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| **SPECIFICATION: CLINICAL CODING APPLICATION - EPR PROJECT** | |
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1. **Overview of the Requirement**

Countess of Chester Hospital NHS Foundation trust plans to introduce a new EPR (Cerner Millennium) in late 2020 to replace the current EPR system, this has resulted in the requirement for a new clinical encoding system to interface with the new EPR. The clinical coding solution is expected to improve efficiency and quality assurance as well as provide effective reporting on healthcare service delivery.

The clinical coding team currently uses basic software to create reports which are sent over to the trust’s Business Intelligence team for further processing and reporting, in line with NHS requirements. This process is inefficient and time consuming, and is not in line with current initiatives to embed digital platforms in healthcare service provision.

The new clinical coding system is expected to interface with the new EPR to enable computer-assisted coding, clinical documentation improvement, performance monitoring and quality outcomes reporting.

The proposed encoding solution is expected to provide the following:

**Clinical Encoding Classification**

This accepts clinical terms and cross-maps them to appropriate ICD10 codes which comply with WHO and UK National Standards. The built-in prompts and flags support users to improve the accuracy and speed of the data captured. This ensures that all relevant activity is accurately recorded and ultimately, appropriately reimbursed.

**Real-time HRG Validation and Rules Investigation**

The Trust’s income depends on the accuracy of the HRG’s (Health Resource Group) information generated from the coded clinical data. The HRG function in the clinical encoding system provides real-time user prompts in HRG which directs the coder to consider all relevant information for the current episode of care.

**Healthcare Service Provision Auditing**

A robust auditing solution should streamline the audit process and use the full NHS clinical coding audit methodology to improve auditor efficiency. This allows for a larger percentage of activity to be routinely validated.

1. **Background to the Department**

The Clinical Coding department is responsible for the translation of medical terminology, as written by the clinician to describe a patient complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised to support both statistical and clinical uses. Coded clinical data (generated from classifications OPCS-4 and ICD-10) uses rules and conventions that, when applied accurately, result in the provision of high quality reporting to support secondary uses of data for statistical purposes - such as; operational and strategic planning, epidemiology, public health analyses of population health and reimbursement. This directly affects clinicians and all healthcare professionals, financial teams, information managers and data analysts, along with IT professionals.

1. **Essential Product Requirements**

In order for the product to provide the expected functionality and optimum performance, the specifications outlined below are essential.

(ICD10/OPCS) Inpatient Classification Encoder **MUST** include:

* Template Coding
* Advanced coding Auditing Suite
* Real-time HRG Validation and Rules Investigation Module
* Medical Dictionary - Dorland’s Data Set

**Inpatient Clinical Coding**

**Code from a Dynamic Online List of Coding Tasks**

**Expected functionalities:**

* Provide a comprehensive list of online clinical coding tasks which correspond to Inpatient Activity encounters.
* Use the online list of clinical codes to auto-create coding tasks for any admission or discharge of an Inpatient Activity encounter.
* Permit the use of online clinical codes to auto-create coding tasks for any admission or discharge of an Inpatient Activity encounter.
* Allow a Clinical Coder to select a task from the online list and select the appropriate consultant episode to code.
* Allow a Clinical Coder to access the Patient Chart from the EPR Coding solution to review documentation for a particular encounter.
* Enable the Clinician to record any Diagnosis, Procedures and lifelong conditions using SNOMED vocabulary.

**Code from an Uncoded Discharge Report**

**Expected functionalities:**

* Add patient data on the Uncoded Discharge Report upon the discharge of a Consultant Episode.
* Display any discharged Consultant Episodes and/or Discharged Encounters in the EPR coding system which do not have a diagnosis codes recorded against them.
* Generate a report listing episodes which need to be coded.
* Use the Patient Search facility within the EPR coding system to locate Consultant Episodes which require coding.

**Clinical Coding – Outpatient Clinical Coding:** OPCS4 nomenclature (SNOMED, ICD-10, OPCS-4, HRG) content used to support Clinical Coding.

**Required Data:** Favourites folders of OPCS4 codes accessible within the Patient Chart.

*In addition to the above, please provide information on the technical specification for suitable server and client hardware, i.e. the minimum server hardware requirements and what the ideal client platform is.*

1. **Desirable Requirements**

Desirable requirements include:

* Data quality analytics
* Medical history assurance capabilities

1. **Warranty Requirements**

Details of frequency of system updates and patches

1. **Other Requirements**

**The quotation should include the cost of:**

* Access licenses for 20 users (including concurrent use)
* Installation
* Configuration
* Comprehensive training of 20 users
* Cost of a single server Copy
* Interfacing to an EPR
* Set up and configuration to a fully functional state
* Go-live support
* Training (System Management and User Support) for up to 10 people.
* Any firewall requirements
* Suitably specified connectivity link