

GP2GP Redactions

How to send redacted information in a
GP2GP transfer

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Problem Statement

It is common for a GP practice to redact parts of a patient's record, so the patient doesn't have access to that information when they view their clinical record. When a patient transfers from one GP practice to another, the GP2GP standard is used to electronically transfer the patient record. However, the GP2GP standard does not currently support redaction. This means that the receiving GP practice has to manually examine the new patient's record, and apply redaction in the new practice.

This document/pack forms an amendment to the GP2GP standard to allow for notification of the redacted parts of a GP record during a GP2GP transfer.

It is assumed that GP suppliers have implemented the GP2GP standard from MiM 4.2.0.

The MiM 4.2.0 GP2GP Model & Redaction Level

MiM 4.2.0 specifies the GP2GP standard in an ISO 13606 style, using an Extract -> Folder -> Composition -> Entry (although called Statement in the MiM) format.

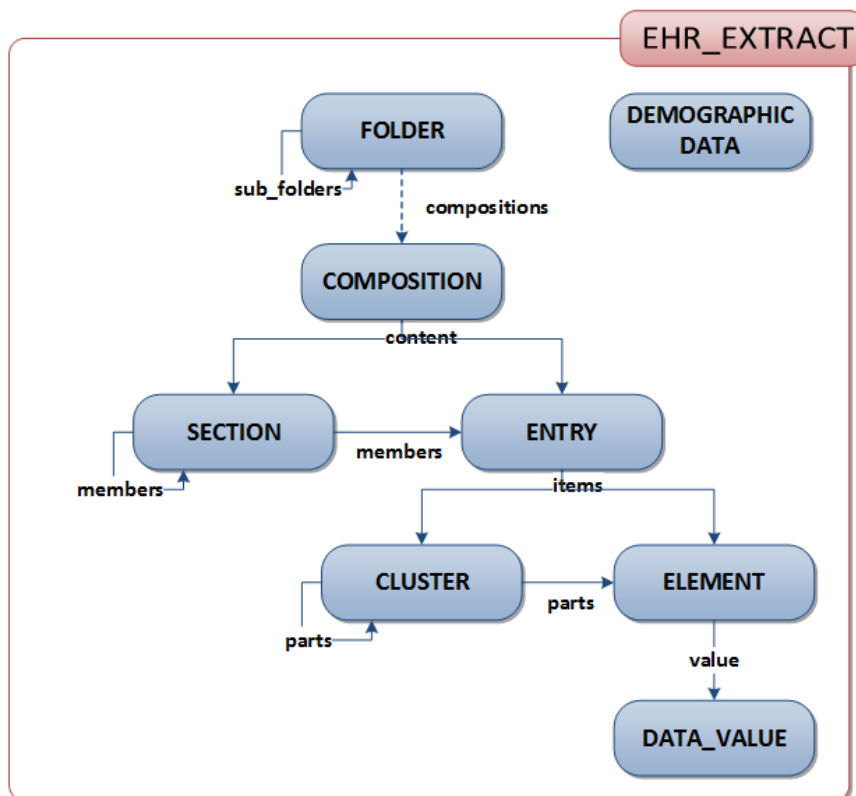


Figure 1 - 13606 Model

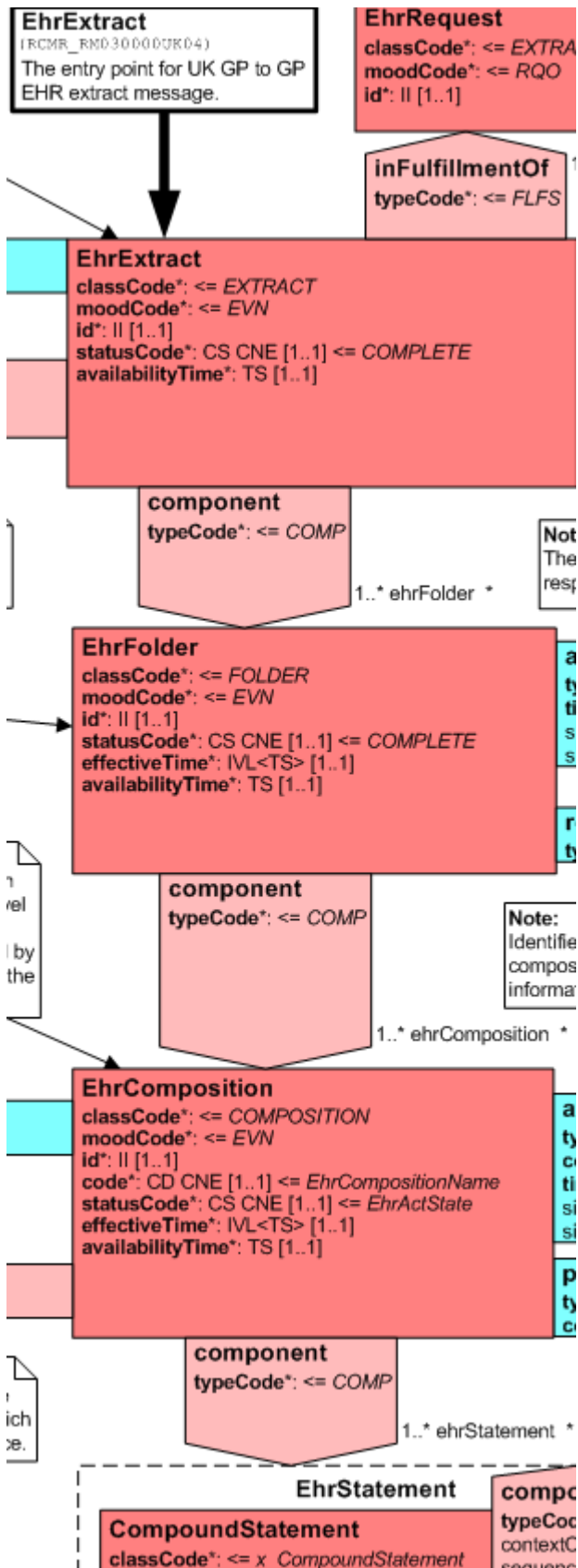


Figure 2 - MiM 4.2.0 GP2GP Structure

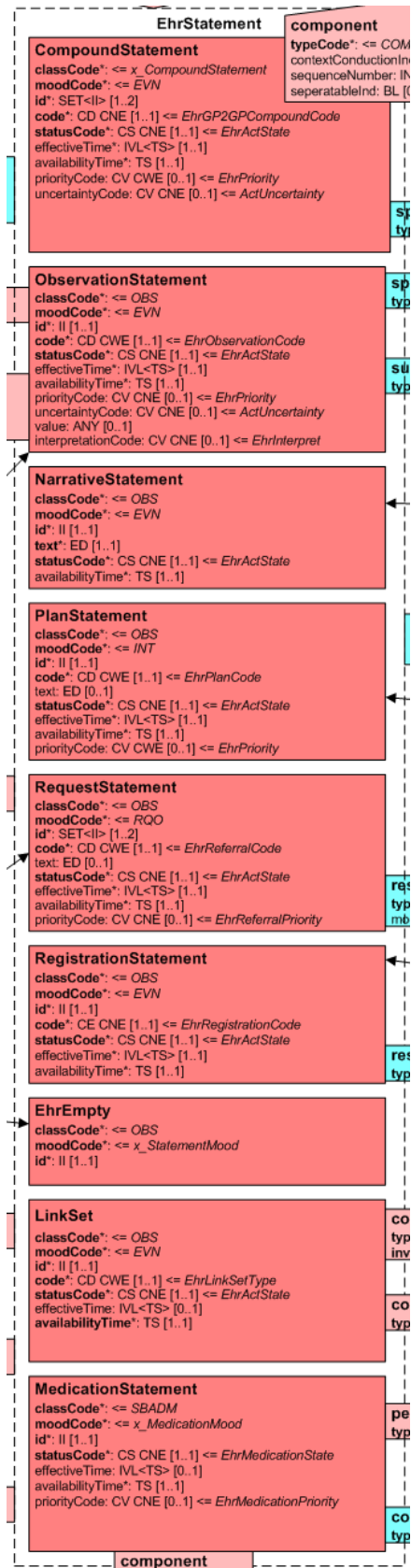


Figure 3 - MiM 4.2.0 GP2GP EhrStatement Classes

GP suppliers have the capability to redact information at different levels. For example, some suppliers may redact at the Composition level, whilst others may redact at the lower Entry (Statement) level.

To allow for effective and simple inclusion of redaction information in the GP2GP message, the redaction flag can be placed in the following elements in the EHR structure:

- **EHRComposition** (indicating that the entire composition is redacted) OR
- One or more of the child **EHRStatement** objects (indicating that only a child part of the composition is redacted)

When receiving a GP2GP transfer, the receiving supplier system should attempt to redact information at the same level as indicated in the incoming message.

If that is not possible, a strategy of ‘over redaction’ should apply – if a supplier is unable to solely apply a redaction to a child **EHRStatement** object, the redaction should be applied to the parent **EHRComposition**.

How Statements Will Be Marked As Redacted

Unfortunately, there is no way to change the MiM model diagram & tabular views, so the explanation of how statements in the record will be marked as redacted is given here.

A new version of the schema that governs the GP2GP payload (RCMR_MT030101UK04.xsd) in MiM 4.2.0 is created (RCMR_MT030101UK05.xsd) to include the redaction flag. The new schema version will retain all the includes and data types that were in the previous version. The only change is the introduction of the “redaction flag”. Redaction will be achieved by the inclusion of a confidentialityCode element within an EHRComposition or EhrStatement.

```
<xs:complexType name="RCMR_MT030101UK04.CompoundStatement">
  <xs:sequence>
    <xs:element name="id" type="II" minOccurs="1" maxOccurs="2"/>
    <xs:element name="code" type="CD" minOccurs="1" maxOccurs="1"/>
    <xs:element name="statusCode" type="CS" minOccurs="1" maxOccurs="1"/>
    <xs:element name="effectiveTime" type="IVL_TS" minOccurs="1" maxOccurs="1"/>
    <xs:element name="availabilityTime" type="TS" minOccurs="1" maxOccurs="1"/>
    <xs:element name="priorityCode" type="CV" minOccurs="0" maxOccurs="1"/>
    <xs:element name="confidentialityCode" type="CV" minOccurs="0" maxOccurs="1"/>
    <xs:element name="uncertaintyCode" type="CV" minOccurs="0" maxOccurs="1"/>
  </xs:sequence>
</xs:complexType>
```

Figure 4 - Example of inclusion of confidentialityCode in schema

The confidentialityCode is optional in the schema. Only include the confidentialityCode when redaction of the EHRComposition or EhrStatement is required. Omission of the confidentialityCode implies that a EHRComposition or EhrStatement is not redacted.

The confidentialityCode is a Codes Value (CV), and should only ever be populated with the following values

```
<confidentialityCode code="NOPAT" codeSystem="2.16.840.1.113883.4.642.3.47"
  displayName="no disclosure to patient, family or caregivers without attending provider's
  authorization"/>
```

(see <https://www.hl7.org/fhir/R4/valueset-security-labels.html>).

Schema changes

New schema version	Replaces	Purpose & Change
RCMR_MT030101UK05.xsd	RCMR_MT030101UK04.xsd	Defines the GP2GP payload Added in confidentialityCode in every EhrStatment class
RCMR_IN030000UK07.xsd	RCMR_IN030000UK06.xsd	Defines the GP2GP interaction (includes payload) Changed to reference the new version RCMR_MT030101UK05.xsd

Populating the Redaction Flag as a GP2GP Sender for EhrStatements

If records are not redacted, you must NOT include the confidentialityCode element in the EHRComposition or EhrStatements. Population of the GP2GP payload will be as is, with no additional elements included.

If the entire Composition is redacted, include confidentialityCode at the EHRComposition level.

For example, a redacted ENRComposition might look like this

```

<component>
  <ehrComposition classCode="COMPOSITION" moodCode="EVN">
    <id root="00887850-BEF1-4669-80F4-4E12585986C9"/>
    <code codeSystem="2.16.840.1.113883.2.1.3.2.4.15" code="25651000000106" displayName="Home Visit Note"/>
    <statusCode code="COMPLETED"/>
    <effectiveTime value="19980930200000"/>
    <availabilityTime value="20030113"/>
    <confidentialityCode code="NOPAT" codeSystem="2.16.840.1.113883.4.642.3.47" displayName="no disclosure to patient, family or caregivers without attending provider's aut
    <author typeCode="AUT">
      <time value="20030113200000"/>
      <agentRef classCode="AGNT">
        <id root="84204657-DBC6-47A9-B870-78B034D50AFF"/>
      </agentRef>
    </author>
  </ehrComposition>
</component>
  
```

Figure 5 - Example of a redaction of an EHRComposition

If individual EhrStatements are redacted, then include confidentialityCode on the relevant Statements.

For example, a redacted MedicationStatement might look like this:


```

<component typeCode="COMP">
  <MedicationStatement classCode="SBADM" moodCode="INT">
    <id root="14BD879D-A805-4CCD-B750-31FCF06622E9"/>
    <statusCode code="COMPLETED"/>
    <effectiveTime value="19981012"/>
    <availabilityTime value="19981012"/>
    <confidentialityCode code="NOPAT" codeSystem="2.16.840.1.113883.4.642.3.47" displayName="no disclosure to patient, family or caregivers without attending provider's
authorization"/>
    <consumable typeCode="CSM">
      <manufacturedProduct classCode="MANU">
        <manufacturedMaterial classCode="MMAT" determinerCode="KIND">
          <code codeSystem="2.16.840.113883.2.1.6.4" code="05616002" displayName="salbutamol breath actuated dry powder inhaler 200mcg/act">
            <translation codeSystem="2.16.840.1.113883.2.1.3.2.4.15" code="2752101000001109" displayName="salbutamol breath actuated dry powder inhaler 200mcg/act"/>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <component typeCode="COMP">
      <ehrSupplyAuthorise classCode="SPLY" moodCode="INT">
        <id root="14BD879E-A805-4CCD-B750-31FCF06622E9"/>
        <code codeSystem="2.16.840.1.113883.2.1.3.2.4.15" code="394823007" displayName="NHS Prescription"/>
        <statusCode code="COMPLETED"/>
        <effectiveTime>
          <center value="19981012"/>
        </effectiveTime>
        <availabilityTime value="19981012"/>
        <repeatNumber value="1"/>
        <quantity xsi:type="PQ" value="1" unit="1"/>
      </ehrSupplyAuthorise>
    </component>
    <pertinentInformation typeCode="PERT">
      <pertinentMedicationDosage classCode="SBADM" moodCode="RMD">
        <text>inhale 1 dose as needed</text>
      </pertinentMedicationDosage>
    </pertinentInformation>
  </MedicationStatement>
</component>

```

Figure 6 - Example of a redaction of a MedicationStatement

Receiving the Redaction Flag as a GP2GP Receiver for EhrStatements

When receiving a GP2GP transmission, EHRComposition and EhrStatements may have a confidentialityCode element included. If a confidentialityCode is identified, the code attribute should be examined to check that its reads “NOPAT”. This means that this statement in the receiving practice should be redacted (using the receiving practice redaction methods).

Documents and Redaction

GP2GP allows for the sending of documents alongside EhrStatements in the ExternalDocument class

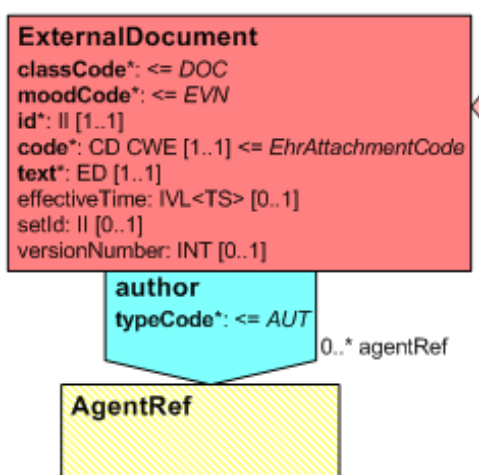


Figure 7 - ExternalDocument class

In terms of redaction, documents may be either not redacted, partially redacted, or fully redacted in a patient’s record.

It is proposed to add the confidentialityCode element to the ExternalDocument class, and use this element to indicate whether there is a level of redaction within the sent document (whether that be partially redacted, or a fully redacted document). The same NOPAT code will be used to indicate whether there is a level of redaction in the document#

```
<confidentialityCode code="NOPAT" codeSystem="2.16.840.1.113883.4.642.3.47"
displayName="no disclosure to patient, family or caregivers without attending provider's
authorization"/>
```

Populating the Redaction Flag as a GP2GP Sender for Documents

If the document being sent has no redacted parts, then the confidentialityCode element is omitted, and processing occurs as at present.

If the document being sent has any form of redaction (partial or whole document), then the confidentialityCode in the ExternalDocument class will be populated with the NOPAT code, to indicate that the receiving system needs to take action on this document.

Receiving the Redaction Flag as a GP2GP Receiver for Documents

If the document (ExternalDocument class) being received does not have the confidentialityCode element present, then it is assumed that the document is unredacted, and may be stored in the receiving local system and presented to patients on request.

If the document (ExternalDocument class) being received has the confidentialityCode element present, the code attribute should be examined to check that it reads "NOPAT". If confirmed, the receiving practice, as the new data controller of the patient record, must make the decision about which parts of the document should be redacted (including whether the whole document should be redacted). The document in its entirety should be viewable by the practitioner, and only the non-redacted parts of the document should be viewable by the patient.