SNOMED CT®

What is SNOMED CT®?

SNOMED CT is an organised collection of standardised clinical phrases, that when used in patient records provide for consistent understanding across the healthcare domains. When used in software systems, data coded using the appropriate SNOMED CT terms allows for the data to be transferred seamlessly between systems and enables features such as decision support and clinical alerts.

SNOMED CT is considered to be the most comprehensive, multilingual clinical healthcare terminology in the world.

Further Information

The UK Terminology Centre (UKTC) develops and distributes the content within SNOMED CT along with other products that support its implementation in systems.

The UKTC also provides a range of user and technical guidance, webinars, eLearning, case studies, presentations and videos which can be found on the Training and Resources pages of the UKTC website.

Useful links

UKTC website:
www.nhscfh.nhs.uk/uktc

NHS Network site:
www.networks.nhs.uk/nhs-networks/snomed-ct

Helpdesk:
datastandards@nhs.net

Distribution site for SNOMED CT:
www.uktcregistration.nss.cfh.nhs.uk

For more information please contact the UKTC training lead for SNOMED CT by emailing:
snomedtraining@nhs.net.

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SNOMED CT®

Providing the content for clinical data in patient records across all healthcare.

How much do you know?

This leaflet provides a brief overview of SNOMED CT and why the NHS is moving to SNOMED CT for its clinical terminology.

SNOMED CT is an acronym for the ‘Systematized Nomenclature of Medicine Clinical Terms’. It is a clinical terminology that has been developed to support the effective clinical recording of data within patient records, with the overall aim of improving patient care. It covers areas such as diseases, symptoms, operations, treatments, devices and drugs.

It is expected that those involved with recording, retrieval and analysis of patient records will use SNOMED CT.

Those entering or reading clinical data will benefit from a basic understanding; those involved with the classifications coding or information analysis will benefit from a more detailed understanding of SNOMED CT.

For further resources see overleaf.

Why SNOMED CT®

The move to a single terminology across the NHS will take time; but offers potential significant benefits. So why SNOMED CT?

All Healthcare; All Clinical Specialities

... provides content for all healthcare professions and all the different clinical specialities. Dynamic so it continues to support today’s’ requirements.

Improved Expressivity

... provides the different levels of detail in clinical phrases required by both clinical specialities and general practitioners. For example, microbiology and radiography are more extensively represented in SNOMED CT than in Read v2.

International

... is an international terminology, which gives it potential to support cross border data communications and language translation; but also enables a more efficient market for systems development and technology offerings.

Supports logical Analysis of data

The features within SNOMED CT provide a wide range of analysis techniques to support clinical audit and research work.

Today’s Technology, an evolution

... has been developed with the knowledge of previous terminologies, while embracing the requirements of today’s technologies to ensure it can support features such as decision support, clinical alerts and knowledge base enquiries.

Benefits of SNOMED CT®

In essence, recording of clinical data using SNOMED CT will enable consistent communication of patient data across different healthcare systems. In addition, data collated from the same or across different systems can be consistently retrieved and analysed to support evidenced based care and service improvement.

- It provides for the capture of clinical information at the different levels required by different healthcare professions.
- Through sharing data in a common form it can dramatically reduce the need to repeat health history at each new encounter with a healthcare professional.
- Information can be recorded by different people in different locations and combined into simple information views within the patient record.
- Use of a common terminology decreases the potential for differing interpretation of the same information.
- Electronic recording in a common way reduces errors and can help to ensure record completeness.
- A clinical terminology allows identification of patients based on specified information, to effectively manage screening, treatments and follow up.

For further resources see overleaf.