SNOMED CT in Vision - FAQs

Introduction
This document provides some useful frequently asked questions for practices and health boards about SNOMED CT in Vision products.

What is SNOMED CT?
You may have heard the term SNOMED CT in recent months. Here is a brief explanation:

SNOMED CT stands for Systematised Nomenclature of Medicine - Clinical Terms and is a common, standardised clinical coding language that will replace Read/CTV3 codes within the NHS by April 2018.

SNOMED CT is the most comprehensive and precise clinical health terminology product in the world. It includes diagnosis and procedures, symptoms, family history, allergies, assessment tools, observations, devices and other content to support healthcare delivery.

Why do we have to have a new coding system?
There are four main reasons for changing to the SNOMED CT coding system:

- The NHS needs a single clinical terminology, for clinical data to be exchanged accurately and consistently across all care settings. This will allow better patient care and improve how clinical data can be analysed and reported on.
- SNOMED CT is an international clinical terminology. It will allow the UK to take part in more effective research and analysis of health information, to support national and global health care improvements.
- Two versions of clinical codes (Read v2 and CTV3) currently exist in General Practice. Not all GP systems use the same coding system.
- Parts of the Read dictionary are full and new codes are allocated to unrelated areas. This makes analysis more difficult.
How will this work in Vision?

For Vision 3 users, the impact of SNOMED CT implementation is minimal. This is because we are going to continue to use Read on the screens you use, to find and enter clinical data in Vision 3 but in the background each code will be mapped to a SNOMED CT code. Therefore, each data entry item will have both a Read and a SNOMED CT code assigned to it. As this is all done automatically for you, you don’t need to change the way you enter data. In effect, you will be saving SNOMED CT terms and codes, and will be able to report on these, but the Read equivalents will be displayed in Vision 3 as you are used to.

For Vision Anywhere users, native SNOMED CT data is recorded and will also be assigned a mapped Read code so that you can view it in Vision 3 in the usual way. We are keeping Vision 3 and Vision Anywhere aligned in this sense and keep the difference of selectable terms to a minimum. In turn, reports, audits and extracts throughout our Vision 3 are able to use a mixture of SNOMED CT and Read as necessary. See more information on this in the below FAQs.

When will Vision deliver this?

SNOMED CT implementation for Vision 3 has already partially been delivered and we will continue to deliver further elements over a series of future DLM releases. It will be fully implemented by April 2018 and you will be informed of the changes as they are released.

Vision Anywhere updates will continue to be delivered via store versions of the applications. The delivery mechanism for the Vision Anywhere Windows 7 version is currently being refined.

What is Vision doing to help with this change?

We will issue more detailed guidance in line with releases. As the changes are of low impact, we don’t envisage the need for any training. Our comprehensive digital learning materials will tell you all you need to know.

What (if any) action/preparation do we have to take before the switch?

We advise that relevant staff in your practice are informed of the imminent change to the system for good practice. Staff involved in creating and managing searches should be aware of the contents of this documents and future communications.

Will the way I enter data change?

As previously mentioned, there is no change to the way you find clinical codes and enter data in our systems. For Vision Anywhere, as you use keywords to find SNOMED CT terms for data entry, you may notice that there are more items returned in the clinical term search results – this is due to the greater volume of SNOMED CT terms. In Vision 3, where you will use either keywords or enter the exact Read code, you may see further results depending on how many Vision-specific Read codes we need to create to accommodate (see What about new codes or SNOMED CT codes that aren’t in the Read dictionary?).

It is worth noting that data entered in Vision 3 will have a Read code and SNOMED CT concept id recorded. Data entered from Vision Anywhere and Vision+ will have a
SNOMED CT concept id, description id and Read code recorded. However, to the average user, this does not need to be a consideration. All the hard work is done for you.

**Will my Read formulary be affected?**

Your existing Read formulary does not require any adjustments and you can continue to maintain it as per usual process in your practice.

**What about templates eg guidelines and Vision+?**

There is no need for existing templates being used to change as they will all still work. Dual coding (Vision will store both Read and SNOMED CT codes, based on clinically assured maps between the two terminologies) will happen automatically when data is added from a template.

New templates will be able to be created as before, and in Vision 3 these will continue to allow associations with Read codes.

Vision+ templates will display and enter SNOMED CT terms and codes. Just like with Vision Anywhere, a corresponding Read code will be entered into Vision 3 so you can see it in the usual way. Making Vision+ SNOMED compliant means that its reporting function will also be SNOMED CT compliant. Should you require a new SNOMED CT code for your template, you will be able to request this via the Hive.

**What happens to historical data?**

Historical content will remain the same in the patient record with the original Read code assigned.

In the background, historical data will have a SNOMED CT concept ID assigned. This is done using the approved mapping tool. The term text on the screen will be the original term text at the time of data entry.

**What about new codes or SNOMED CT codes that aren’t in the Read dictionary?**

As SNOMED CT will be introducing new codes, Vision will assess each SNOMED CT release and will consider whether to map the new SNOMED CT code to an existing Read code or introduce a new Vision-specific Read code in our own ongoing Read dictionary, within the appropriate Read hierarchy to ensure that every SNOMED CT item has a corresponding Read entry. For example, if a new type of flu develops, a SNOMED CT code will be created so that it can be recorded in Vision. We’ll then map it to a new Vision-specific Read code. You’ll be able to find that Read code in a logical place within the Read code hierarchy. We’ll keep you fully informed of any new codes we’ve generated like this. This means that Vision will release our own bi-annual Vision-specific Read code updates and you will be kept up to date accordingly. This position has been discussed with, and accepted by NHS Digital as the agreed way forward.

**Our local enhanced service contains a SNOMED CT code which doesn’t have a Read code. How can this be implemented for use in Vision 3?**

In the same way as above - we plan to liaise closely with CSUs/CCGs to have early sight of any local enhanced services or extractions which are reliant on such SNOMED CT codes. We can then make them available in Vision 3 in the way described above.
Is decision support affected eg drug checks?
All decision support tools within the Vision product will be updated within the system by Vision using SNOMED CT which is mapped to Read. You will not notice any differences in this functionality.

Are there any changes to reporting, audits and extracts?

National Extracts/Messaging
Vision products will be able to manage all extract requirements in local and national projects just as we do now (eg GPES, KIS, GP2GP, SCR). We can accommodate this because of the dual SNOMED CT and Read mapping.

QOF
QOF 2017/18 will be processed using the business rules as specified in the Read dictionary. For England, QOF 2018/19 will have business rules using SNOMED CT.

Again, this should have no impact on your management of QOF as new SNOMED CT codes will be appropriately mapped to Read codes for you. Any QOF prediction functionality will take account of new SNOMED CT codes and mapped Read codes when running the business rules.

Ad-hoc searches
Existing Search and Reports will still search new and historical data entered when the coded entry has a SNOMED CT term with a Read equivalent. Where coded entries do not have an equivalent in the published maps, these will not be picked up in the search but you will still be able to run these historical searches at your own risk. SNOMED CT codes which do not need to be specifically mapped to Read are assigned Read code Rz.00 and contain the original description of the SNOMED CT code. Search and Reports will search for patient data using the mapped Read to SNOMED CT dictionary.

From April 1st 2018, you will be able to make use of patient groups which are automatically generated from Vision+ using SNOMED CT for each major diagnoses and suggest that these groups are used as a basis of your ad-hoc searches. This will ensure that searches against the common clinical conditions that are identified by SNOMED CT codes are possible. We will issue further guidance on this nearer the time.
**Clinical Audit / Vision+**

Both Clinical Audit and Vision+ are being enhanced to use SNOMED CT directly for searching purposes but also use Read codes in the background.

The following diagram may help explain the all of the above but remember as a user you will not notice anything different...

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**How long does Vision plan to keep dual coding going beyond April 2018?**

Dual coding means that Vision will store both Read and SNOMED CT codes, based on clinically assured maps between the two terminologies. Vision intend to support dual coding for the foreseeable future.

**How do I request a new Vision-Specific Read code that maps to SNOMED CT?**

There will be a dedicated page on the Hive where you can make new Vision-specific Read code requests.