SNOMED Clinical Terminology: Countdown to 2013.
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In June 2011 the Information Standards Board issued an Advanced Notice stating that from 2015 the only clinical terminology supported for use in the NHS will be SNOMED clinical terminology (CT). Clinical terminology may not be the most inspiring topic but here are 3 reasons why you should read on:

1. By 2015 all occupational therapists [OTs] in England will have to use SNOMED CT to routinely record key patient information.
2. If we do not structure our own language it will be difficult and time consuming to code patient information correctly, as currently SNOMED terms are organised in a hierarchy that reflects a medical perspective on healthcare.
3. As a profession we have to identify and agree upon sets of related terms that we would expect to find grouped together. For example, 'interventions' should be grouped together under a meaningful heading such as 'occupational therapy interventions'. If we do not get this right OTs will have difficulty selecting coded terms accurately and reliably, will fail to record key information, and will use a variety of terms for the same concept making the information recorded useless for commissioning, audit or research.

Some answers to key questions:

1. What is Clinical Terminology?
Healthcare professionals use many specialised words when recording information about assessments, care plans and outcomes for patients. Those words are described collectively as clinical terminology.

2. Why is it important?
The use of coded SNOMED terms will facilitate greater consistency in the recording and electronic transfer of patient information ensuring that such information is more accurate and trustworthy. Coding is essential for commissioning, central returns, audit and NHS research and improved quality of patient information will facilitate better care for patients and better support for carers.

3. How is it used?
Coded CT will be used in patient summaries, discharge summaries, clinical documentation, care plans, research documents and messages which convey patient related data from one system to another.

4. Does this only apply to OTs working in the NHS?
No. Clinical terminology will also be used by those commissioned to provide services on behalf of the NHS.

5. Does the mandate only apply to England?
Initially yes. However, COT and other professional bodies support the development of information and record standards that apply across the UK. Policy decisions from Northern Ireland, Scotland and Wales are awaited.

6. How do we prepare for this development?
Work on OT CT has already started, the subsets for 'aims' and 'outcomes for patients' will be completed shortly. However there are more subsets to develop, e.g. 'occupational therapy interventions'. We need to consult with members to generate an initial framework of terminology, and then develop a consensus on the terms to be included in each subset.

7. What is the timescale?
2015 may seem a long way off but OT CT needs to be finalised by 2013 as the process of incorporating a subset is long and complex.

8. I don't know much about IT can I get involved?
Developing CT has nothing to do with technology, it is about ensuring that the language used by OTs is integrated into care record systems. This is why is it so important for practitioners to contribute to this work to ensure the CT reflects our diverse areas of practice.

9. How can I get involved?
Over the next few months we will determine the process for generating and agreeing the OT subsets and then explain, via OTN and other networks, how you can support this work.

10. Where can I find out more?
Visit the COT website and under 'Research & UKOTRF' follow the link eHealth (Information management), where you can also sign up to the monthly COTIM bulletin to keep up to date with developments in this area.