Enclosure No:	6/AWMSG/0526
Agenda item No:	10 – History-based penicillin allergy de-labelling in adults
Author:	Clara Tam, antimicrobial pharmacist, BCUHB & Meryl Davies, antimicrobial pharmacist, PHW
Contact:	Tel: 02921 82 6900 awttc@wales.nhs.uk

1.0 Action for AWMSG

AWMSG members are asked to consider the *History-based penicillin allergy de-labelling in adults* document for endorsement. Consultation responses received in February 2026 and resulting actions are summarised at the end of the document. AWTTC's equality and health impact assessment form is also enclosed.

2.0 Purpose

About 6% of the UK general population have a penicillin allergy label on their record. Evidence indicates that more than 90% of patients labelled with a penicillin allergy are not allergic to penicillin and associated beta-lactams when formally assessed.

In many cases the allergy label may be due to an adverse reaction affecting the gastrointestinal system or a skin rash that occurred during a course of penicillin in childhood. In addition, many patients' reactions to penicillin occurred over 10 years ago and details of the reaction are not recalled or clearly documented.

The Public Health Wales (PHW) Human Health Delivery Group primary care workstream has acknowledged that removing false penicillin allergy is a key intervention to enable achievement of the improvement goals set out by the *Welsh Health Circular (2024)038 – Healthcare associated infections and antimicrobial resistance goals 2024 to 2025* and would contribute to the UK national action plan *Confronting antimicrobial resistance 2024 to 2029*.

The document was developed by the PHW History-Based Penicillin Allergy De-Labelling Task & Finish Group. This group is chaired by Dr Laurence Alexander Gray (Consultant in clinical pharmacology & therapeutics – Cardiff and Vale), vice chaired by Clara Tam (Antimicrobial pharmacist – Betsi Cadwaladr), with secretary support from Dr Amber Hughes (Foundation trainee doctor – Betsi Cadwaladr). Key project members include Meryl Davies (Lead antimicrobial pharmacist in primary care – PHW), Laura Maynard (Specialist Pharmacy Technician – Betsi Cadwaladr) and Amie Bain (Antimicrobial Pharmacist – Powys). Other members of the Task & Finish Group include colleagues from PHW, community pharmacists, primary care (pharmacists, pharmacy technicians, prescribing advisors, GP, nurses, GP out of hours), secondary care (pharmacists, emergency care, acute medicine), microbiology, immunology, Welsh Ambulance Services NHS Trust and Digital Health and Care Wales.

This guideline is for reviewing people, in primary care and other settings, with a very low risk of having a true penicillin allergy and who do not require oral challenge for de-labelling. This guidance is relevant to all prescribers, pharmacists, pharmacy technicians, GPs, out of hours/NHS 111 workers, nurses, Welsh ambulance teams, community pharmacists, and the general public.

This guidance can be used by any registered healthcare professional and in any settings where penicillin allergy history taking or reconciliation is conducted. The aim is to support healthcare professionals to review patients with a penicillin allergy label appropriately and ensure a consistent all Wales approach to recording penicillin allergy de-labelling.

2.1 Process

- December 2025: Draft document considered by AWPAG
- January 2026: Draft document out for consultation
- March 2026: Consultation comments and responses considered by AWPAG for sign-off
- *May 2026: Document presented to AWMSG for endorsement*

2.2 Consultees

Consultees include, but are not limited to:

- Directors of Pharmacy
- Medical Directors
- Assistant Medical Directors
- Health Board Chief Executives
- Directors of Nursing
- Local Medical Committees
- Directors of Public Health
- General Practitioners Committee (GPC) Wales
- Royal College of General Practitioners (RCGP)
- British Medical Association (BMA) Cymru
- Llais Cymru
- Community Pharmacy Wales (CPW)
- Public Health Wales (PHW)
- Welsh Government
- NHS Wales Joint Commissioning Committee (JCC)
- National Institute for Health and Care Excellence (NICE)
- AWMSG members and deputies
- AWPAG members and deputies

Contents

1.0 Introduction 2
1.1 Background 2
1.2 Purpose 3
2.0 Good practice guide to de-labelling in the GP setting 3
2.1 Identifying patients for potential de-labelling 5
2.2 Contacting patients to explore de-labelling 5
2.3 Conducting the allergy assessment 5
2.3.1 One-page penicillin allergy assessment 6
2.3.2 History taking 7
2.3.3 Risk assessment 7
2.3.4 Reported reaction and subsequent doses 9
2.3.5 Discussion with patient 9
2.4 Documenting assessment and outcome 10
2.4.1 Removing the penicillin allergy code from the electronic care record 11
2.4.2 Documenting a confirmed penicillin allergy 13
2.4.3 Documenting a minor side effect to penicillin 13
3.0 Good practice guide to de-labelling in other settings 14
3.1 Identifying patients for potential de-labelling 14
3.2 Conducting the allergy assessment 14
3.3 Documenting assessment and outcome 16
4.0 Audit and evaluation 17
5.0 Acknowledgements 17
6.0 Resources 17
7.0 References 18
Appendix 1: Penicillin de-labelling assessment digital resources 19
Appendix 2: Contacting patients to explore de-labelling – SMS message 20
Appendix 3: Allergy to penicillin – Patient information leaflet 21
Appendix 4. One-page penicillin allergy assessment 25
Appendix 5: Allergy card 26
Appendix 6: Outcome communication and satisfaction survey invitation – SMS 27
Appendix 7: Satisfaction survey 28
Appendix 8. De-labelling based on history alone – Template letter for GP/community pharmacy/any other healthcare providers 30
Appendix 9. Poster for waiting areas 31

1.0 Introduction

Penicillin allergy de-labelling has been identified as a key initiative to improve antibiotic prescribing and antimicrobial stewardship[1].

About 6% of the UK general population have a penicillin allergy label on their record[2]. Evidence indicates that more than 90% of patients labelled with a penicillin allergy are not allergic to penicillin and associated beta-lactams when formally assessed[3-7].

In many cases, the allergy label may be due to an adverse reaction affecting the gastrointestinal system or a skin rash that occurred during a course of penicillin in childhood. In addition, many patients' reactions to penicillin occurred over 10 years ago and details of the reaction are not recalled or clearly documented. Even if the recorded reaction was a true penicillin allergy, in up to 80% of patients sensitivity can be lost with time and individuals can become tolerant to penicillin after 10 years[8,9].

Having a label of penicillin allergy often results in patients receiving alternative, less appropriate antibiotics, which can lead to increased risk of specific adverse healthcare outcomes, including multidrug-resistant or opportunistic infection[1,2,10,11]. Patients with a penicillin allergy label are often prescribed more expensive antibiotics; in addition, they experience longer hospital stays, more frequent readmissions, and more frequent outpatient visits[1,2,7,10-12].

Several studies investigating the economic impact of penicillin allergy labels have concluded that there are benefits to removing incorrect labels, including the potential for significant cost savings to the healthcare system[12-14]. These potential savings include the costs associated with excess bed days and the increased antibiotic spend associated with a penicillin allergy label.

In a 750-bed English hospital, N. Powell et al. showed that patients with a penicillin allergy label accounted for 3,522 additional bed days annually and were associated with over £1 million of excess spend. In terms of drug cost, there was an additional annual antibiotic spend of £10,637 (2.61% of annual antibiotic spend) for patients with a penicillin allergy label on their record[15].

It is therefore beneficial to assess whether patients have experienced a true allergic reaction to penicillin and consider removing their allergy label if not.

1.1 Background

In 2023, Betsi Cadwaladr University Health Board (BCUHB) conducted an audit to evaluate the quality of allergy recording in line with National Institute for Health and Care Excellence (NICE) Clinical Guideline (CG) 183. Ninety-three GP practices were included with a total of 710,418 registered patients. The audit found that 7.3% (n = 51,845) of these patients were labelled with a penicillin allergy. Due to the high number of patients with a penicillin allergy label, each practice was asked to audit 20 randomly selected patients. The audit found only 35% of patients had the nature of their allergy recorded, and out of this cohort only 23% had a true allergy (level 2 and level 3 reaction – see Table 1) recorded.

Table 1. Symptoms associated with level of penicillin reaction[16]

	Level 1	Level 2	Level 3
Symptoms	Gastro-intestinal symptoms (nausea, vomiting, diarrhoea) Secondary infection (e.g. thrush or *C. difficile* colitis) Mild symptoms (e.g. headache, joint pain, change of taste in mouth) Family history of penicillin allergy but without personal history of it Mild renal/hepatic impairment (unless resulting in severe renal failure/ impairment)	Diffuse or localized rash with no other symptoms more than 1 hour post dose Non-specific childhood rash	Collapse requiring resuscitation Itchy rash/urticaria (hives) within 1 hour of dose Blistering/peeling of the skin Oral/genital ulceration New wheeze Swelling of lips/tongue/ eyes (angioedema) Severe renal/hepatic impairment/failure (e.g. significant deranged biochemistry or requiring dialysis/ transplant)

This audit showed that a large proportion of patients who have been labelled as having an allergy to penicillin have no clear evidence of a true allergy recorded. De-labelling these patients can allow use of penicillin, which is associated with better treatment outcomes, reduced risk of healthcare-acquired infections and shorter length of stay in hospital. Additionally de-labelling could save or re-direct the costs associated with alternative antibiotic use and reduce treatment costs.

1.2 Purpose

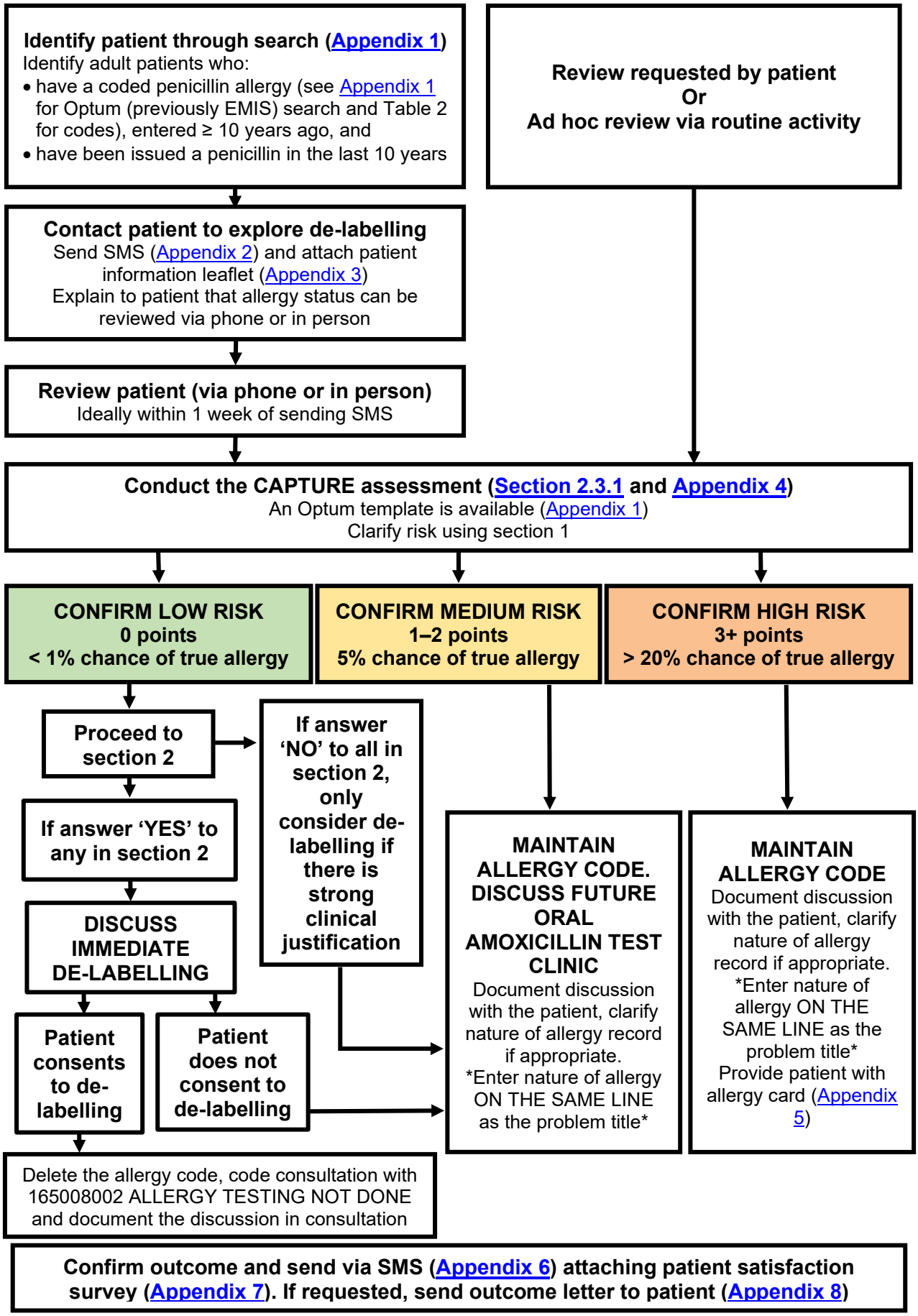
This guidance can be used to support identification of people who have a very low risk of having a true penicillin allergy and can be safely de-labelled based on history alone. This guidance is intended as a framework for best practice for those wishing to conduct penicillin allergy de-labelling based on history alone. It can be used by any registered healthcare professional and in any settings where penicillin allergy history taking or reconciliation is conducted.

This guidance is suitable for local adaptation within NHS Wales.

2.0 Good practice guide to de-labelling in the GP setting

This section outlines a structured process for identifying, contacting and reviewing patients, who have a very low risk of having a true penicillin allergy, for potential penicillin de-labelling in primary care is outlined in this section. An overview of the process stages is provided in Figure 1 and details of the process are provided in sections 2.1–2.4.

Figure 1. Process for reviewing patients with a penicillin allergy label in a GP setting



2.1 Identifying patients for potential de-labelling

Patients can be identified through a search or through routine activity.

A search has been developed for Optum (previously EMIS) (Appendix 1), using the codes in Table 2.

Table 2. SNOMED clinical terms for identifying patients eligible for penicillin de-labelling assessment

SNOMED clinical term	Concept ID
Allergy to penicillin	91936005
Allergic reaction caused by penicillin	15911801000119104
Adverse reaction to penicillins	292954005
Adverse reactions to Penicillins	1013271000006101
All child codes should be included under the parent code	

The search for identifying patients who have a very low risk of having a true penicillin allergy is based on the following criteria (which are met by less than 1% of the population):

- Patients (≥ 18 years old) coded as having a penicillin allergy for 10 or more years, **and**
- Patients coded as having been issued a penicillin derivative within the last 10 years.

2.2 Contacting patients to explore de-labelling

Patients identified from the Optum search should be sent a penicillin allergy patient information leaflet (see Appendix 3). This contact could be via SMS, in which case a template message is available in Appendix 2. Sending the leaflet ahead of the consultation allows the patient time to consider the information prior to the assessment. To improve time efficiency, consider providing an appointment booking link in this initial contact to allow patients to select a suitable appointment time to conduct the review.

A qualified healthcare professional should then conduct the allergy assessment either by telephone or in person approximately one week after the initial contact.

2.3 Conducting the allergy assessment

In discussion with the patient, conduct an in-depth review of the patient's penicillin allergy history and previous reaction to reach a joint decision on whether the allergy label could be safely removed. The one-page ChAllenging Penicillin allergy staTUs – A REview with patient (CAPTURE) assessment (Section 2.3.1 and Appendix 4) provides a framework for this discussion and can be used to capture the findings from the review. Complete the CAPTURE assessment using the Optum template (Appendix 1) or upload a completed copy.

The electronic care record, paper record and patient should all be used as sources of information. Do not rely on the patient as your sole source of information. Often the suspected allergic reaction occurred in childhood and patients are unaware of the specific details related to the allergy.

During the conversation try to obtain as much detail as possible regarding the patient's reaction. Remember that the search identifies patients with a penicillin allergy recorded more than 10 years ago and who have subsequently been issued a penicillin derivative within the last 10 years.

2.3.1 One-page CAPTURE penicillin allergy assessment

ChAllenging Penicillin allergy staTUs - A REview with patient (CAPTURE)

Name:
Patient number:
NHS number:
Date of birth:

Over 2.7 million people in the UK are incorrectly labelled as having a penicillin allergy. This can cause harm and lead to worse health outcomes. By completing the following assessment, it is possible to identify people who are not truly allergic to penicillin and discuss removing this label with them.

Section 1: Does the patient have an allergy or adverse drug reaction to penicillin on record?

☐ Yes - proceed ☐ No - STOP

When was this last recoded? Click or tap here to enter text.

Which penicillin was involved? ☐ Unknown or ☐ Specify: Click or tap here to enter text.

Details related to index reaction: Click or tap here to enter text.

Exclusion criteria: Under 18 years or unable to give consent

Was this suspected allergy within the last 5 years?	☐ **Yes** (2 points)	☐ **No** (0 points)
Anaphylaxis or angioedema? **OR** Severe cutaneous adverse reaction?* **OR** Urticarial rash?	☐ **Yes** (2 points)	☐ **No** (0 points)
Was treatment required for reaction? (e.g. hospital admission, antihistamine, steroid or adrenaline)	☐ **Yes** (1 points)	☐ **No** (0 points)

* Stevens-Johnson syndrome/toxic epidermal necrolysis, acute generalised exanthematous pustulosis (AGEP), drug reaction with eosinophilia & systemic symptoms (DRESS), Any severe delayed rash with mucosal involvement

Total score:

☐ **0 points: Proceed to section 2** There is < 1% (less than 1 in 100) chance it is a true penicillin allergy

☐ **1-2 points: Allergy remains on record** There is a 5% (1 in 20) chance it is a true penicillin allergy

Would the patient like to receive an oral amoxicillin test if available in the future?

☐ Yes ☐ No

☐ **3+ points: Allergy remains on record** There is at least a 20% (1 in 5) chance it is a true penicillin allergy

Section 2: Reported reaction to penicillin:

Mild GI symptoms (nausea, vomiting, mild abdominal pain, diarrhoea)?	☐ **Yes**	☐ **No**
Thrush or *C. difficile* bowel infection after taking penicillin?	☐ **Yes**	☐ **No**
Mild symptoms like headache, joint pain, change of taste in mouth?	☐ **Yes**	☐ **No**
Family history of penicillin allergy but without personal history of it?	☐ **Yes**	☐ **No**
Has taken and tolerated **any penicillin** following the initial reaction?	☐ **Yes**	☐ **No**

If answered 'Yes' to any of the above, discuss removing penicillin allergy status with patient. If answered 'No' to ALL the above, only consider removing penicillin allergy if there is strong clinical justification.

Does the eligible patient consent to remove penicillin allergy from active record?

☐ Yes - patient is comfortable taking penicillin in the future and removing allergy record

☐ No - but would like to have oral amoxicillin test in the future if service is available

☐ No - clarify nature of reaction on records

Name of assessor: **Signature:** **Date of assessment:**

2.3.2 History taking

When taking a penicillin allergy history consider the following factors:

- Is a penicillin allergy label present on the patient's record?
- What penicillin was the patient given?
- What was the formulation (injection, tablet etc.)?
- How long ago did the reaction occur?
- What type of reaction occurred (facial swelling, anaphylaxis, gastrointestinal upset etc.)?
- When was the onset of the reaction relative to the penicillin administration (minutes, hours, weeks)?
- After which dose in the course did the reaction occur (first, second, third etc.)?
- Did the patient experience a severe cutaneous adverse reaction (SCAR)? This is a type 4 hypersensitivity reaction, and includes:
    - Stevens-Johnson syndrome/toxic epidermal necrolysis
    - Acute generalised exanthematous pustulosis (AGEP)
    - Drug reaction with eosinophilia and systemic symptoms (DRESS)
    - Any severe delayed rash with mucosal involvement
- Did the patient experience urticarial rash?
- What treatment was required (in particular, was adrenaline given)?
- Was there any contact with healthcare services?

It is also important to review medication records where possible and note whether the patient has received subsequent penicillin and whether any reaction recurred.

2.3.3 Risk assessment

Screen for severe reactions to penicillin using a modified PEN-FAST penicillin allergy clinical decision tool (see Tables 3 and 4, and section 1 of the CAPTURE assessment [section 2.3.1 and Appendix 4]). This is a validated scoring system for assessing reported penicillin allergy.

Table 3. PEN-FAST score criteria (modified for history-based de-labelling only)

	Penicillin allergy test evaluation	Yes	No
F	**F**ive years or less since reaction	+2	0
A **S**	**A**naphylaxis/Angioedema OR **S**evere cutaneous adverse reaction (SCAR)* • Stevens-Johnson syndrome/toxic epidermal necrolysis • Acute generalised exanthematous pustulosis (AGEP) • Drug reaction with eosinophilia and systemic symptoms (DRESS) • Any severe delayed rash with mucosal involvement OR **Urticarial rash**** (Do not score rashes that do not exhibit features of urticaria)	+2	0
T	**T**reatment required for allergy episode e.g. hospital admission, steroids, adrenaline, antihistamines	+1	0

*SCAR criteria. Features of SCAR include painful erythema, ulceration, skin shedding, blistering, and pustules.

**Acute urticaria typically appear < 1 hour after exposure to the index allergen and disappear again in < 1 day. Some guidelines classify isolated urticaria (no other symptoms) and/or focal urticaria as non-severe and therefore not qualifying for a score under the PEN-FAST criteria.[17] This guide suggests assigning 2 points for urticaria, as it is intended for history-based de-labelling only, while acknowledging that the supporting evidence is limited.

Table 4. Interpretation of PEN-FAST score

Score	Risk of true penicillin allergy	Recommendation
0	< 1% (less than 1 in 100)	Continue with assessment.
1–2	5% (1 in 20)	Keep penicillin allergy label on record and ask if patient would like to receive an oral amoxicillin test in the future if the service is available.
3+	At least 20% (at least 1 in 5)	Keep penicillin allergy label on record.

For patients scoring 0 in section 1, section 2 of the CAPTURE assessment should be completed.

2.3.4 Reported reaction and subsequent doses

If, after completing section 2 of the CAPTURE assessment, the patient history clearly shows one or more of the below, then the patient can be de-labelled without an oral amoxicillin test:

- a non-allergic reaction such as minor symptoms unrelated to any form of allergic reaction (headache, arthralgia, strange taste in mouth), gastrointestinal upset (nausea, abdominal pain, diarrhoea) or candidiasis,
- a family history of penicillin allergy without personal history of allergy, or
- the patient has received subsequent doses of penicillin without incident.

People who experienced a mild rash and are at low risk of having a true penicillin allergy can also be considered for de-labelling based on history alone if they have tolerated a penicillin since the first reaction. The original reaction may have been caused by an infection and misclassified as an allergy, or the sensitivity may have been lost with time.

If the patient seeks reassurance of their tolerance to penicillin, an oral amoxicillin test may be appropriate. Refer the patient for an oral amoxicillin test if the service is available.

2.3.5 Discussion with patient

A decision should be made jointly with the patient (refer to NICE guideline: Shared decision making NG197) as to whether they have a true allergy or can comfortably be de-labelled.

(i) Eligible for de-labelling based on history

- If the patient can be de-labelled based on their history which suggests that it was a non-allergic reaction i.e. side effect(s) or they have tolerated the same penicillin as the index penicillin after the initial reaction, explain to the patient that they can receive a penicillin-type antibiotic for any future infections and that their history does not suggest that they had an allergic reaction. However, if the patient is not comfortable with being de-labelled, the allergy status can remain on their record. In these situations, discuss whether an oral amoxicillin test may be appropriate (if available).
- If the patient can be de-labelled based on their history which suggests that they tolerated a penicillin after the initial reaction, but it could not be confirmed that it was the same penicillin that caused the initial reaction, explain to the patient that it is highly unlikely that they are allergic to penicillin (less than 1% chance), and that they can receive a penicillin-type antibiotic for any future infections. However, if the patient is not comfortable that they have a small chance of true penicillin allergy, the allergy status can remain on record. In these situations, discuss whether an oral amoxicillin test may be appropriate (if available).

Patient consents should be obtained according to GMC consent standards.

(ii) Severe reactions that are not an allergy

- Some patients might have experienced severe reactions to penicillin that are not allergy reactions. These reactions can understandably mean that the patient will wish to avoid future penicillin treatment. The patient should be made aware of the impact of having a penicillin allergy/adverse reaction record and avoiding penicillin. After this discussion, if the patient would still prefer to avoid penicillin, the penicillin allergy/adverse reaction record should remain.

The decision to remove the penicillin allergy label must be made jointly between the healthcare professional and the patient. Consent must be obtained prior to de-labelling. Even after thorough counselling and provision of other options, such as an oral amoxicillin test, the patient may decide not to provide consent for de-labelling and would prefer that their penicillin allergy status is maintained.

(iii) Confirmed true allergy

- If the patient cannot be de-labelled as a review of their history confirmed that it was likely a true allergy, counsel the patient explaining that they do have a likely true allergy to penicillin and that they should inform clinicians of their allergy when prescribed antibiotics. The patient should be offered a penicillin allergy card (see Appendix 5).

2.4 Documenting assessment and outcome

Detailed records should be made of the discussion, and details of the reaction recorded in the patient record. Documentation capabilities and the processes for removing allergy labels will vary between GP software systems. This guidance is based on the Optum system. A similar approach is recommended on other systems, where feasible.

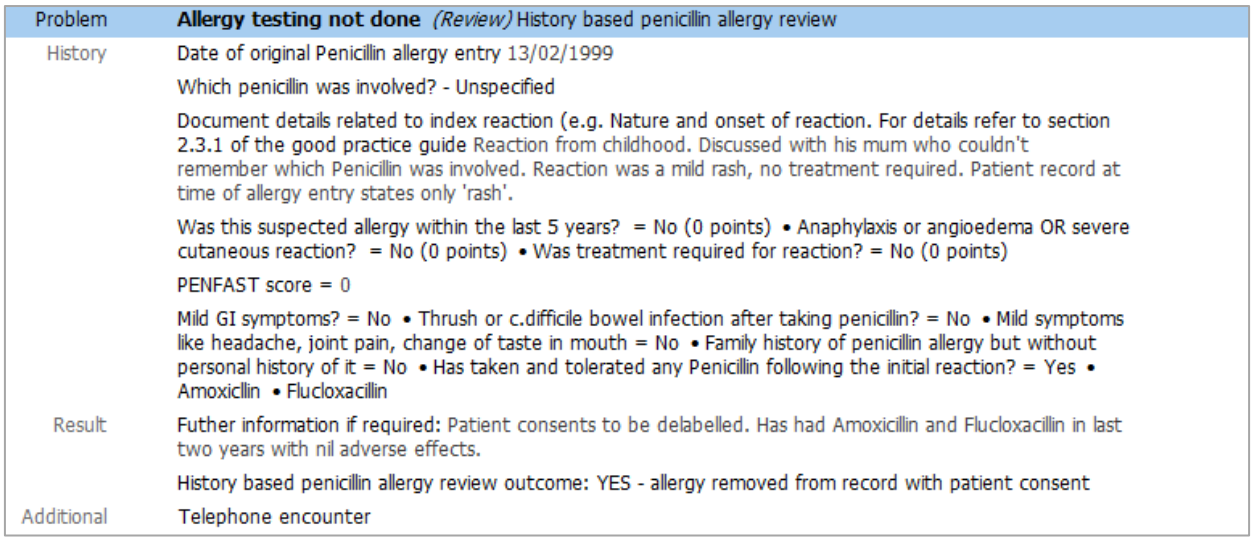
Based on the outcome of the discussion, the patient can be assigned to one of the following categories:

1. If a patient is happy to be de-labelled, the penicillin allergy code should be deleted (see Section 2.4.1).
2. Future oral amoxicillin test – If it is uncertain if the patient has a true allergy or if the patient is not comfortable to be de-labelled based on history alone, then discuss with the patient that there may be future allergy testing that can be carried out if and when the service becomes available
3. True allergy – severe/life-threatening reaction – Allergy code to remain on record. Offer allergy card (see Appendix 5).
4. Patient does not provide consent for de-labelling – If the patient wishes for the allergy label to remain on their record (even if it is clearly based on a non-allergic reaction), keep the allergy label and add details of the reaction recorded on the same line as the codes.

Completion of the Optum template will result in a comprehensive record and will code the consultation as ‘Allergy testing not done’ (see Figure 2). If the template is not used, an equivalent level of detail should be manually recorded and the consultation needs to be coded with SNOMED ID concept ALLERGY TESTING NOT DONE 165008002.

Documentation of allergy history should be undertaken in accordance with NICE CG183 Drug allergy: diagnosis and management.

Figure 2. Example of good documentation



Problem	**Allergy testing not done** *(Review)* History based penicillin allergy review
History	Date of original Penicillin allergy entry 13/02/1999
	Which penicillin was involved? - Unspecified
	Document details related to index reaction (e.g. Nature and onset of reaction. For details refer to section 2.3.1 of the good practice guide Reaction from childhood. Discussed with his mum who couldn't remember which Penicillin was involved. Reaction was a mild rash, no treatment required. Patient record at time of allergy entry states only 'rash'.
	Was this suspected allergy within the last 5 years? = No (0 points) • Anaphylaxis or angioedema OR severe cutaneous reaction? = No (0 points) • Was treatment required for reaction? = No (0 points)
	PENFAST score = 0
	Mild GI symptoms? = No • Thrush or c.difficile bowel infection after taking penicillin? = No • Mild symptoms like headache, joint pain, change of taste in mouth = No • Family history of penicillin allergy but without personal history of it = No • Has taken and tolerated any Penicillin following the initial reaction? = Yes • Amoxicllin • Flucloxacillin
Result	Futher information if required: Patient consents to be delabelled. Has had Amoxicillin and Flucloxacillin in last two years with nil adverse effects.
	History based penicillin allergy review outcome: YES - allergy removed from record with patient consent
Additional	Telephone encounter

Following the discussion with the patient, an SMS (Appendix 6) should be sent detailing the outcome of the discussion and inviting them to complete an anonymous satisfaction survey (Appendix 7). Feedback obtained from the survey will allow the project manager/lead to monitor how the project is progressing. If requested by the patient, the letter confirming the outcome of assessment should be sent (Appendix 8).

2.4.1 Removing the penicillin allergy code from the electronic care record

If the patient is happy to be de-labelled, the relevant coded entries need to be removed in the electronic care record. This is the only way to stop the decision support software flagging penicillin allergy when prescribing. It is not considered best practice to simply delete the original entry as the penicillin allergy status will likely have influenced previous clinical decisions. The recommendation is to re-enter a description of the penicillin allergy code in the care record as free text with the same date as originally entered. The entry should look the same as before but without the associated code attached.

Completing the Optum penicillin allergy de-labelling template enables the relevant information to be re-entered using an ‘error entry deleted’ code on the original date and enables the inclusion of associated free text (see Figure 3). Following completion of the template, the original allergy code needs to be deleted.

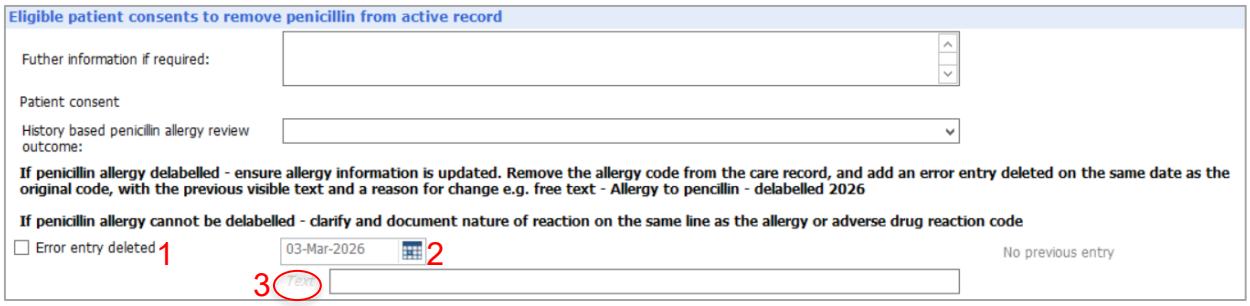
Figure 3. Adding an 'error entry deleted' code using the Optum (previously EMIS) template

Step 1 – Identify the original penicillin allergy entry and note the date and associated text.

Step 2 – Complete the Optum penicillin allergy de-labelling template.

Step 3 – If the patient can be de-labelled, complete and save the following information at the end of the template:

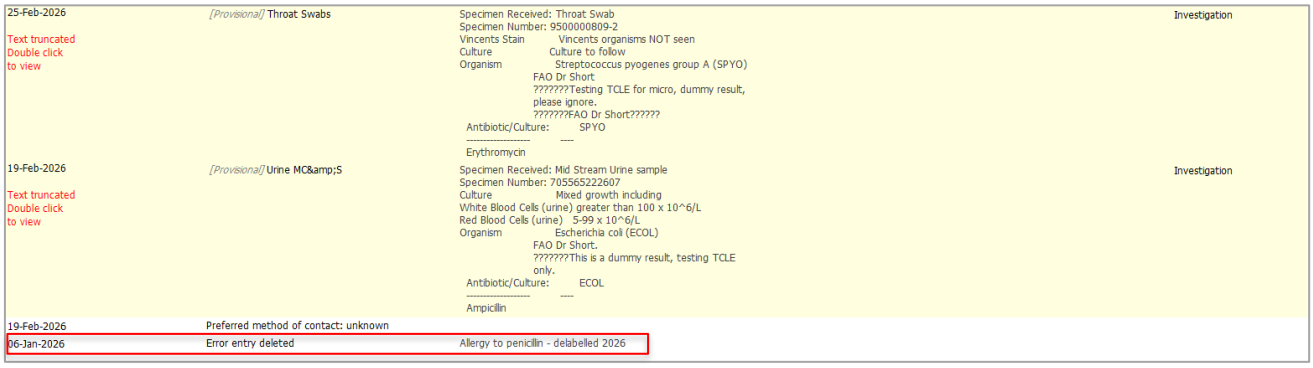
1. Tick 'error entry deleted' box.
2. Enter the date that the penicillin allergy code was originally entered in the care record.
3. Add 'Allergy to penicillin – de-labelled 2026' to the free text box along with any previously visible associated text from the original entry.



Step 4 – Delete the original coded entry.

Once completed the consultation view in Optum will show the following information, with the date in brackets showing the original date the penicillin allergy was added.

The information appears against the original entry date in the care history.



Please remember, this process will only add the 'error entry deleted' code and associated information – once this is complete the original allergy code needs to be deleted.

2.4.2 Documenting a confirmed penicillin allergy

GP practices are recommended to consider the following to improve documentation of allergies and transfer of records:

- When coding a patient with an allergy, ensure the following is recorded as recommended in NICE CG183
  - The named drug associated with the allergy (not just the class)
  - The nature of the reaction
  - The onset date of the reaction
- Adding allergy codes to a medical record
  - Optum – Enter allergy coding with the exact drug and nature of reaction in free text next to the problem title.
    When adding an adverse reaction problem title, include details about the 'nature of reaction' in **free text ON THE SAME LINE as the coding title**. This allows the information to appear in a patient summary. Ensuring the date of reaction is correct is also important.
    Example 'Adverse reaction to amoxicillin. Rash on hands, face and torso' (date correct).
  - Vision – Enter allergy coding with the drug, nature of reaction and onset date in the patient summary. This allows the information to appear in the patient summary and the hospital GP Portal information.
- Ensure all staff (including administrative and locum staff) are aware of the recommended standards in NICE CG183. Administrative staff may handle discharge letters containing allergy information or transfer summaries of records from a previous practice. Ensure all relevant information is transferred onto the GP record.

2.4.3 Documenting a minor side effect to penicillin

During the transfer of records between settings, it is often difficult to distinguish between minor side effects and true allergies. To improve documentation, GP practices are recommended to document minor side effects with either 'Medication stopped – side effect' or 'Medication side effects present' (see Figure 4). Include free text information on the drug and the nature and severity of the side effect experienced. This method would leave a record of minor side effects experienced, but it would not display under ADR/Allergies. This group of patients would still be able to benefit from having penicillin.

Figure 4. Example of SNOMED CT codes

3.0 Good practice guide to de-labelling in other settings

It may be appropriate to assess patients for potential history-based penicillin allergy de-labelling in other settings, including the emergency department, pre-operative assessment clinics (POACs), outpatient clinics or as in-patients in the community hospital setting. A recommended process for reviewing these patients is provided in Figure 5 and details of the process are outlined in sections 3.1–3.3.

Where the intended approach is to explore de-labelling via oral amoxicillin testing in a secondary care setting, a separate AWMSG guideline is available: All Wales guidance for penicillin allergy de-labelling in adults in secondary care.

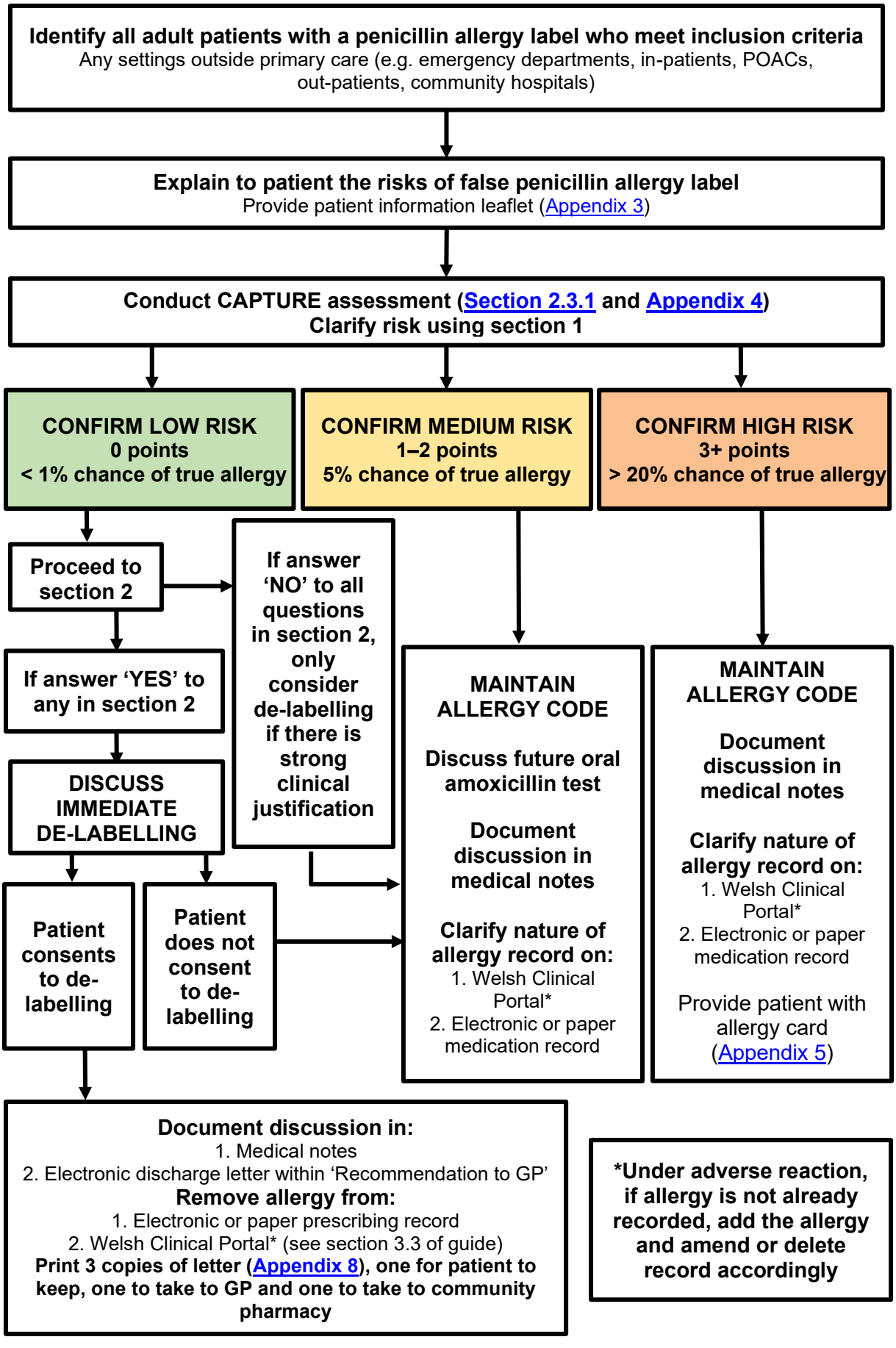
3.1 Identifying patients for potential de-labelling

Any patient who has an adverse drug reaction or allergy to penicillin on record is eligible for history-based penicillin allergy assessment.

3.2 Conducting the allergy assessment

Follow section 2.3 Conducting the allergy assessment.

Figure 5. Process for reviewing patients with a penicillin allergy label in other settings

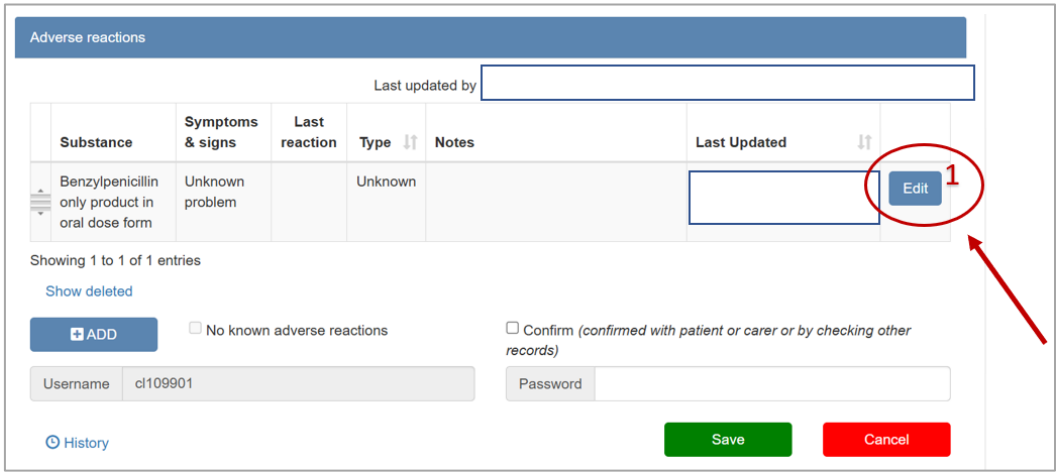


3.3 Documenting assessment and outcome

- Update the outcome of the assessment in medical notes and under the allergy section of the electronic or paper prescribing record.
- Update the allergy section on the Welsh Clinical Portal.

For removal of an allergy from a record on the Welsh Clinical Portal, see Figure 6 for a step-by-step guide. Please note: If the penicillin allergy was not recorded on the existing record, add it, save it and delete it following the below steps.

Figure 6. Step-by-step guide to removing an allergy label on the Welsh Clinical Portal



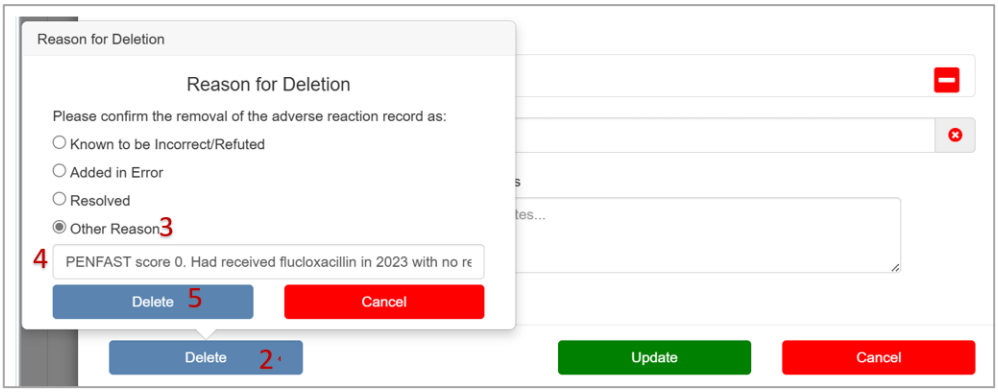
Step 1: Click on **"Edit"**

Step 2: Click on **"Delete"**

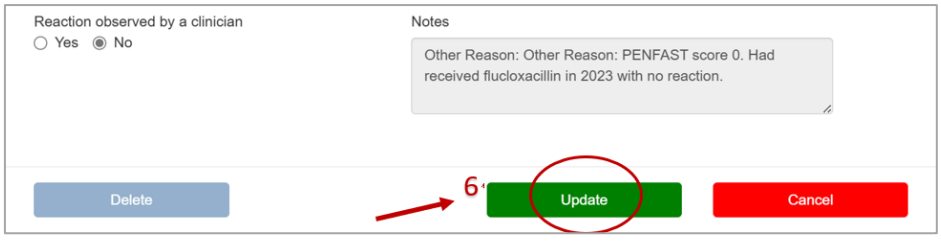
Step 3: Select **"Other reason"**

Step 4: Type in **PEN-FAST score** and **reason for removing allergy** according to the assessment criteria

Step 5: Then **"Delete"** again



Step 6: Click **"Update"** to save



4.0 Audit and evaluation

A SNOMED code for penicillin allergy de-labelling is currently under development. Once this becomes available it should be used to aid audit, evaluation and collection of outcome data.

Engagement with penicillin allergy de-labelling can be further supported with patient resources such as waiting room posters (Appendix 9).

5.0 Acknowledgements

Caryn Chan – Medicine Optimisation Specialist Pharmacist, North of England Care System Support (NECS NHS), Amanda Bell – Senior Medicines Optimisation Pharmacy Technician, North of England Care System Support (NECS NHS), and PHW History Based Penicillin Allergy De-labelling Task & Finish Group.

6.0 Resources

Health Education and Improvement Wales (HEIW) Penicillin Allergy Awareness: This page provides resources for healthcare professional use, to support and raise awareness of penicillin allergy.

Royal Pharmaceutical Society (RPS) Penicillin allergy checklist: This page provides information and a guide to help pharmacists and other healthcare professionals to diagnose if a patient is allergic to penicillin or not.

7.0 References

1. Powell N, Upton M, Kent B et al. Is penicillin allergy de-labelling about to find its place in UK antimicrobial stewardship strategy? *Clin Med (Lond).* 2023;23(1):76–77.
2. West RM, Smith CJ, Pavitt SH et al. 'Warning: allergic to penicillin': association between penicillin allergy status in 2.3 million NHS general practice electronic health records, antibiotic prescribing and health outcomes. *J Antimicrob Chemother.* 2019;74(7):2075–2082.
3. Lee RU. Penicillin Allergy Delabeling Can Decrease Antibiotic Resistance, Reduce Costs, and Optimize Patient Outcomes. *Fed Pract.* 2020;37(10):460–465.
4. Macy E, Schatz M, Lin C et al. The falling rate of positive penicillin skin tests from 1995 to 2007. *Perm J.* 2009;13(2):12–18.
5. Sacco KA, Bates A, Brigham TJ et al. Clinical outcomes following inpatient penicillin allergy testing: A systematic review and meta-analysis. *Allergy.* 2017;72(9):1288–1296.
6. Sandoe JAT, Ahmed S, Armitage K et al. Penicillin allergy assessment pathway versus usual clinical care for primary care patients with a penicillin allergy record in the UK (ALABAMA): an open-label, multicentre, randomised controlled trial. *The Lancet Primary Care.* 2025;1(1) Accessed 2025/11/13.
7. Savic L, Ardern-Jones M, Avery A et al. BSACI guideline for the set-up of penicillin allergy de-labelling services by non-allergists working in a hospital setting. *Clin Exp Allergy.* 2022;52(10):1135–1141.
8. Ponvert C, Weilenmann C, Wassenberg J et al. Allergy to beta lactam antibiotics in children: a prospective follow-up study in retreated children after negative responses in skin and challenge tests. *Allergy.* 2007;62(1):42–46.
9. Shenoy ES, Macy E, Rowe T et al. Evaluation and Management of Penicillin Allergy: A Review. *JAMA.* 2019;321(2):188–199.
10. Krah NM, Jones TW, Lake J et al. The impact of antibiotic allergy labels on antibiotic exposure, clinical outcomes, and healthcare costs: A systematic review. *Infect Control Hosp Epidemiol.* 2021;42(5):530–548.
11. Mabilat C, Gros MF, Van Belkum A et al. Improving antimicrobial stewardship with penicillin allergy testing: a review of current practices and unmet needs. *JAC Antimicrob Resist.* 2022;4(6):dlac116.
12. Sousa-Pinto B, Blumenthal KG, Macy E et al. Penicillin Allergy Testing Is Cost-Saving: An Economic Evaluation Study. *Clin Infect Dis.* 2021;72(6):924–938.
13. Pagani NR, Moverman MA, Puzzitiello RN et al. Preoperative Allergy Testing for Patients Reporting Penicillin and Cephalosporin Allergies is Cost-Effective in Preventing Infection after Total Knee and Hip Arthroplasty. *J Arthroplasty.* 2021;36(2):700–704.
14. Sobrino-García M, Muñoz-Bellido FJ, Moreno E et al. A Comprehensive Prospective Study of the Costs Associated With Evaluation of ß-Lactam Allergy. *J Investig Allergol Clin Immunol.* 2021;31(1):52–57.
15. Powell N, Honeyford K, and Sandoe J. Impact of penicillin allergy records on antibiotic costs and length of hospital stay: a single-centre observational retrospective cohort. *J Hosp Infect.* 2020;106(1):35–42.
16. Brayson J, Barrett S, Baqir W et al. CATALYST: challenging antibiotic allergy status. *J Antimicrob Chemother.* 2023;78(5):1241–1244.
17. Joean O, Sermet K, Ashkenazi-Hoffnung L et al. ESCMID Clinical Guidelines on the Evaluation and Management of a Reported Antibiotic Allergy. *Clinical Microbiology and Infection.* Available at: https://doi.org/10.1016/j.cmi.2026.02.011. Accessed 2026/03/05.

Appendix 1: Penicillin de-labelling assessment digital resources

The Optum (previously EMIS) search and CAPTURE assessment template will be included here when the document is published.

Appendix 2: Contacting patients to explore de-labelling – SMS message

Before the review, send an SMS with a link to the patient information leaflet (Appendix 3). Consider including an appointment booking link to enable the patient to book in. Code with Concept ID SNOMED: 58332002 Allergy Education.

SMS example:

Do you think you are allergic to penicillin? Over 90% of people with a penicillin allergy on their medical record are not truly allergic to penicillin. An incorrect record of penicillin allergy may be harmful – please read the attached penicillin allergy information. We will contact you to ask about your allergy in more detail, to make sure that you receive the most appropriate treatment when you need it.

Ydych chi'n meddwl bod gennych chi alergedd i benisilin? Nid oes alergedd i benisilin gwirioneddol gan dros 90% o bobl sydd ag alergedd i benisilin wedi'i nodi ar eu cofnod meddygol. Gall cofnod anghywir o alergedd i benisilin fod yn niweidiol – darllenwch y wybodaeth am alergedd i benisilin sydd ynghlwm. Byddwn yn cysylltu â chi i ofyn am eich alergedd yn fanylach, er mwyn sicrhau eich bod yn derbyn y driniaeth fwyaf priodol pan fydd ei hangen arnoch.

Appendix 3: Allergy to penicillin – Patient information leaflet

What is penicillin?

Penicillin is a type of antibiotic. It works very well to treat common infections caused by bacteria, such as chest infections, tonsillitis, ear infections, sinus infections and skin infections.

Types of penicillin-based antibiotics include amoxicillin, flucloxacillin, co-amoxiclav and phenoxymethylpenicillin.

What is penicillin allergy?

An allergy is a reaction of your body's immune system. An allergy to penicillin causes a range of symptoms. For most people these symptoms are mild and do not need treatment.

Sometimes a severe allergic reaction called anaphylaxis can happen. This is rare, but it can be life-threatening. Symptoms of anaphylaxis include: a rash that spreads fast, swelling of the mouth, throat or tongue, breathing difficulties and collapse. Most people recorded as having an allergy to penicillin will not have had any of these symptoms.

Knowing if you are allergic to penicillin is important, to make sure that you are given the best antibiotic for you.

How common is penicillin allergy?

Around 6% of people in the UK are currently recorded as having an allergy to penicillin. However, evidence suggests that more than 9 out of 10 of these people are not truly allergic when tested.

Why might your medical record show a penicillin allergy when you don't truly have an allergy?

You might have been told that you had a reaction to penicillin as a child. This might have been a rash, which could have been caused by a viral infection and not an allergy or reaction to a penicillin antibiotic.

Sometimes, you might have had non-allergic side effects after taking penicillin. These could include: diarrhoea, feeling sick, being sick, indigestion, headache and thrush. These side effects are common to all types of antibiotics and do not show that you have an allergy to penicillin.

What are the risks of being incorrectly labelled as allergic to penicillin?

Penicillins are often the first antibiotics given to treat an infection. If your medical record shows you have a penicillin allergy, when you need antibiotics you must be given a different type of antibiotic to penicillin to treat the infection.

If penicillin allergy on your medical record is wrong, it can stop you being given the most appropriate medicine to treat an infection.

Evidence suggests that people with a recorded penicillin allergy stay in hospital for longer, and have a higher risk of:

- being readmitted to hospital
- surgical wound infections
- infections (such as MRSA) that are resistant to antibiotic treatment
- severe infections
- being admitted to intensive care.

If your medical record shows you have a penicillin allergy when you don't truly have one, you could miss out on the best and safest treatments for common bacterial infections and be at unnecessarily higher risk of the conditions listed above.

How can I find out if I'm truly allergic to penicillin?

Your GP practice is reviewing people whose medical records state that they have a penicillin allergy.

If you think your medical record might incorrectly suggest that you are allergic to penicillin, then please contact your GP practice to ask them about it.

Alergedd i benisilin – Gwybodaeth i gleifion

Beth yw penisilin?

Math o wrthfiotig yw penisilin. Mae'n gweithio'n dda iawn i drin heintiau cyffredin a achosir gan facteria, fel heintiau ar y frest, tonsilitis, heintiau clust, heintiau sinws a heintiau croen.

Mae amoxicillin, flucloxacillin, co-amoxiclav a phenoxymethylpenicillin yn fathau o wrthfiotigau sy'n seiliedig ar benisilin.

Beth yw alergedd i benisilin?

Alergedd yw adwaith gan system imiwnedd eich corff. Mae alergedd i benisilin yn achosi ystod o symptomau. I'r rhan fwyaf o bobl, mae'r symptomau hyn yn ysgafn ac nid oes angen triniaeth arnynt.

Weithiau, gall adwaith alergaidd difrifol o'r enw anaffylacsis ddigwydd. Mae hyn yn anghyffredin iawn ond gall fygwth bywyd. Mae symptomau anaffylacsis yn cynnwys: brech sy'n lledaenu'n gyflym, chwyddo yn y geg, y gwddf neu'r tafod, anawsterau anadlu a llewygu. Ni brofi'r unrhyw un o'r symptomau hyn gan y rhan fwyaf o bobl y cofnodir bod ganddynt alergedd i benisilin.

Mae gwybod a oes gennych alergedd i benisilin yn bwysig, er mwyn sicrhau eich bod yn cael y gwrthfiotig gorau i chi.

Pa mor gyffredin yw alergedd i benisilin?

Ar hyn o bryd cofnodir bod gan tua 6% o bobl yn y DU alergedd i benisilin. Fodd bynnag, mae tystiolaeth yn awgrymu pan gânt eu profi bod mwy na 9 allan o 10 o'r bobl hyn heb alergedd mewn gwirionedd.

Pam y gallai eich cofnod meddygol ddangos alergedd i benisilin pan nad oes gennych alergedd mewn gwirionedd?

Efallai y cawsoch wybod eich bod wedi cael adwaith i benisilin pan yn blentyn. Gallai hyn fod wedi bod yn frech, a allai fod wedi cael ei achosi gan haint feirysol ac nid alergedd neu adwaith i wrthfiotig penisilin.

Weithiau, efallai eich bod wedi profi sgil-effeithiau nad ydynt yn arwydd o alergedd ar ôl cymryd penisilin. Gallai'r rhain gynnwys: dolur rhydd, teimlo'n sâl, bod yn sâl, diffyg treuliad, cur pen a'r llindag. Mae'r sgil-effeithiau hyn yn gyffredin i bob math o wrthfiotigau ac nid ydynt yn dangos bod gennych alergedd i benisilin.

Beth yw’r risgiau o fod ag alergedd i benisilin?

Yn aml math o benisilin yw'r gwrthfiotigau cyntaf a roddir i drin haint. Os yw'ch cofnod meddygol yn dangos bod gennych alergedd i benisilin, pan fydd angen gwrthfiotigau arnoch rhaid i chi gael math gwahanol o wrthfiotig i benisilin i drin yr haint.

Os yw’r alergedd i benisilin ar eich cofnod meddygol yn anghywir, gall eich hatal rhag cael y feddyginiaeth fwyaf priodol i drin yr haint.

Mae tystiolaeth yn awgrymu bod pobl y cofnodwyd bod ganddynt alergedd i benisilin yn aros yn yr ysbyty am gyfnod hirach, ac mae ganddynt risg uwch o:

- gael eu haildderbyn i'r ysbyty
- heintiau clwyfau llawfeddygol
- heintiau (fel MRSA) sy'n gwrthsefyll triniaeth gwrthfiotigau
- heintiau difrifol
- cael eu derbyn i ofal dwys.

Os yw'ch cofnod meddygol yn dangos bod gennych alergedd i benisilin pan nad oes gennych un mewn gwirionedd, gallech golli’r cyfle i gael y triniaethau gorau a mwyaf diogel ar gyfer heintiau bacterol cyffredin a wynebu risg uwch diangen o'r cyflyrau a restrir uchod.

Sut alla i ddarganfod a oes gen i alergedd gwirioneddol i benisilin?

Mae eich practis meddyg teulu yn adolygu pobl y mae eu cofnodion meddygol yn nodi bod ganddynt alergedd i benisilin.

Os ydych chi'n meddwl y gallai eich cofnod meddygol awgrymu yn anghywir bod gennych alergedd i benisilin, yna cysylltwch â'ch meddyg teulu i’w holi amdano.

Appendix 4. One-page CAPTURE penicillin allergy assessment

ChAllenging Penicillin allergy staTUs - A REview with patient (CAPTURE)

Name:
Patient number:
NHS number:
Date of birth:

Over 2.7 million people in the UK are incorrectly labelled as having a penicillin allergy. This can cause harm and lead to worse health outcomes. By completing the following assessment, it is possible to identify people who are not truly allergic to penicillin and discuss removing this label with them.

Section 1: Does the patient have an allergy or adverse drug reaction to penicillin on record?

☐ **Yes - proceed** ☐ **No - STOP**

When was this last recoded? Click or tap here to enter text.

Which penicillin was involved? ☐ Unknown or ☐ Specify: Click or tap here to enter text.

Details related to index reaction: Click or tap here to enter text.

Exclusion criteria: Under 18 years or unable to give consent

Was this suspected allergy within the last 5 years?	☐ **Yes** (2 points)	☐ **No** (0 points)
Anaphylaxis or angioedema? **OR** Severe cutaneous adverse reaction?* **OR** Urticarial rash?	☐ **Yes** (2 points)	☐ **No** (0 points)
Was treatment required for reaction? (e.g. hospital admission, antihistamine, steroid or adrenaline)	☐ **Yes** (1 points)	☐ **No** (0 points)

* Stevens-Johnson syndrome/toxic epidermal necrolysis, acute generalised exanthematous pustulosis (AGEP), drug reaction with eosinophilia & systemic symptoms (DRESS), Any severe delayed rash with mucosal involvement

Total score:

☐ **0 points: Proceed to section 2** There is < 1% (less than 1 in 100) chance it is a true penicillin allergy

☐ **1-2 points: Allergy remains on record** There is a 5% (1 in 20) chance it is a true penicillin allergy

Would the patient like to receive an oral amoxicillin test if available in the future?

☐ Yes ☐ No

☐ **3+ points: Allergy remains on record** There is at least a 20% (1 in 5) chance it is a true penicillin allergy

Section 2: Reported reaction to penicillin:

Mild GI symptoms (nausea, vomiting, mild abdominal pain, diarrhoea)?	☐ **Yes**	☐ **No**
Thrush or *C. difficile* bowel infection after taking penicillin?	☐ **Yes**	☐ **No**
Mild symptoms like headache, joint pain, change of taste in mouth?	☐ **Yes**	☐ **No**
Family history of penicillin allergy but without personal history of it?	☐ **Yes**	☐ **No**
Has taken and tolerated **any penicillin** following the initial reaction?	☐ **Yes**	☐ **No**

If answered 'Yes' to any of the above, discuss removing penicillin allergy status with patient. If answered 'No' to ALL the above, only consider removing penicillin allergy if there is strong clinical justification.

Does the eligible patient consent to remove penicillin allergy from active record?

☐ **Yes - patient is comfortable taking penicillin in the future and removing allergy record**

☐ **No - but would like to have oral amoxicillin test in the future if service is available**

☐ **No - clarify nature of reaction on records**

Name of assessor: **Signature:** **Date of assessment:**

Appendix 5: Allergy card

I have a penicillin allergy

Do not prescribe any medicine that contains penicillin (see list on other side)

Peidiwch â rhagnodi unrhyw feddyginiaeth sy'n cynnwys penisilin (gweler y rhestr ar yr ochr arall)

Mae gennyf alergedd i benisilin

These antibiotics have penicillin in them:
Mae penisilin yn y gwrthfiotigau hyn:

- Penicillin (phenoxymethylpenicillin)
- Amoxicillin
- Ampicillin
- Benzylpenicillin
- Flucloxacillin
- Co-amoxiclav (Augmentin)
- Piperacillin/tazobactam (Tazocin)
- Pivmecillinam
- Temocillin
- Co-fluampicil (flucloxacillin + ampicillin)

I have a penicillin allergy

Do not prescribe any medicine that contains penicillin (see list on other side)

Peidiwch â rhagnodi unrhyw feddyginiaeth sy'n cynnwys penisilin (gweler y rhestr ar yr ochr arall)

Mae gennyf alergedd i benisilin

These antibiotics have penicillin in them:
Mae penisilin yn y gwrthfiotigau hyn:

- Penicillin (phenoxymethylpenicillin)
- Amoxicillin
- Ampicillin
- Benzylpenicillin
- Flucloxacillin
- Co-amoxiclav (Augmentin)
- Piperacillin/tazobactam (Tazocin)
- Pivmecillinam
- Temocillin
- Co-fluampicil (flucloxacillin + ampicillin)

I have a penicillin allergy

Do not prescribe any medicine that contains penicillin (see list on other side)

Peidiwch â rhagnodi unrhyw feddyginiaeth sy'n cynnwys penisilin (gweler y rhestr ar yr ochr arall)

Mae gennyf alergedd i benisilin

These antibiotics have penicillin in them:
Mae penisilin yn y gwrthfiotigau hyn:

- Penicillin (phenoxymethylpenicillin)
- Amoxicillin
- Ampicillin
- Benzylpenicillin
- Flucloxacillin
- Co-amoxiclav (Augmentin)
- Piperacillin/tazobactam (Tazocin)
- Pivmecillinam
- Temocillin
- Co-fluampicil (flucloxacillin + ampicillin)

I have a penicillin allergy

Do not prescribe any medicine that contains penicillin (see list on other side)

Peidiwch â rhagnodi unrhyw feddyginiaeth sy'n cynnwys penisilin (gweler y rhestr ar yr ochr arall)

Mae gennyf alergedd i benisilin

These antibiotics have penicillin in them:
Mae penisilin yn y gwrthfiotigau hyn:

- Penicillin (phenoxymethylpenicillin)
- Amoxicillin
- Ampicillin
- Benzylpenicillin
- Flucloxacillin
- Co-amoxiclav (Augmentin)
- Piperacillin/tazobactam (Tazocin)
- Pivmecillinam
- Temocillin
- Co-fluampicil (flucloxacillin + ampicillin)

Appendix 6: Outcome communication and satisfaction survey invitation – SMS

Outcome SMS examples

De-labelled:

After a thorough review of your penicillin allergy history, we can advise you that: **There is no evidence to support a "penicillin allergy" label.** "Penicillin allergy" has now been removed from your active record. As discussed, you will be able to take penicillin antibiotics in the future if required. Please inform your other healthcare providers, such as your community pharmacy and dentist, of these results so they can provide you with the most appropriate care in the future.

Please take a few minutes to complete a survey via (To be inserted by local health board)

OR

Label remaining:

After a thorough review of your penicillin allergy history, we can confirm that your penicillin allergy label will remain on your record, and we have updated information related to your penicillin allergy as discussed.

Please take a few minutes to complete a survey via (To be inserted by local health board)

Outcome SMS examples (Cymraeg):

Dadlabelu:

Ar ôl adolygiad trylwyr o'ch hanes yn ymwneud â'ch alergedd i benisilin, gallwn ddweud: **Nid oes unrhyw dystiolaeth i gefnogi'r label "alergedd i benisilin".** Mae "alergedd i benisilin" bellach wedi'i dynnu oddi ar eich cofnod actif. Fel y trafodwyd, byddwch yn gallu cymryd gwrthfiotigau penisilin yn y dyfodol os bydd angen. Rhowch wybod i'ch darparwyr gofal iechyd eraill, fel eich fferyllfa gymunedol a'ch deintydd, am y canlyniadau hyn fel y gallant roi'r gofal mwyaf priodol i chi yn y dyfodol.

Rhowch ychydig funudau o'ch amser i gwblhau arolwg ar (To be inserted by local health board)

NEU

Label yn parhau:

Ar ôl adolygiad trylwyr o'ch hanes alergedd i benisilin, gallwn gadarnhau y bydd eich label alergedd i benisilin yn aros ar eich cofnod, ac rydym wedi diweddaru gwybodaeth sy'n ymwneud â'ch alergedd i benisilin fel y trafodwyd.

Rhowch ychydig funudau o'ch amser i gwblhau arolwg ar (To be inserted by local health board)

Appendix 7: Satisfaction survey

Penicillin allergy review – Online satisfaction survey: (content is shown below)

When you submit this form, it will not automatically collect your details like name and email address unless you provide them yourself.

*Required

1. Before this allergy review, did you think you were allergic to penicillin?*

☐ Yes

☐ No

2. Before being contacted by your GP practice, were you aware of the potential harms caused by having an incorrect penicillin allergy record?*

1				5
Not aware at all	2	3	4	Fully aware

3. Did you receive the patient information leaflet via SMS?*

☐ Yes (proceed to Question 4)

☐ No (proceed to Question 6)

4. How easy was the patient information leaflet to read (sent via SMS)?

1				5
Difficult to read	2	3	4	Easy to read

5. How helpful was the patient information leaflet (sent via SMS)?

1				5
Unhelpful information	2	3	4	Helpful and informative

6. Did you have your penicillin allergy label removed as a result of this review?*

☐ Yes (proceed to Question 7)

☐ No (proceed to Question 8)

7. How comfortable do you feel about taking penicillin in the future? (Skip to Question 9)

Very comfortable	Somewhat comfortable	Neither comfortable nor uncomfortable	Somewhat uncomfortable	Not at all comfortable

8. What was the reason for keeping the penicillin allergy on your record?

☐ I would prefer to have an allergy test before making a decision on removing penicillin allergy from my record

☐ I am uncomfortable with taking penicillin

☐ This review confirmed that I am truly allergic to penicillin

9. How would you rate your overall experience with this penicillin allergy review?*

10. Would you be happy to be contacted for a patient story as part of our public health campaign?*

☐ Yes

☐ No

☐ Maybe

11. Name and contact telephone number:

12. Do you have any other comments to help us to improve this service?

Appendix 8. De-labelling based on history alone – Template letter for GP/community pharmacy/any other healthcare providers

PENICILLIN ALLERGY DE-LABELLING

Patient name:

Patient date of birth:

Patient hospital or NHS number:

Dear XXXXXXXXXX

The patient listed above underwent assessment of their penicillin allergy label during a recent XXXXXXXX (input health service attended i.e. clinic) attendance.

After a thorough review of their penicillin allergy history, we can advise you that:

There is no evidence to support a "penicillin allergy" label.

This has been discussed with the patient who understands they will be able to take penicillin antibiotics in the future if required.

This information should be shared with other healthcare providers including their regular GP, community pharmacy and dentist if possible, so they can provide the most appropriate care in the future.

Best wishes,

Insert name and job title

Enquiries contact: *insert details*

Appendix 9. Poster for waiting areas

Allergic to Penicillin?

Only 1 in 10 people with a penicillin allergy on their medical records truly have an allergy.

The 9 out of 10 who are not truly allergic to penicillin may be at risk of harm from not being given a penicillin to treat their infection. This is because:

- The alternative antibiotics we use for people with penicillin allergy may not work as well, and increase risks of developing side effects and difficult-to-treat infections.
- People with penicillin allergy on their medical records spend longer in hospital, and need more medication to be given intravenously through a drip.
- Penicillin allergy is lost over time, after 5 years 50% are resolved, increasing to 80% after 10 years.
- Side effects like diarrhoea and nausea are not nice, but they are not allergies, and will usually pass once the course of treatment is finished.
- Sometimes symptoms of the infection (e.g. rash) can be misinterpreted as an allergic reaction.

Ask your healthcare professional
"Do I really have a penicillin allergy?"

#KeepAntibioticsWorking

Alergedd i benisilin?

Dim ond 1 o bob 10 o bobl sydd ag alergedd i benisilin ar eu cofnodion meddygol sydd ag alergedd go iawn.

Gall y 9 allan o 10 nad oes ganddynt alergedd i benisilin mewn gwirionedd fod mewn perygl o niwed o beidio â chael penisilin i drin eu haint. Mae hyn oherwydd:

- Efallai na fydd y gwrthfiotigau amgen rydyn ni'n eu defnyddio ar gyfer pobl sydd ag alergedd i benisilin yn gweithio cystal, a gallent gynyddu'r risg o ddatblygu sgil-effeithiau a heintiau sy'n anodd eu trin.
- Mae pobl sydd ag alergedd i benisilin ar eu cofnodion meddygol yn treulio mwy o amser yn yr ysbyty, ac mae angen rhoi mwy o feddyginiaeth yn fewnwythiennol drwy ddrip.
- Mae alergedd i benisilin yn diflannu dros amser, ar ôl 5 mlynedd mae 50% yn cael gwared ar yr alergedd, gan gynyddu i 80% ar ôl 10 mlynedd.
- Nid yw sgil-effeithiau fel dolur rhydd a chyfog yn ddymunol, ond nid ydynt yn alergeddau, a byddant fel arfer yn diflannu unwaith y bydd y cwrs triniaeth wedi dod i ben.
- Weithiau gellir camddehongli symptomau'r haint (e.e. brech) fel adwaith alergaidd.

Gofynnwch i'ch gweithiwr gofal iechyd proffesiynol “Oes gen i alergedd i benisilin mewn gwirionedd?”

#CadwGwrthfiotigauYnGweithio

History-based penicillin allergy de-labelling in adults
Consultation responses

Respondent and DOI	Page/section	Comment	Response and action taken
Respondent 1: Betsi Cadwaladr University Health Board *(DOI - We would be expected to carry out this work)*	Is there anything you would like to see removed from the document?	Whilst I feel this looks very good work for patients and a safety agenda and will have direct benefit. I am very worried by the amount of work that it would require of General Practice if no funding to complete this work was provided. According to your calculation we would need to review 7% of our population, and the document suggests a face to face or phone appt for each patient to do this. For my practice of 10,000 that means an approximate additional 700 appointments – that equates to approximately 28 full days of GP work (assuming 25 appts per day) - so an additional months worth of unpaid work, clearly this is not possible without funding to allow additional capacity to do this. This needs to be considered to stop this great project going to waste as the pressures within primary care will not allow for unfunded work. If Funds are provided we can employ extra staff to cover the time required and would be keen to do this work.	Thank you for your comment. About 7% of the general population carry a penicillin allergy. However, the search that we created will only identify patients with very low risk of having a true penicillin allergy (i.e. who had received a penicillin since the first reaction). From our pilot, this narrows down to about 0.7% of the population. Resource and funding are outside the scope of this document. AWTTC's remit is to ensure the guidance is clinically suitable and appropriate for use. A sentence has been added in section 1.2 Purpose to clarify this guidance is a best practice framework for those wishing to undertake penicillin allergy de-labelling based on history.
Dr Jennifer Ellis Lead GP for Urgent Primary Care Centres – West, BCU		I think this is a very useful document. Can it be made clear that there is not an expectation on primary care to seek out patients to review their allergy status without funding for this. I think it may prove most useful on an adhoc basis when a patient is recorded as having a penicillin allergy and decisions are being taken regarding prescribing.	A sentence has been added in section 1.2 Purpose to clarify this guidance is a best practice framework for those wishing to undertake penicillin allergy de-labelling based on history.
Dr Sara Bodey North Wales Local Medical Committee *(DOI - I work as a GP Partner at Bryn Darland Surgery in Coedpoeth*	Is there anything you would like to see added to the document?	• North Wales LMC supports the principle of safe, history-based penicillin allergy de-labelling, as it improves patient outcomes and aligns with Welsh AMR/HCAI goals and the UK AMR National Action Plan. However, the draft guidance risks creating a significant, unfunded transfer of workload into General Practice at a time of severe workforce and capacity pressure. • To be deliverable and safe, any primary-care role must be commissioned and fully resourced by Health Boards as a Supplementary Service/LSS, with defined specifications, governance, IT support, indemnity, and payment. De-labelling	Resource and funding are outside the scope of this document. AWTTC's remit is to ensure the guidance is clinically suitable and appropriate for use. A sentence has been added in section 1.2 Purpose to clarify this guidance is a best practice framework for those wishing to undertake penicillin allergy de-labelling based on history.

I am responding here on behalf of North Wales LMC in my role as Chair of the Committee)		cannot be assumed to fall within “core” GMS under the Unified Contract. The primary operational model should be Health Board–led hubs, with GPs contributing only to opportunistic clarification during routine care and updating records following structured notifications unless there is a clearly commissioned supplementary service agreed.	
		The guidance should explicitly require compliance with NICE CG183 (drug-allergy documentation), GMC prescribing and consent standards, NICE NG197 (shared decision making), and the use of the validated PENFAST tool. Patients with PENFAST ≥1 or any uncertainty should be routed to commissioned specialist services.	Wording to recommend compliance with NICE CG183 (drug-allergy documentation) has been added to section 2.4 Documenting assessment and outcome, GMC prescribing and consent standards has been added to section 2.3.4 Discussion with patient. Compliance to NICE NG197 (shared decision making) is already specified in section 2.3.4 Discussion with patient.
		We recommend adding a Commissioning & Funding section stating GP participation is optional and dependent on Health Board commissioning	A sentence has been added in section 1.2 Purpose to clarify this guidance is a best practice framework for those wishing to undertake penicillin allergy de-labelling based on history.
		We recommend adding explicit role delineation and SNOMED-based documentation standards	Specified in section 1.2. This guidance can be used by any registered healthcare professional and in any settings where penicillin allergy history taking or reconciliation is conducted. Specified in section 4.0. An explicit SNOMED code for penicillin allergy de-labelling activity is under development. The guidance will be updated when the explicit SNOMED code is available.
		We recommend adding clear pathways for structured updates to GP, WCP and community pharmacy	Whilst awaiting DHCW development of a shared allergy record, we acknowledge that communication of allergy information between different clinical systems remains a challenge. Best practice for communication has been written within the guide.
		We recommend adding an All-Wales audit dataset including PENFAST score, outcome, coding, and AMR indicators.	Audit is an important part of this work going forward and it will follow when structured data, e.g. an explicit SNOMED code, are available.
	Is there anything you would like to see removed from the document?	We recommend removing any text implying that proactive searches, structured assessments, recalls or de-labelling in GP are core GMS obligations. • North Wales LMC is supportive of the overall aims but emphasises that safety, feasibility and contractual clarity require a commissioned, well-governed, and adequately resourced model.	This guide does not suggest de-labelling in general practice is a core GMS obligation. Specified under section 1.2 This guidance is suitable for local adaptation. It will be up to individual health boards to adapt and implement.

	7	In the PENFAST score table (table 3) we find the advice under 'do not score is unclear' – we have been unable to be sure whether we would or would not include a severe urticarial rash for example	Table 3 has been amended to clarify PENFAST score, intended for use in history based de-labelling only
	6 and 7	There needs to be recognition that the vast majority of penicillin allergies in GP records are historic, often dating back many years to childhood. Details as to the type of reaction may well not be easily available, as it wasn't recorded in detail at the time, and the patient was too young to remember. This practical point is not mentioned in the document, but is the most common scenario in GP practice, and there needs to be clarity about management for this cohort. It would be vanishingly rare for a child to have had a blood test to look for an eosinophilia in these circumstances, and the PENFAST tool doesn't seem to reflect the reality of some of the data it depends on not being available	Where the allergy is unknown and the patient has subsequently received penicillin then the allergy can be removed. Research suggests that those with an unknown allergy have as much chance of reaction as patient with no allergy.
	Overall /oral amoxicillin tests	We are concerned about the safety of any oral amoxicillin testing in community settings given current ambulance waiting times and would advise strongly that, when they are commissioned, these should be based on hospital sites where resuscitation support is promptly available if needed, rather than in the community	This document does not suggest that oral challenge needs to be performed in the community. There are studies where this has been done. It is up to local health boards to decide where appropriate location is.
Alwyn Fortune Royal Pharmaceutical Society	Is there anything you would like to see added to the document?	At the RPS we are extremely supportive and welcome the guidance for penicillin allergy de-labelling. With recent studies showing that almost 90% of people whose medical records labelled them as allergic to penicillin, were not truly allergic[1], this is a necessary focus to support antibiotic choice and prescribing, antimicrobial stewardship, together with cost effective prescribing.	Thank you for your comments.
		We are pleased to see this guidance with a focus on primary care, following on from previous AWTTC guidance for de-labelling within secondary care. The importance of not only good documentation following a patient assessment, but the appropriate digital sharing of information across settings is vital, so that every healthcare professional involved in a patient's care is aware an assessment has taken place, and a patients allergy status may have changed. This is particularly important for patients, to ensure continuity of care, and not to have to explain multiple times to different healthcare professionals involved in their care of any update to their allergy status, when all healthcare professionals should be able to access this information digitally.	Added text to outcome SMS messages and letter to "de-labelled" cohort: Please inform your other healthcare providers, such as your community pharmacy and dentist, of these results so they can provide you with the most appropriate care in the future.

[1] Penicillin allergy assessment pathway versus usual clinical care for primary care patients with a penicillin allergy record in the UK (ALABAMA): an open-label, multicentre, randomised controlled trial
Jonathan A T Sandoe, Shadia Ahmed, et al., The Lancet, July 2025. Accessed via https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143(25)00006-8/fulltext

		Of note, within primary care, is ensuring a patients community pharmacy is also informed when an assessment has taken place and a patients allergy status may have been updated. Community pharmacies may not always have the necessary access they need to a patient's medical record, through digital barriers, and subsequently from previous consultations with patients may (or may not) have recorded on a patient's community pharmacy PMR separately that the patient has an allergy to penicillin. Any change in status must be communicated to the community pharmacy, to allow them to update records and prevent future potential medicines supply issues. For example, if a penicillin based antibiotic was prescribed to a patient who had been assessed and de-labelled as allergic, if the community pharmacy is not made aware of this and holds their own historic records about allergy status, this may cause unnecessary confusion and a delay to treatment, if the community pharmacy has to proactively find out this information when presented with a prescription. This further demonstrates the need for community pharmacies to have read write access to a patient's digital medicines record. Within primary care, if there was an expectation that pharmacists based in community pharmacies could also assess patients for penicillin allergy de-labelling, whilst they have the clinical skills to do so, they must be supported with the correct digital infrastructure and appropriate read write medicines access.	
	Page 11, Line 298 and page 13, line 312	Noting the points made above. The importance of ensuring all healthcare professionals (HCP) involved in a patients care, across all settings, are adequately informed/able to access the appropriate patient record to show where an assessment of penicillin allergy status has taken place, and where this may have been de-labelled, or not. This prevents confusion for both patient and HCP, ensures patients receive the most appropriate medicine in a timely manner, and avoids the necessary frustration for patients of having to 'tell their story' multiple times to different HCPs.	Thank you for your comment.
		We are very supportive of this work and guidance at the RPS. We have previously supported media campaigns in this area, whilst also producing a penicillin allergy checklist informed by our Antimicrobial Expert Advisory Group, to support pharmacists and other healthcare professionals in their work.	Thank you for your comment. We have added useful links to Section 6.0 Resources.

		https://www.rpharms.com/recognition/all-our-campaigns/antimicrobial-resistance-stewardship/penicillin-checklist We look forward to working with AWTTC in the future to help support this important workstream, ensuring we best support our members in this area and aid wider public messaging and education.	
Respondent 5: Aneurin Bevan University Health Board	Is there anything you would like to see added to the document?	More information around the governance for amending the records in the systems. A flowchart or table with the outcomes from a PENFAST score (see comments below)	See section 2.4.4 for an example of good documentation. PEN-FAST outcome table has been added.
	Pg 9/238	"*It worries me deleting the code as altering prev records etc.*. "- Practice Pharmacist	Best practice of record keeping has been discussed extensively within the Task & Finish Group. Whilst removing the code may not be seen as usual practice, there is no other way to disable an incorrect allergy from an active record. On balancing the risks and benefit of optimising future antimicrobials treatment and best record keeping. The guide recommends removing the code and replacing with an entry with detailed documentation on why the allergy was removed or confirmed (See figure 2 under section 2.4 for an example of good documentation) along with the recommended CT SNOMED code for such activity. A template to aid documentation has been added.
	Pg9/238	"*You should never "remove" (delete) anything from the patient record, you must only "replace*""- Microbiologist	
	General question on de-labelling	"*If the patient scores >0 e.g. reaction <5 yrs or had an antihistamine (obvs. not the serious reactions) but has had subsequent doses of a penicillin how would we manage?"-Practice Pharmacist*	Management may vary depending on the index penicillin and the penicillin that they receive and tolerated.
	Pg9/238	"*deleting the allergy code can delete the whole initial historical consultation. EMIS does ask for a reason why you are deleting and there will be an audit trail for that but just asking the Q from a medico-legal perspective and the difficulty in retrieving that information if needed in the future?*"-Practice Pharmacist	Deleting the allergy code does not delete the other information within the consultation. The guide strongly recommends a consultation is put in along with the assessment outcome and all necessary information, should it be needed in the future to justify why an allergy code was deleted. See figure 2 under section 2.4 for an example of good documentation
	Pg12/311	"a general comment about roles and responsibilities between different healthcare settings. We've had a couple of discharges that state "GP to consider de-labelling penicillin allergy" when they have been administered a penicillin as an in-patient. Shouldn't the secondary care setting take ownership of the whole process, obtain	Thank you for your comment. This lies beyond the scope of this guidance. Guidance for communication from secondary care on de-labelling activity is available in the "All Wales guidance for penicillin allergy de-labelling in adults in secondary care"

		consent and remove the allergy from WCP - perhaps complete the review paperwork and upload the WCP/forward to GP rather than passing on for the GP to do +/- duplication of work? Not sure who this ties in with the secondary care guideline?"	
	Pg 8- 167-188	"Would be useful to have this text as a flowchart/table/something graphic (similar to what already in the secondary care documents)"- Consultant Antimicrobial Pharmacist	PEN-FAST outcome table has been added.
Respondent 6: GP, Hywel Dda	Is there anything you would like to see added to the document?	The opening sections would benefit from a clearer statement of the primary intended users of the guidance and the settings in which it is expected to be applied. Explicitly identifying which services should not undertake de-labelling would be as helpful as stating who should.	Allergy history taking or reconciliation is undertaken by a wide range of HCPs across different settings. Each profession has their professional code of conduct which includes acting within their own competency. HCPs should be given the skills to de-label as part of their role. Otherwise, we risk having reoccurring incorrect allergy labels if this guide is restricted to certain professions only. Depending on the individual health board situation, the guidance offers flexibility for health boards to apply it the most suitable way for their locality.
	Is there anything you would like to see removed from the document?	The document attempts to address an extremely wide audience, including prescribers, pharmacists, pharmacy technicians, GPs, out-of-hours/NHS 111 staff, nurses, Welsh Ambulance Service teams, community pharmacists, and the general public. This breadth risks producing guidance that is insufficiently tailored to the responsibilities, competencies, and governance arrangements of each group. Section 3 Good Practice Guide to De-labelling in Other Setting should be removed and the scope of the guidance be restricted to primary care. The majority of the document focuses on primary care including record searches, patient contact, and documentation within GP systems. Extending the guidance into undefined other settings introduces unnecessary ambiguity and detracts from the otherwise targeted primary care focus of the resource.	The guide is tailored to HCPs who undertake penicillin allergy history taking or reconciliation as part of their role. Allergy history taking or reconciliation is undertaken by a wide range of HCPs across different settings. We risk having reoccurring incorrect allergy labels if this guide is restricted to certain settings only.
	3 Section 1.2	The guidance is described as applicable to all registered healthcare professionals across different care settings. However, the document does not clearly define which professional groups are expected to undertake de-labelling in practice. This wording could reasonably include nurses, physiotherapists, podiatrists, radiographers, and other allied health professionals. The absence of clear professional boundaries, scope of practice, and accountability frameworks creates ambiguity and potential patient safety concerns.	Allergy history taking or reconciliation is undertaken by a wide range of HCPs across different settings. Each profession has their professional code of conduct which includes acting within their own competency. HCPs should be given the skills to de-label as part of their role. Otherwise, we risk having reoccurring incorrect allergy labels if this guide is restricted to certain professions only.

	11 Line 301	There is already secondary care guidance for penicillin allergy de-labelling in adults, which includes history based assessment and the option of an oral amoxicillin challenge. Emergency departments and pre-operative assessment clinics should be covered within that guidance rather than within this document, particularly as this guidance does not explain how to undertake an amoxicillin challenge.	We have added a link to the refer to the secondary care guideline for when oral amoxicillin challenge is done in secondary care setting. History based penicillin de-labelling can be applied in any setting as it is related to the clinical history of the patient.
	General	The document does not clearly evidence whether dentists or community pharmacy professionals were involved in developing the guidance, despite the fact that dentists frequently prescribe penicillin antibiotics and community pharmacy teams routinely encounter allergy labels during patient counselling. Issuing national guidance intended for broad use without clearly demonstrating engagement from these groups raises questions about whether the recommendations reflect real world workflows in those settings.	Community pharmacists are members of the Task and Finish Group for the development of this guideline. Dental representatives were invited to join the Task and Finish Group and were sent a copy of the consultation draft for comment.
	Page 29	The inclusion of a poster encouraging patients to ask whether they truly have a penicillin allergy may increase queries across a wide range of clinical environments. However, the document does not explain how clinicians in different settings should respond, whether they are expected to undertake assessments themselves, or where patients should be referred. Without defined clinical pathways or resourcing, these risks raising expectations that services may not be able to meet.	The guide recommends history-based assessment be undertaken. If it is not possible to de-label based on history alone, but the patient is eligible for oral amoxicillin challenge, refer if the service is available.
	General	The document does not specify training or competency requirements for staff undertaking history-based de-labelling, nor does it clearly describe governance arrangements, documentation standards, or professional accountability should an adverse reaction occur following de-labelling. Given the clinical risks associated with incorrect allergy removal, these safeguards should be explicit.	There is evidence that de-labelling can be undertaken by non-specialists with guidance. Allergy history taking or reconciliation is undertaken by a wide range of HCPs across different settings. Each profession has their professional code of conduct which includes acting within their own competency. Risk can be not completely reduced to zero, however, the population included in this group has a very low risk of having a true penicillin allergy. The patient should be fully informed of the risks with the information leaflet provided and counselling. An allergy label will only be removed when informed consent is obtained from the patient.
	General	The guidance assumes that healthcare professionals will have time and system capacity to undertake de-labelling activities. It does not acknowledge pressures in primary care, dental services, or community settings, nor the variability in access to specialist allergy services across Wales. Without addressing these operational realities, the recommendations appear aspirational rather than deliverable at scale.	Resource and funding are outside the scope of this document. AWTTC's remit is to ensure the guidance is clinically suitable and appropriate for use. A sentence has been added in section 1.2 Purpose to clarify this guidance is a best practice framework for those wishing to undertake penicillin allergy de-labelling based on history.

	3	The document would benefit from clearer scope of who the guidance is for, what actions are expected, and which services should not undertake de-labelling.	Allergy history taking or reconciliation is undertaken by a wide range of HCPs across different settings.
Helen Jarvis on behalf of the Cardiff and Vale PCIC Medicines Management Team Cardiff and Vale UHB *(DOI - I have been involved in the History Based Penicillin Allergy De-Labelling Group/meetings. However, the feedback provided in this form is collated feedback from members of the Cardiff and Vale PCIC Medicines Management Team.)*	Title	Include population we are reviewing? i.e. History-Based Penicillin Allergy De-labelling in adults 18 years and over	Title amended to "History-based penicillin allergy de-labelling in adults"
	Pg 6 / Section 2.3.1 / line 139	Under section 2 of the one-page penicillin allergy assessment, If the patient doesn't recall what reaction they had or it wasn't documented in their notes, then potentially they would tick 'No' for all the reactions (even if they only had mild symptoms at the time) – the suggested action would be to only consider removing penicillin allergy if there is strong justification – would this rule out quite a significant proportion of people where de-labelling could apply?	The one-page assessment is designed to identify patients for history-based de-labelling only if they can confirm the label was based on a non-allergic reaction, if the patient tolerated penicillin following the initial reaction or if there is another strong clinical justification for removing the penicillin allergy label.
	Pg 2 / Section 1 / line 39	Please could examples of 'associated beta-lactams' be provided	This is for background information only; there is no need for extensive details in this section for the purpose this guide.
	Pg 2 / Section 1 / lines 43-45	What if the recorded/initial reaction was a **severe** true penicillin allergy?	A detailed history should be taken according to section 2.3 Conducting the allergy assessment to determine whether the person is eligible for de-labelling. If a true penicillin allergy is confirmed, update the record according to section 2.4 Documenting assessment and outcome.
	Pg 2 / Section 1 / line 52/53	Suggest a full stop after studies, then a new sentence. 'These concluded…etc'	This sentence has been reworded.
	Pg 2 / Section 1 / lines 57 – 61	Over what time span was this audit done?	Please see reference 15 for full article.
	Pg 3 / Section 1.1 / line 75 – table 1	Under level 3 reaction column – the last statement on severe renal / hepatic impairment / failure – need a closed bracket at the end of the examples here.	This has been amended
	Pg 6 / Section 2.3.1 / line 131-139 – one page penicillin allergy assessment	One of the questions in the one-page penicillin allergy assessment asks 'was this suspected allergy within the last 5 years', however the search is for patients who have had an allergy to penicillin coded greater than or equal to 10 years ago and who have had a penicillin since. Not sure if the search would therefore pick up if the patient has had the suspected allergy in the last 5 years?	The purpose of the search is to identify patients who would answer "No" to "Was the suspected allergy within the last 5 years". The team found having patients who were coded >10 years and had a penicillin gave the largest cohort of patients who are most likely eligible for de-labelling.
	Pg 6 / Section 2.3.1 / line 131-139 – one page penicillin allergy assessment	Under total score – 1-2 points: 'Patient would like to receive oral amoxicillin test if available in the future?' – consider rewording as: "Would the patient like to receive an oral amoxicillin test if available in the future?"	This has been amended

	Pg 9 / Section 2.3 / line 228	Sentence under 'confirmed true allergy': suggest adding a full stop after 'prescribed antibiotics' and starting new sentence as "Patient should be offered a penicillin allergy card (see appendix 5)".	This has been amended
Dan Robbins on behalf of Swansea Bay UHB Medicines Management	94	The flow charts mention oral amoxicillin test clinics is that something that is suggested that they do in the practice or is it a referral to another service? Do we have that pathway available. I can see elsewhere it mentions when available and so that may also need to be clear in the flowchart so that patients / HCPs expectations can be set.	This document does not recommend that oral challenge testing must be conducted in a community setting. Although studies have demonstrated that this can be performed safely in such settings, decisions regarding the appropriate location and referral pathway should be determined by local health boards. These decisions will depend on local service availability and infrastructure.
	102	Is the search for anyone with an allergy for over 10 years AND who has received a penicillin antibiotic? If it is AND why is the 10 years important? If it's OR is that search is going to return a large number of patients for assessment?	The search identifies anyone with an allergy for over 10 years AND who has received a penicillin antibiotic within the last 10 years (after having the allergy label).
		If the allergy is an adverse effect not an allergy, I'm not sure why any timeframe is needed. Surely it's missing a group of patients unnecessarily here, who didn't have a reaction in the first place?	This guidance is designed to identify only patients at very low risk of true penicillin allergy. Therefore, a validated assessment process is required to provide clinical reassurance.
	P6, line 95 Identify patient through search box	this is not clear, should be made little simple and more clear, too much information.	Thank you for your comment.
		sorry stated all patients then is 18 and over???	This has been amended to adult patients.
		should we used both the SNOMED CT/codes as this is 2 different thinks one is the ID code for the clinical term- Should this be more clear across the document? To ensure	This has been amended to Concept ID
		why 10 years ago??? what is rational behind that.	It is designed to capture allergy reaction > 5 years ago. Various combinations of search criteria has been tested and this criteria has given the largest proportion of return.
	P6, line 95 Contact patient to explore de-labelling box	No other method of contacting patients? Why specifically SMS? What about Welsh version	A Welsh version will be available prior to publication.
	P7, line 99	No search available to comment on.	Thank you for your comment. This is still being developed.
	P7, line 99	101327100006101- code does not exist	This has been amended: 1013271000006101
	P7, line 101 Table 2	Label: should this be SNOMED clinical term	This has been amended.
	P7, line 101 Table 2	SNOMED CT code: Description ID	This has been amended.
	P7, line 102	Maybe it should be clearer that this is 2 separated searches.	This is a single combined search.

	P7, line 103-106	As I understood this is as one search, why searches? 'the searches criteria' and why 10 years. Also, this searches will only cover patients who had allergies recorded + had penicillin prescribed? What about other patients? Are we concentrated on this patients first?	This has been amended. Yes, the focus of this document is to identify and review patients with a low risk of penicillin allergy i.e. who had an allergy recorded and subsequently had penicillin prescribed.
	P7, line 107	Same as above, why SMS only? should be other options for patient to received the information?	SMS is considered the most efficient way of contacting patients, but other methods can be used. Wording amended to reflect this.
	P7, line 107	Also, they are using SMS, but not really clear what the SMS means? Should be for GP practices to decide the method how they will informed patients? Do all GP practices using SMS, what about the carer or patients relatives?	Yes, GP practices can decide the best method to use to inform their patients. Wording amended to reflect this.
	P19, line 403	should be in Welsh?	A Welsh version will be available prior to publication.

AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

Equality and Health Impact Assessment
History-based penicillin allergy de-labelling in adults

AWTTC will fill in an Equality and Health Impact Assessment in parallel with each development stage of our projects. This will help us to follow the five ways of working for public bodies, and work to achieving the wellbeing goals, outlined in the Well-Being of Future Generations (Wales) Act 2015.

Date: 06/05/26

1.	AWTTC contact details	Tel: 02921 826900 Email: awttc@wales.nhs.uk
2.	State the objectives of the project.	Penicillin allergy de-labelling has been identified as a key initiative to improve antibiotic prescribing and antimicrobial stewardship. The aim of this document is to guide best practice to support the identification and removal of penicillin allergy labels in patients who have not experienced a true hypersensitivity reaction
3.	Evidence and background information considered. For example: • population data • staff and service users' data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages	About 6% of the UK general population have a penicillin allergy label on their record. Evidence indicates that more than 90% of patients labelled with a penicillin allergy are not allergic to penicillin and associated beta-lactams when formally assessed. In many cases the allergy label may be due to an adverse reaction affecting the gastrointestinal system or a skin rash that occurred during a course of penicillin in childhood. In addition, many patients' reactions to penicillin occurred over 10 years ago and details of the reaction are not recalled or clearly documented. The PHW Human Health Delivery Group primary care workstream has acknowledged that removing false penicillin allergy is a key intervention to enable achievement of the improvement goals set out by the *Welsh Health Circular (2024)038 – Healthcare associated infections and antimicrobial resistance goals 2024 to 2025* and would contribute to the UK national action plan *Confronting antimicrobial resistance 2024 to 2029*.

	Population pyramids are available from Public Health Wales Observatory.	The document was developed by PHW History Based Penicillin Allergy De-labelling Task & Finish Group and will comprise a standard evidence-based tool for healthcare professionals to review patient with penicillin allergy label appropriately, a consistent all Wales approach to recording penicillin allergy de-labelling and a patient information leaflet to support shared decision making.
4.	Who will this project affect?	This guidance would be relevant to all prescribers, pharmacists, pharmacy technicians, GPs, out of hours/111 workers, nurses, Welsh ambulance teams, community pharmacists, patients and the general public. This guidance can be used by any registered healthcare professional and in any settings where penicillin allergy history taking or reconciliation is conducted.

5. EQIA – How will the project impact on people?
Questions in this section relate to the impact on people based on the 'protected characteristics' of the Equality Act 2010, and other factors.

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
5.1 Age For most purposes, the main categories are people aged: • under 18 years; • between 18 and 65 years; • over 65 years.	Inclusion criteria state adult patients ≥18 years old who have a low risk for true penicillin allergy, providing no exclusion criteria met. We expect the guidance being developed to have a positive impact on the health and well-being of adults within Wales who believe they have a penicillin allergy. Children will not be included at this stage, as there is a different set of criteria and evidence for this age group	N/A	N/A

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
	We do not expect that this guidance will affect individuals unequally based on their age.		
5.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	People with learning disabilities, dyslexia or visual impairments may require patient information to be provided in more accessible, understandable formats. Patient information leaflets will be produced in easy-read formats.	All related documents published on the AWTTC website will meet accessibility requirements.	
5.3 People of different genders: Consider men, women, people undergoing gender reassignment. **N.B.** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender.	We do not expect a potential negative, or unequal, impact on people based on their gender, or on people undergoing gender reassignment.	N/A	N/A
5.4 People who are married or who have a civil partner.	We do not expect a potential negative, or unequal, impact on people based on their marital status or being in a civil partnership.	N/A	N/A
5.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	We do not expect a potential negative, or unequal, impact on women who are expecting a baby, are breastfeeding, or are on a break from work after having a baby.	N/A	N/A

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
5.6 People based on race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies and travellers, migrant workers. The Runnymede Trust	We do not expect a potential negative, or unequal, impact on people according to their race, nationality, colour, culture or ethnic origin.	N/A	N/A
5.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief. Implications of religious beliefs on selection of medicines (BMJ) In practice: guidance on religion, personal values and beliefs (General Pharmaceutical Council)	We do not expect a potential negative, or unequal, impact on people who have a religion or belief, or people with no religion of belief.	N/A	N/A
5.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual). Stonewall	We do not expect a potential negative, or unequal, impact on people based on who they are attracted to.	N/A	N/A
5.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design.	We do not expect a potential negative, or unequal, impact on people who communicate using the Welsh language.	Any patient-facing materials will be produced in Welsh and English, in line with the Welsh language standards, including easy read booklets.	

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
5.10 People according to their income related group.	We do not expect a potential negative, or unequal, impact on people based on their income-related group.	N/A	N/A
5.11 People according to where they live.	We do not expect a potential negative, or unequal, impact on people based on where they live.	N/A	N/A
5.12 Consider others who face health inequalities, such as: • Looked after and accommodated children and young people • Carers: paid/unpaid, family members • People who are homeless or those who experience homelessness: people on the street; those staying temporarily with friends/family; those in hostels/B&Bs • People involved in the criminal justice system: offenders in prison or on probation, ex-offenders • People with addictions and substance misuse problems • People who have poor literacy • People living in remote, rural and island locations	We expect the associated guidance being developed to have a positive impact on the health and well-being of adults living in Wales. We do not expect that this guidance will affect individuals unequally based on health inequalities.	N/A	N/A
5.13 Consider any other groups and risk factors relevant to this project.	N/A	N/A	N/A

6.0 HIA – How will the project impact on the health and wellbeing of people in Wales and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people, and the impact on the population in Wales.

How will the project impact on, or affect:	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Actions taken (and who by)
6.1 People being able to access the service offered.	We do not expect a potential negative, or unequal, impact on people's ability to access the service offered.	N/A	N/A
6.2 People being able to improve or maintain healthy lifestyles.	We do not expect a potential negative, or unequal, impact on people's ability to improve or maintain healthy lifestyles.	N/A	N/A
6.3 People in terms of their income and employment status.	We do not expect a potential negative, or unequal, impact on people in terms of their income and employment status.	N/A	N/A
6.4 People in terms of their use of the physical environment.	We do not expect a potential negative, or unequal, impact on people's use of the physical environment.	N/A	N/A
6.5 People in terms of social and community influences on their health.	We do not expect a potential negative, or unequal, impact on people in terms of social and community influences on their health.	N/A	N/A
6.6 People in terms of macro-economic, environmental and sustainability factors.	We do not expect a potential negative, or unequal, impact on people in terms of macroeconomic, environmental and sustainability factors.	N/A	N/A

7.0 Please fill in section 7.1 after completing the EqHIA, and fill in the action plan.

7.1 Please summarize the potential positive and/or negative impacts of the project.	We expect the guidance being developed to have a positive impact on the health and well-being of adults living in Wales, guiding best practice to support the identification and removal of penicillin allergy labels in patients who do not have a true hypersensitivity reaction.

Action plan for mitigation or improvement and implementation

	Action	Lead(s)	Timescale	Actions taken *(state who by)*
7.2 What are the key actions identified as a result of completing the EqHIA?	All related documents published on the AWTTC website will meet accessibility requirements. Any patient-facing materials will also be produced as easy-read booklets in Welsh and English.	AWTTC	Prior to publication	
7.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment needed?	No	N/A	N/A	N/A
7.4 What are the next steps?	Send to AWMSG for endorsement	AWTTC	May 2026	
7.5 Review of project and EqHIA	EqHIA will be reviewed at each stage of progression of the project and this info recorded in boxes above. All finished projects will be reviewed after a specified time, and the EqHIA will be reviewed at the same time.	AWTTC	Ongoing	

AWTTC's EqHIA template is adapted from the Cardiff & Vale University Health Board EHIA template.