7.1.1 Historical Summaries

One major ambition of healthcare IT is to make effective summaries of a patient's clinical history available to healthcare providers (especially in emergency situations). Typically a patient's clinical data is scattered across a number of healthcare institutions using a variety of information models and coding systems. Even within a single institution patient data may be captured across many episodes of care, many devices, and often many software systems.

SNOMED CT can help to support the integration of this information by serving as a common reference terminology into which other code systems can be mapped (see section 5.2 Mapping Other Code Systems to SNOMED CT). It can also be used to unlock clinical data that was captured by source systems in free text narrative (see section 5.1 Natural Language Processing), and to summarize large volumes of data by grouping codes together into more general categories (see section 6.2 Subsumption). SNOMED CT can also be used to enable clinicians to filter large volumes of data to select those records that are relevant to the current care episode – for example identifying all previous records of a heart attack.

One significant example of this is the UK NHS Summary Care Record (SCR) service[^1], which uses SNOMED CT to represent a number of types of clinical information including medical history, medications, adverse reactions and allergies. This service uses a summary extracted from detailed patient care records held in a variety of disparate systems. Where the source data is not stored natively in SNOMED CT, they are mapped into SNOMED CT prior to transmission. Over 40 million people in England (80% of the population) now have a summary care record. This service now contributes to the safe and efficient assessment and treatment of these people, and has greatly improved the accuracy and timeliness of medicines reconciliation.[^2]