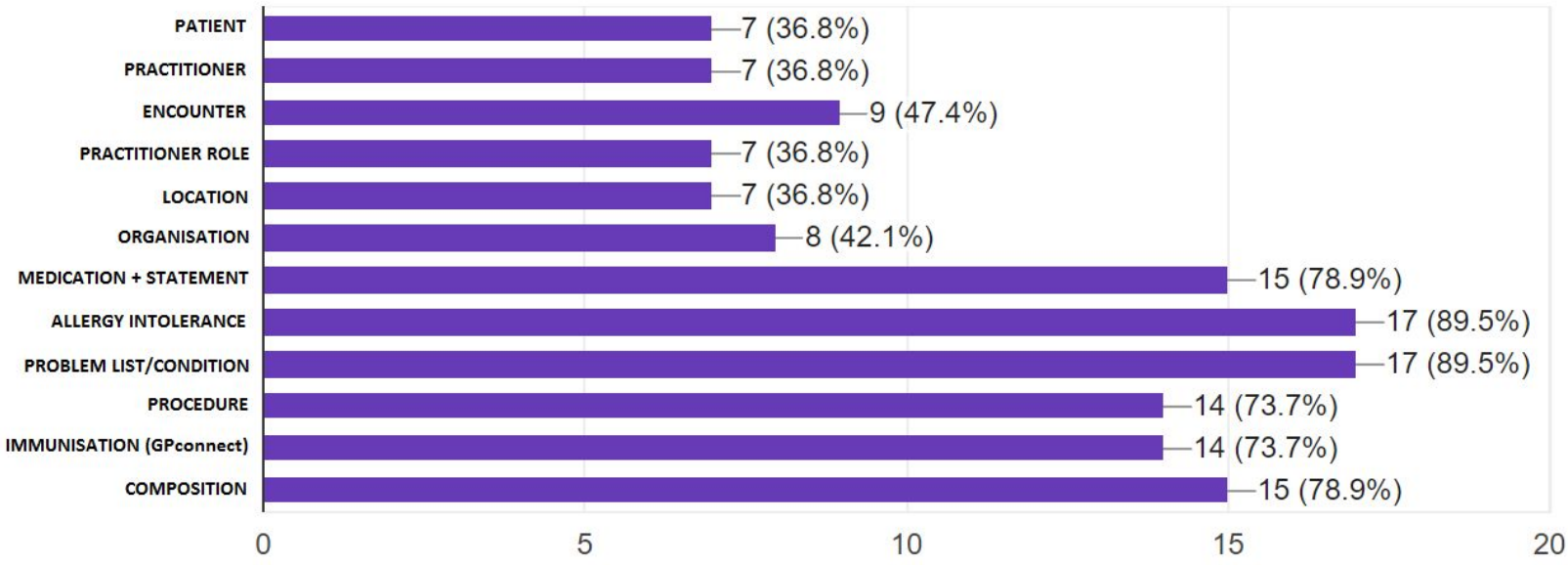


If 'other', please specify:

- Understanding of PRSB information models as HIU developed them

I have been involved in the curation of the following profiles (please tick all that apply):

19 responses



Section 2: **Overall Curation Process for GPConnect and Transfers of Care**

What went well?

1. working via webex very effective
2. Attendance at calls was very good and helped ensure that the profiles represent a wide range of clinical settings as much as possible.People on the calls also seemed to actively participate rather than staying quiet.
3. Having people from all aspects in a 'room' together works very well.
4. Passionate debate about the merits and current approaches
5. Precise chairing with direction and summarising; excellent level of debate showed lots of learning needs for me!
6. Good discussion about known issues, input from a wide range of people.
7. Very constructive conversations. Clinician input essential to decision making. Logical models very useful to help get proposed designs across.
8. Great collegiate atmosphere. Good to have detailed vendor involvement + conversations between information modellers/terminologists. This is work that is hard but needs to be done or we will fall far short of the expectations of interoperability.

9. I think trying to get as many people involved as possible worked well. The use of a WebEx and a single face-to-face was good.
10. Useful to have clinicians, informaticians and vendors working together
11. The engagement of suppliers, terminologists, clinical informaticians together worked really well - it helped those who will be implementing the headings understand the rationale and detailed content. It also challenged the clinical requirements where they were insufficiently detailed, resulting in a more robust definition. Having the clinical information models driving the technical specification was really good. Having the shared documents on Google was great as was having a discussion forum.
12. The process got through a lot of interoperability content in a very short time period. In this aspect the process was very efficient. There was good input from a wide range or stakeholders who have not been involved in previous interoperability work. This was a very ambitious undertaking and the result is a minimal viable product that may need to be revisited.
13. I found the whole curation process was managed very efficiently and from the point at which I joined it pretty much stayed to the timetable. The DDM, where it was commented on, is a great way to see peoples views on the topic prior to the curation call and to confirm understanding.
14. Participation was wide & enthusiastic
15. We managed to gain a consensus of opinion with a wide variety of stakeholders over a large number of subject areas in a relatively short space of time.
16. I think the profiles for GP Connect that were the outputs of the process
17. Good spread of people, clinical and technical, involved in process. Focus on PRSB Transfer of Care Information Model/use case worked well. Medications Workshop, Problem Lists and Immunisation in particular all prompted good discussion, elaboration of issues and pragmatic decisions.

What could have been improved?

1. For those of us with 2 screens 2 simultaneous webex screens would have worked well
2. Need tangible examples and worked examples with representative patients to be able to visualise the conversations quickly.
3. Process needs properly defining and needs to be streamlined to make less time consuming. Suggest that the documentation re the profile is sent out in advice for comment. Perhaps have a walk-through of the profile to explain what's what before call. This would highlight areas of concern in advance and allow prior research for people.
4. How do PRSB specifications based on paper communication relate to data structure and terminology used in the NHS?
5. The web-call meetings work well but it is too hard for people to interact with the documentations or follow the decision-making process (as an outsider or retrospectively). The overall process has worked so far but too reliant on web calls to scale to meet the forthcoming challenges. We need to be able to interact asynchronously with a much bigger community without tying people into webcalls.
6. Are PRSB specifications 'source of truth' with respect to requirements.
7. Clarity on purpose: aiming to replicate or build for future? Some decisions came across more like the former rather than the latter.
8. Ryver as a system generates a lot of live alerts, which can be intrusive if contributing to the project in limited capacity."
9. Although it's expensive, face-to-face is more productive.

10. More work needed to understand how FHIR should work with SNOMED CT as they have information models with quite different and overlapping data models.
11. When we got bogged down we should probably have agreed an action to address it, eg refer back to the core team or someone else to do more work. The Ryver discussion forum topics were difficult to look back in and find specific topics - sometimes they appeared under the meeting and other times as specific topics. It would be helpful to include the meeting invites the topics to be covered in the curation calls, updating if they change.
12. There was no clear definition for having the clinical safety team presents in all these sessions. We have captured a list of hazards flagged during these sessions. These hazards still need to be reviewed by the FHIR team. We've had no feedback on these. The agreement with the CS team was to assure FHIR's Clinical Safety Case Report and the Hazard Log, but not to author them. However, we have done so for the HL. The CS team is in the process of devising a Clinical Risk Management Plan and this will detail individual's responsibilities.
13. Documentation of final decisions
14. There was no common model for representing the complex relationship between terminology and record structure that underpinned the design decisions so it felt that some arbitrary decisions were made that may need to be revisited.
15. View of screen with rapid changes hard to follow without audio commentaryAlthough we looked at detail at the resource or profile level and most of the time that was the correct thing to do it would have been useful to be able to step back and look at the wider context. For instance I have said previously in GP Connect we should look at the entire GP record and try to decide what type of resources would be required to represent the full record. This may also be true of other care settings.
16. As we progressed through the process it worked well but when we got near to the end of the process we weren't good at finishing the curation of profiles and there were often questions left over that were not addressed.
17. As raised early on in this current review cycle I believe the approach to documentation and documenting design decisions could be improved and made more methodical as found it hard to track both how an information model or use case was mapped to CareConnect Level 2 resource profile and what the overall implications for the CareConnect Level 2 resource profile were by looking at the final documentation. I think this situation could be improved by separating out documenting mapping to specific information models or use cases to CareConnnect Level 2 resource profiles from documentation about decisions from a specific CareConnect Level 2 resource perspective. The documentation of decisions at a Level 2 CareConnect resource profile could make reference to elements that a specific information model or use case has referenced but think it would be better to document decisions about mapping a particular information model or use case element to a specific Level 2 CareConnect resource profile element separately.
18. I think the GP Connect use cases could have been better articulated, possibly through sharing of a GP Record information model that could be mapped to. Something like this seemed to be being fed in informally but think this could have been improved.

How could we improve documentation of design decisions and actions (in the DDM or other method) ?

1. The DDM has grown to be a substantial document and it can be difficult to find what you need to find in it. It may be worth looking at other tooling methods to see if there is something that would better cope with the growing amount of information?
2. I like the idea of the DDM however feel it was a bit difficult to keep track of different peoples comments on the decisions by having them in the same sheet
3. Proven examples with patient centred information
4. I think the DDM can be a bit user unfriendly, I would prefer a table based on the FHIR Resource. This would be easier to refer to against the standard. Can provide more info if wanted. Fan of google but not the NHS digital way (windows 365)
5. Complex to capture all information, and google docs seems a good way of addressing this. I wonder if comments/feedback could have been capture separately, distinct from an original and final decision matrix.
6. Perhaps signed off models
7. Separating out documenting design decisions as they relate to mapping Use Cases and/or existing Information Models to CareConnect Level 2 esource profiles and documenting decisions from a Level 2 CareConnect resource profile perspective. The Curation Methodology documents already outlines a methodology for how decisions about a Level 2 CareConnect resource profile should be documented, see INTEROPen FHIR Curation Methodology and INTEROPen CareConnect Resource Profiiling Design Approach and Change Tracking These methodology documents could be expanded to detail how design decisions should be documented as part of mapping to existing information models and/or use cases. Overall the Curation Methodology documentation should be updated to reflect whatever methodology has been agreed as at the moment we don't seem to be following what has been documented and agreed so far.
8. This for me has been the major drawback of the current approach. I found working with the spreadsheet very difficult and it was noticeable that very few people added comments in advance of the web calls. It is particularly difficult to interact with comments from others.
   This is not a criticism of the spreadsheet design per-se. It is probably as good as it can be with spreadsheet technology. I am used to working with custom tooling like the openEHR CKM tool which (while still complex) is very much easier for both reviewers and the core team to collect and collate review comments and feedback the outcomes/actions. The CKM tool is by no means perfect but it does feel much closer to the kind of tooling required to support this work.
   It will become doubly important as we find ourselves having to curate FHIR profiles based on much more abstract resources e.g Observations / Care plans where the technical overlay of the profiles will increasingly obscure the 'clinical content'. "
9. DDM works well. Actions list didn't quite work - needs managing and review plus close off the actions when completed and a decision reached.
10. There were fewer comments made on the DDM towards the end of the curation process and I wonder if this is because more people were using ryver to put their thoughts across and get feedback.
11. The DDM is a very large document and it becomes difficult to see where comments / edits have been made.
12. By having a discussion log & a final design decision log
13. As a way of documenting design decisions the DDM seems to work. With the short turnaround in this cycle it was not a problem but this may not be the case when/if it needs to be revisited for future work.
14. The giant spreadsheet took some time to navigate around

What are your recommendations for action (if any)?

1. Look at better ways to record comments against the DDM. Maybe something simple such as adding notes to cells in the spreadsheet?
2.
3. Visualise the standards being discussed to have a more concrete example
4. Check back through the DDM to make sure all outstanding items have been resolved and clear recommendation made.
5. Define process and get documented and agreed. Streamline the approach.
6. The key missing component here is review tooling. We need to reduce the burden of interaction for reviewers and, even more so for the curation group (editors).
7. NHS Digital to share the deliverables in draft - ie the FHIR spec, implementation guidance and safety report - it would be good to review them together to ensure that they are aligned.
8. NHS Digital need to create a (virtual) data model for representation and communication of data using SNOMED CT so that suppliers have a common model to and from which they can transform data. This needs to take account of the SNOMED CT data model and constrain some elements of the FHIR model.
9. Issue "reading list" of probable docs / URLs to be referenced in the discussion, for preview - for benefit of those unfamiliar with them.
10. Process review meeting between PRSB and NHS D to discuss how we engage the wider PRSB where clinical queries are raised and how these are fed back into the curation process.
11. Some higher level planning that looks to produce a bigger picture/matrix of national services/known projects against FHIR resources. It may also be worth meeting with the NDA team who are using FHIR to help them build their data architecture. Having someone whose role it is to be responsible for the ompletion of the process/DDM and managing the outstanding actions. I think also that sometimes as calls were so long it was struggle to maintain focus for the entire call. If we are going to have calls that go on for 3 hours or more we should have a break. Also it may have been better to try to publish the profiles as we went along rather than as a batch at the end. This might have provided more focus to finish the process and chase up outstanding actions.
12. Propose following the existing Curation Methodology documentation approach in terms of documenting decisions about Level 2 CareConnect resource profiles and amending Curation Methodology documentation to outline Methodology for documenting decisions about mapping to use cases and information models. For DSTU2, these are the documents that were created for documenting design decisions in relation to Level 2 CareConnect resource profiles. For STU3, I proposed some amendment to template for documenting design decisions from a Level 2 CareConnect resource profile perspective and have partially completed the following by way of illustration INTEROPen STU3 CareConnect Profile - Patient - Curation DDM Review Log. This includes some amendments to what is currently described in the Curation Methodology documentation , specifically in relation to mapping have columns for mapping to information models and use cases and also in relation to documentating relation to relation to US Core implementation guide http://www.hl7.org/fhir/us/core/ so clear where they deviate. In terms of mapping use cases or information models such as Transfer of Care, propose following an approach similar to that illustrated in document below for PRSB General Discharge Summary where I have made a start on transposing design decisions from existing google sheet PRSB General Hosptial Discharge CareConnect Mapping. This approach would I believe make it easier to be more methodical in ensuring all items of the information model oruse case being mapped to

have been covered and should not cause issues such as those currently occurring where items are listed/mapped in more than one tab causing documentation around decision to be spread out and hard to follow. With the current documentation format it is very hard to ascertain if all the items from the Transfer of Care information model have been covered and exactly what they were mapped to.

Section 3: **Curation Webex Calls**

What went well?

1. Presentations were a welcome addition and helped the structure and focus of the calls.
2. 3 participants said “See above comments”
3. Use of the putting hands up function it improved the calls and was more manageable for the chair.
4. People involved in debate are clearly motivated to make a positive change
5. All in all they are OK but certain areas were discussed at great length when no real use case .
6. Generally good quality.
7. Good method to pull everyone together
8. Calls are a useful way of maximising 'attendance' and contributions.
9. WebEx is an efficient way of involving a wide range of stakeholders. The calls were well managed and people seemed to get a chance to comment.
10. Again, good progress gained having people covering different aspects.
11. Again these were efficiently managed and didn't over run. There seemed to be a good mix of technical and clinical attendees, prompting discussion rather than a blanket acceptance of recommendations.
12. Participation was excellent
13. Rapid session timetable achieved; each session also well controlled to timetable

What could have been improved?

1. Web-ex calls are a bit long and 3 hours is a long time to keep people focused
2. In the absence of face-to-face meetings these could have been more visual. It was easier to get a better understanding where slides were presented and test cases discussed rather than just looking at the DDM on the screen.
3. Including developers either in this curation process or to be able to debate the merits of the technical decisions being taken and the impact.
4. See previous section
5. Clear questions/ goals for each call (for the various stakeholders) to focus the discussion
6. Comms from a technical viewpoint
7. Need to ensure that the clinical informaticians involved are the right ones for the topic being curated and that all fully participate (PRSB role).
8. Improve definition of role of clinical safety team. We have captured a list of hazards flagged during these sessions. These hazards still need to be reviewed by the FHIR team. We've had no feedback on these. The agreement with the CS team was to assure FHIR's Clinical Safety Case

Report and the Hazard Log, but not to author them. However, we have done so for the HL. The CS team is in the process of devising a Clinical Risk Management Plan and this will detail individual's responsibilities.

9. I think would benefit from going back to using a single Curation Team action log for keeping track of actions that occur from meeting to meeting as was being done previously
10. We did cram quite a lot into a small space of time and as a result the process took up a more of my working week than I really had time for. Finding time to do 3 calls a week and be properly prepared was difficult as I have other responsibilities. I guess this is my problem but it made me wonder if there was a different/more efficient way of working.
11. Towards the end there were small presentations to help understanding - these could have been used more
12. There were some areas where it may have been better to take a broader view of some resources.

Are there topics that you think would be better curated in a face-to-face meeting rather than by Webex? If so, please name which topics:

1. None
2. Allergy and composition
3. Face to Face can be better but in my opinion not a viable option. WebEx should work ok.
4. I think webex works well
5. Complex issues that generate conflicting or contrary views by calls e.g. allergy, medication (which was face to face)
6. Allergies and Medication were worth having the initial f2f meetings. In retrospect we might have been better to have a f2f for Problem lists and ?? Negation/empty list issues.
7. Problems/conditions would have been a good thing to do as a face to face.
8. I think nearly all of them might be useful to have a single face-to-face.
9. It would also have been good to curate condition/list in a workshop.
10. Those topics that prompted more heated debate would have benefitted from more time in a face-to-face meeting although it's difficult to know in advance which they might be. Composition and problem list may possibly have better curated face-to-face.
11. Face to face is better, but it's also expensive, so on balance it was probably OK
12. The face to face meetings excluded some stakeholders so at should be hosted in venues that could accommodate more people. Multiple webexs may be a better way of achieving the same goal.
13. All but the most straightforward would benefit but not sure if the value outweighs the cost.
14. 1 or 2 became apparent during the webex - but arranging a F2F ad-hoc would cause delay.

What are your recommendations for action (if any)?

1. Maybe split the calls from 3 hours to 2 x 2 hours a week?
2. Would it be possible to do some of the curation calls (initial meetings) face to face. Maybe to try and do a number of profiles in a couple of days? 4 profiles in
3. Examples of use either through technical partners implementing, active development partners or simply visualising the technical messages for the audience discussing the proposed changes
4. Not much. Perhaps be a little more ready to go for f2f where there are likely to be tricky issues.
5. Advise all to use headsets - esp if on phone (implies use mobile phone)

6. I think it would be be good to create opportunities for those involved in the curation process to meet face to face at some point as think it could improve communication. Possible through some kind of kick of meeting where scope of proposed cycle outlined at start.

Section 4: **Communication with the Curation Team**

What went well?

1. Core team are very quick to respond to any comms and are always easy to get in touch with
2. Weekly calls
3. Comms were v clear - all in all a good show
4. Regular scheduled calls keep up momentum. A published set of dates for discussion profiles helped provide clarity and allow future planning
7. Conversions were good, feedback questions etc. Still not quite joined up but believe vast improvement least few weeks
8. Friday calls go well but I think it can be difficult for vendors to hang around for the key parts of the call that are of interest.
9. Very easy to communication with.
10. All inclusive approach and good communication through various channels overall.
11. Curation team were great at chairing and keeping very complex discussions moving along + bringing in different views where needed.
12. Using Ryver to update on topics and deadlines
13. The preparation was well thought through
14. publishing timetable

What could have been improved?

1. Not sure ryver email works well
2. Engagement with those outside the core curation team
3. Sometimes I wasn't sure how the feedback from PRSB was to be used in the FHIR specifications and we didn't go back to agree this.
4. Publish the dates, schedule and process in a more public place than Ryver. A clearer process for the changes and actions from calls would improve the speed of profile development
5. More communication with everyone about the process etc . thing two many people out the loop.
6. Need to find ways for easier async communications - spreadsheet does not work
7. Webex invitations frequently broken

What are your recommendations for action (if any)?

1. Improve comms and engagement with those outside the core team, give them up to month to reply. Include call outs on social media and any other comms channel so interest groups and stakeholders are aware.
2. Tooling
3. The timings of these calls were not quite convenient as most of them were scheduled during lunch time and involved 3-hours sessions with no [comfort] break.
4. Be more transparent. Include worked examples if possible. Publish all decided amendments and debates so it is not lost in case the decisions need to be revisited
5. Question use of RYVER we have too many of these types of forums

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Section 5: **General Feedback**

Please describe what you see as benefits of the curation process:

1. As mentioned above, helps to ensure the profiles are as suitable to various clinical settings as possible.
2. Engagement by the INTEROPen community into a process.
3. The ability to get that amount of feedback / input from such a wide range of people in very valuable. However concerned that some implementers/ vendors , GDEs etc. may not be involved.
4. Allows multiple interests groups - clinical, vendors, terminology and clinical expert have input into the content that the FHIR profiles will be used for
5. Good to get clinicians and technicians around the same table
6. Better profiles with consistent valuesets that can be used across care settings that have the buy in of a wide range of stakeholders (technical, vendor the clinical profession, terminologists)
7. I see an effort to involve clinicians, informaticians, vendors and other interested parties in discussions to make an informed decision about the future of interoperability in the NHS. Though I have not been involved in the earlier parts of the process, I have always imagined the timelines would be challenging given the nature of the discussions and the different stakeholders involved. Yet to have made as much progress as we did is remarkable and should be seen an indicator of the agreement around the table that this process actually benefits everyone involved. One clear benefit is a learning on all sides - e.g. where sometimes the PRSB guidance isn't clear, we ask for clarity and at other times when FHIR's resources have to be extended to meet clinical needs. The end result are interoperability artefacts more fit for purpose.
8. Essential. No one organisation could do it with any hope of a workable outcome. With the curation process, although there will inevitably still be teething troubles, there should be very many less surprises.
9. Engagement of industry should ensure a better technical solution. Engagement of clinical terminologists ensures that structured and coded terms are available, enabling interoperability.
10. The curation process will produce a FHIR profile that is fit for purpose as it has had both clinical and technical input. By having the vendor input it will produce something that is achievable and usable in the real world of clinical practice. It's really positive to see market competitors working together during the curation.
11. As a form of participatory design I think there are potential benefits to improved decisions being made, improving reasoning behind why decisions are made and ensuring reasoning is

documented to form a collective organisational memory that should make things more accessible for other to engage with and help contribute to improving in future

12. I have been advocating this kind of detailed clinician, informatician, terminologist collaboration around clinical components for many years. I am delighted to see it happening albeit through the lens of FHIR profile curation. This can seem like overkill to some technical colleagues but without this detailed ' wrangling' we will fall short of the expectations of digitisation. The devil is in the detail and there is a lot of detail in this space. The other major advantage is in up-skilling the clinical informatics expertise in NHS. That was well demonstrated at the medication workshop where the power of dm+d but the challenges of dos v. product-based prescribing, complex meds instructions were simply not apparent to many attendees, even though they would be regarded as 'experts' within their own organisations. That is not a criticism of any individuals, simply a reflection of the lack of the lack of investment in 'clinical informatics' (to include tech people) that was highlighted by Bob Wachter. The Digital academy is addressing this at high-level but we badly need to get people skilled at ""working in the weeds"" and talking cross-sector. We also need to find ways of keeping small 'expert groups' together and ready to be reactivated if/when a new request for a change to a profile emerges. We need to be able to 'get the A-Team back together' so we can draw on their shared knowledge and memory of previous discussions.
13. Consistency in the use of FHIR profiles (leading to better interoperability)
14. It was very efficient.
15. Exciting fast method of working, eliminates travel hassles

Do you believe the curation process should become a 'Business As Usual' function for the CareConnect standards development? Why?

1. Yes, vital to ensure they best represent the various clinical settings
2. I do believe it should but needs the process to be defined and agreed. With quality criteria about what is good curation. It does add value but only if the right type people take part. I was not involved at the a start due to workload and believe some decisions were made without enough knowledge of ToC for example.
3. I think it would be useful ...but perhaps could be less frequent
4. No, because the process used for curation of STU3 profiles was specific to that. But many good aspects came out of it that can be used in curation of new profiles as they come on board. The process is a good basis for doing future work but it could improve. Especially with its adherence to technical aspects of FHIR.
5. Absolutely.
6. Yes as there may be emergent issues as systems mature, especially secondary care systems which are gradually being implemented across more organisations.
7. I think the Curation process drives useful debate and ensures international standards have been thought through about how they apply to the UK healthcare context. However to allow the expansion and use by developers as fast as possible other processes might be considered either alongside or instead of the current curation process. As health IT delivery is multifaceted the involvement of developers and encouragement of processes to facilitate the use of the latest standards, technologies and profiles in perhaps undefined and unthought of ways/behaviours should be described to the INTEROPen community. This will truely allow the community to accelerate the adoption and growth of the Care Connect APIs, increase engagement and empower the INTEROPen community to take on the health challenges of tomorrow…
8. Yes it would make sense to make it BAU function because:

a. The current timelines were ambitious to start with and would have never covered everything that was needed - so an ongoing effort is needed
b. During the process, we have come across other initiatives/programmes within NHS (e.g. Digital Child Health, Reasonable Adjustment, etc) that been looking at FHIR but did not quite approach it from the broader perspective the FHIR curation process does. It makes sense that other initiatives should really participate in this process to make sure their interoperability designs are fit for purpose for all - beyond the scope of just that project
c. FHIR itself is a 'draft standard' and so will change - and the pace of its change has been one of the factors for its popularity. So it would make sense that an on-going BAU function is needed to absorb these changes to FHIR and review them in the context of the UK - this will ensure NHS isn't doing its own thing thereby making it harder (and/or more expensive) for international vendors to work in the UK market.
d. During the FHIR curation process a lot of 'broader' themes emerged (e.g. document versioning and audit) which goes beyond FHIR and requires a consolidated approach across the board (including other interoperability initiatives like IHE-XDS). While we should not set out to solve all the problems in the world, it would make sense that an on-going BAU function is needed to address such broad problems as part of the curation process.
e. Another requirement that seems to have evolved in the process is the need for an adaptable, user-friendly documentation/reviewing tool for clinicians and non-techie folks to understand and participate in the process. If such a 'FHIR curation tool' were to be created - then it would make sense to have a BAU function that would guide the creation and evolution of the tool.

9. Yes
10. Yes definitely. The PRSB process provides a clinical information model, but it is vital to turn this into an implementable technical specification - the curation process enables this. Use cases do differ and it is important to take this approach rather than assuming one size fits all.
11. Yes - so solutions are consistent
12. Yes, although the first priority would be to curate the relevant FHIR resources that are not part of the specific ToC or GPConnect work. Some of the work to date may need to be revisited when suppliers start to implement these resources.
13. Yes, with some refinement to processes to ensure methodology followed is documented.
14. However, for new domains and now that the FHIR resources have been curated, there would be a benefit in a core team working through the models and escalating curation issues through domain focused calls.
15. Yes
16. I think that it needs to be a BAU function but defining the scope of how it works will require careful planning. Things like communication to other projects that may be using FHIR what their role is in the process and making it easy for them to understand why it exists and how it will help them.

Any other comments?

1. Overall it is a good idea but needs to be improved for BAU
2. This is completely the correct direction of travel. The process needs to be slicker and less labour-intensive for all concerned and set in an agile process which expects continual requests for extension and update. This will require tooling.

3. The process for the moment has been skewed towards content and terminology definition. That was good as it brought those groups on board. The technical side seems to have been "passed over" - I believe Dave Barnett deals with the technical side, it is accepted usually without discussion and we move quickly onto content. We need to have a balance between technical and clinical curation going forward.
4. There is a lack of consistency in how the clinical systems are used in primary care and how well records are made. If this is not done properly then the information will not be there to send through to other care organisations. This process has really highlighted to me the need for good clinical systems training that is ongoing. There are so many functionalities within the systems that are not used e.g. linking of medications to problems.
5. Helpful to strengthen mapping to 4 nation requirements and provide more resourcing to bring in all-system knowledge
6. Ryver not as useful as I had hoped: hard to navigate, Topics or Chats distinction unhelpful, no curation so threads just stop, documents searchable only by title.
7. The process is quite intense and at some points was difficult to fit in around the day job. However, i found it exciting to see the direction of travel for care records and the improvements to the system that this curation process will eventually bring.
8. It would be good to review the process end to end including the development of the professional standards to ensure we are doing this as effectively as possible.
9. Kudos to the team behind the team as it couldn't have been easy. I suspect they didn't quite understand what 'curation' would involve in terms of workload and the demands of talking to various stakeholders. I think making this process BAU would give the team an opportunity to look at a more sustainable approach for curation and a better sense of resources required for this process.