GP SUBSET - Important information on the Transition to SNOMED CT

Purpose

This paper is aimed at subsidiary suppliers and GP IT partner organisations, its purpose is to explain and give context to the requirement on subsidiary suppliers to be able to deal with SNOMED CT codes which lay outside the GP Subset

Background

All nationally defined guidance, specifications and commissioning information will now only be developed in SNOMED CT; for business reasons, it may be that these utilise the full scope of concepts provided in the SNOMED CT terminology. Any expressions such as this code and all its descendants will utilise the SNOMED CT hierarchy and can only be interpreted if systems have available the full UK SNOMED CT release.

However, adoption of SNOMED CT has very much been designed as a transition from Read to SNOMED CT, with the appreciation of the extensive use across the NHS of Read/CTV3 codes. Where possible, the principal suppliers will provide coded data in SNOMED CT AND Read/CTV3 but this will not be possible for all coded data.

What is the “GP Subset”?

The “GP Subset” refers to the group of SNOMED CT codes that can be mapped backwards to the legacy terminologies of Read v2 and CTV3. Having these backwards maps allows systems that still rely on Read v2 or CTV3 to find appropriate Read codes when data is entered in SNOMED CT, as long as those codes are within the Subset. This is to help bridge the gap until all systems in England transition over to using SNOMED CT codes.

The GP subset is just a list of codes; it does not contain SNOMED CT relationships (i.e. the hierarchical information) to support queries/searches. As the subsets reflect Read/CTV3 there may be codes outside the subset that are required to reflect correctly the SNOMED CT hierarchy and hence it is not possible to provide this as anything other than a list of codes.

While all clinical codes in Read v2 and CTV3 codes map forwards to SNOMED CT, not every SNOMED CT code can map backwards. This is because either the SNOMED CT concept was never part of the scope of Read/CTV3 OR because while the concept is in Read/CTV3 it is ambiguous, is deemed no longer appropriate for in a patient record (and may have mapped to an inactive code in SNOMED CT) or is not interoperable (e.g. refer to clinic A).

Read v2 and CTV3 each have their own GP Subset, which means there is a Subset for SNOMED CT back to Read v2, and a Subset for SNOMED CT back to CTV3. They are not the same size. The Read v2 subset provides around 86,000 SNOMED CT Terms (representing around 70,000 unique concepts) that map back to Read v2, whereas the CTV3 subset has around 200,000 SNOMED CT terms (representing
around 150,000 unique concepts) that map backwards to CTV3 (largely because CTV3 is so much bigger than Read v2).

The purpose of the GP subset is to enable dual coding in both SNOMED CT and Read/CTV3 for example to allow existing reports to be run without needing to be re-written in SNOMED CT.

**Going Beyond the GP Subset**

All the principal clinical systems facilitate entering some clinical data outside of the GP Subset now.

New codes have been required for the current commissioned services and QOF; the hexavalent vaccine required last year is in SNOMED CT but not in Read v2. There are therefore business requirements for data entry using SNOMED CT terms that cannot be dual coded in Read/CTV3. For such codes these will only be provided to subsidiaries in SNOMED CT and will not be dual coded (e.g. through APIs or extracts).

The following illustrates additional scenarios where data may enter the principal clinical systems and cannot be dual coded:

1. **From incoming electronic data transfers** – For example GP2GP transfers records electronically between primary care systems in England. As CTV3 is much bigger than Read v2, prior to SNOMED CT, any data in CTV3 records that was outside of the scope of Read v2 would degrade to text in Read v2 systems. With the transition to SNOMED CT, these systems will now be presented with a SNOMED CT translation for such CTV3 data; hence the receiving system no longer needs to degrade this to text. The principal clinical system suppliers have mechanisms to manage this and will be adding them to the list of SNOMED CT codes available, but these will be outside of the SNOMED CT to Read v2 GP Subset.

2. **From unrestricted 3rd Part Systems** – Subsidiary systems, such as summarisation or document management tools or data entry for national templates, may well wish to expand quickly from the restricted vocabulary supported by Read/CTV3 to the full lexicon of clinical terms supported by SNOMED CT, allowing users to better summarise incoming documents.

3. **Federated shared record services** – Many users can already see terms captured from SNOMED CT as they view data recorded in, for example, secondary and acute care. As systems meet the requirements of ‘Transfer of Care’ as issued by NHS England, such terms will start to enter GP records.

4. **New Guidance and Recording Keeping Standards** – Just like Read v2 and CTV3, SNOMED CT is updated every 6 months with new clinical codes to keep up with the ever changing and expanding information standards needed to record clinical data. Some of these codes will be referenced specifically in NICE guidelines, CCG template specifications and other data quality and recording rule sets. System suppliers will, just like before, need to expand their supported code lists to include these codes for data entry and reporting. As Read v2 and CTV3 are no longer being updated, all these new codes will be outside the GP Subsets of both Read v2 and CTV3.

**Actions required**

It is therefore important that organisations which utilise primary care clinical data, or provide services or tools using primary care clinical data, ensure that their system functionality is able to handle data outside the GP subset. For systems which run reports on clinical data, the requirement is that they utilise the full SNOMED CT hierarchy.