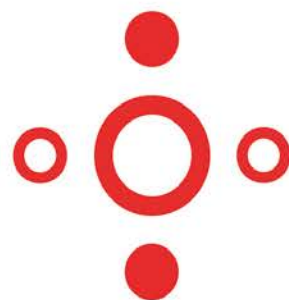


Grŵp Strategaeth Meddyginiaethau Cymru Gyfan  
All Wales Medicines Strategy Group



# Prescribing Dilemmas

## A Guide for Prescribers

February 2021

(July 2021 – Section 15.3 updated following a request for further information)

This document has been prepared by the All Wales Prescribing Advisory Group (AWPAG) with support from the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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## 1.0 INTRODUCTION

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This document provides guidance for health professionals regarding clinical responsibility, prescribing duration, foodstuffs, complementary medicines and alternative therapies, common ailments, fertility treatment, erectile dysfunction, prescribing for self and family, visitors from overseas, travel and occupational health vaccines, prescribing situations not covered by the NHS including private care and private prescriptions, unlicensed medicines, and prescribing outside national guidance.

The information has been collated from various resources including those produced by health boards and trusts, the General Medical Council (GMC) and Welsh Government.

Please note that throughout this document reference has been made to general practitioners (GPs); however, the comments should equally apply to non-medical prescribers who have responsibility for prescribing in the relevant areas.

## 2.0 CLINICAL RESPONSIBILITY

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Legal responsibility for prescribing lies with the prescriber who signs the prescription<sup>1</sup>. However, it should be noted that the British Medical Association (BMA) advises that “Independent prescribers are professionally responsible for their own actions. However, where a nurse prescribes as part of their nursing duties, the employer may also be held responsible”<sup>2</sup>. It is important that prescribers prescribe drugs or treatment, including repeat prescriptions, only when they have adequate knowledge of the patient’s health, and are satisfied that the drugs or treatment serve the patient’s needs<sup>3</sup>.

Non-medical independent prescribers (nurse/pharmacist/optometrist/physiotherapist/chiropract/podiatrist/therapeutic radiographer/paramedic) may prescribe for any medical condition within their area of competence.

Nurse independent prescribers and pharmacist independent prescribers in Wales can prescribe a controlled drug within their clinical competence on the same basis as other medical practitioners and dentists. Optometrists, therapeutic radiographers and paramedic independent prescribers cannot currently prescribe controlled drugs. Physiotherapist and chiropract/podiatrist independent prescribers can currently prescribe a limited list of controlled drugs. The prescribing rights of different professions have changed, and continue to change over time. For up-to-date advice please refer to the Pharmaceutical Services Negotiating Committee website<sup>4</sup>.

All prescribers are encouraged to report suspected adverse drug reactions using the Yellow Card reporting scheme<sup>5</sup>. The GMC states that you must report serious suspected adverse reactions to all medicines and all reactions to products marked with a Black Triangle in the BNF and elsewhere using the Yellow Card Scheme<sup>6</sup>.

At the interface between hospitals and GPs, ‘prescribing responsibility will continue to be based on clinical responsibility. This is good medical practice and is in the best interests of the patient’<sup>7</sup>. Systems should be in place to ensure such responsibility can be accepted, with health boards and local statutory organisations representing various health professionals, e.g. local medical committees (LMCs), working together to identify deficiencies in local arrangements and providing mutually acceptable solutions.

## 2.1 Patients on repeat prescriptions who do not consent to, or fail to attend for monitoring or medication review

Patients who do not consent to, or fail to attend for monitoring or follow-up can present a difficult dilemma for the prescriber who may feel pressurised to prescribe in an unsafe way. Involving patients in the decision-making process is very important at all stages of prescribing. Initial discussions using a shared decision approach when the repeat medication is started, outlining the risks involved and the importance of follow-up, is recommended.

When considering a patient who does not attend for monitoring it is important to be aware of the GMC guidance. The GMC '[Good Practice in Prescribing and managing medicines and devices](#)' states<sup>1</sup>:

[Paragraph 3](#) "You are responsible for the prescriptions you sign and your decisions and actions when you supply and administer medicines and devices or authorise or instruct others to do so. You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicines."

[Paragraph 55](#) "You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats<sup>2</sup> to reduce the need for repeat prescribing."

[Paragraph 51](#) "Whether you prescribe with repeats or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up and review, taking account of the patients' needs and any risks arising from the medicines."

It is important that the practice has a repeat prescription review policy that is followed. This should include guidance on setting appropriate review intervals and how to identify when reviews are due. For patients overdue a review, contact should be made with the patient requesting their attendance for review and an explanatory note attached to the patient's notes so other members of the practice team will be alerted. Communication may be made via standard letter or other method approved by the practice. If that fails and depending upon the risks involved, further approaches to the patient should be made.

GMC paragraph 51 states that "the prescriber needs to take into account the patients' needs and any risks arising from the medicines". The prescriber should therefore contact the patient to understand their concerns and difficulties (e.g. travel, work issue), assess the patient's capacity, and try to address any issues raised.

If these measures fail, the prescriber needs to consider the first rule of patient care "do no harm" and decide if continuing prescribing poses more harm to the patient than not prescribing. The prescriber should contact the patient outlining the risks of continued prescribing in absence of follow-up and either issue shorter prescriptions that the patient will be forced to collect or, depending on the risks, discontinue the medicine if they fail to attend within a given time limit.

In the event of a patient who does not attend for medication review, a team approach is recommended, involving the primary health care team. Community pharmacists may be able to improve patients' understanding of the need for clinical review of their medicines when carrying out a medication use review (MUR) or at the point of dispensing.

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\* Under the repeat dispensing system, the prescriber produces a master 'repeatable' prescription on a standard FP10 (WP10 in Wales) prescription form for the patient's repeat medicines. This is annotated to distinguish it from a standard prescription form and also gives details of how many instalments the prescription contains<sup>8</sup>.

## 2.2 Prescribing of Valproate in Females of Childbearing Age

Children born to women treated with valproate during pregnancy are at an increased risk of birth defects and developmental delay. Consequently, regulations around the prescribing of valproate to females of childbearing age have been strengthened. The Valproate Pregnancy Prevention Programme is a key feature of these [regulations](#)<sup>9</sup>.

Valproate should not be used in females of childbearing potential unless other treatments are ineffective or not tolerated. If a suitable alternative is not available, valproate can be used in females of childbearing potential provided the patient is enrolled and fulfils the conditions of the Pregnancy Prevention Programme. However, patients may not consent to the conditions of the Pregnancy Prevention Programme for personal, medical, religious or cultural reasons. 'Guidance Document on Valproate Use in Women and Girls of Childbearing Years' gives further information on the prescribing of valproate to female patients who have not agreed to the Pregnancy Prevention Programme through completion of an annual risk acknowledgement form<sup>10</sup>. Patients should be reviewed annually and have a completed risk acknowledgement form before receiving ongoing supplies.

## 2.3 Patient requests for medicines of limited benefit

Increasingly prescribers may be faced with patients requesting a treatment that the prescriber considers would not be of overall benefit to them. In such cases, the GMC advises, "If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion."<sup>11</sup>

## 3.0 PRIVATE REFERRAL

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A large number of patients opt to have some or all of their investigations and/or treatment privately. Some use private health insurance, whilst others are willing to pay to be seen more quickly, or for the added convenience or comfort of receiving their care in private facilities.

In addition to the increasing emphasis on patient choice within the NHS, it is also recognised that patients are entitled to choose whether they receive their treatment within the NHS or privately. There has been a blurring of the boundaries between NHS and private treatment, with patients switching freely between the two sectors.

Whilst administratively convenient but not always practical, treatment is defined by 'episodes of care', which may be either continuous or consist of a series of treatment and care episodes, some of which may be funded by the patient and some by the NHS.

### 3.1 Patients who request to be referred privately

Such patients are expected to pay the full cost of any treatment they receive in relation to the care provided privately; consultation fees, diagnostic tests, drugs prescribed or treatment provided by a clinician in the course of a private consultation should be at the patient's expense<sup>12</sup>. Patients should be informed of this expectation prior to referral.

### 3.2 Top-up payments

Top-up payments, where the patient typically pays to receive a medicine (e.g. a cancer drug which has not had National Institute for Health and Care Excellence [NICE] or All Wales Medicines Strategy Group [AWMSG] approval) but then returns to NHS care, may be seen as different to private care, where the patient pays for all ongoing treatment. There is no legal barrier to top-up payments for medicines not routinely funded for use in Wales; a letter was sent to health boards in March 2011 advising the adoption of the 'Improving the Availability of Medicines for Patients in Wales – Top-up

Payments' Implementation Group Report<sup>12</sup> recommendations. The 'Medicines Funding in the NHS' report recommends that patients opting for top-up treatment should not lose their entitlement to NHS treatment<sup>13</sup>. However, health boards have the power to charge for associated monitoring and care (excluding unpredictable events)<sup>12</sup>. There are also recommendations relating to procedural issues that should be considered when top-up treatment packages are introduced<sup>12</sup>.

## 4.0 PRIVATE PRESCRIPTIONS

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### 4.1 Following a private consultation

A private consultant (i.e. the person providing the private opinion, which may be a physician, dentist or other healthcare consultant) may see a patient privately in order to give an opinion to an NHS GP regarding diagnosis or further management. Alternatively, the consultant may treat a private patient for whom they will continue to have clinical responsibility and will personally determine the ongoing treatment for that particular condition. Until the consultant discharges the patient, this remains an episode of care. In this case, the consultant should prescribe privately for their private patient, and a GP may refuse to prescribe on the NHS in such a situation, as they do not have the clinical responsibility for managing that particular condition. Once the private episode of care is completed, a GP may consider providing an ongoing NHS prescription if required. Following completion of the episode of care, if the medicine is not on the health board formulary it would not be expected for the GP to provide an ongoing supply on an NHS prescription. Practitioners providing private treatment should keep this in mind when selecting treatment options. It is advisable that GPs inform patients of this possibility before referral and mention it in any referral letters. The GP must, however, continue to provide NHS treatment and prescriptions for other conditions for which they retain clinical responsibility<sup>13</sup>.

Exceptions to this (i.e. continuing to provide NHS treatment where they retain clinical responsibility) would be where prescribing a medication would be outside the competence of the prescriber, for example specialised medicines not suitable for prescribing in primary care, in which case the prescriber must make arrangements for appropriate care<sup>14</sup>; where the prescriber considers that the treatment would not be of overall benefit to the patient, in which case the prescriber must explain this to the patient and include the option to seek a second opinion<sup>15</sup>; or where the medication is generally not provided within the NHS (e.g. a drug listed under Part XVIII A of the NHS Drug Tariff<sup>16</sup>).

The GMC advises that it is good medical practice to “contribute to the safe transfer of patients between healthcare providers”, “share all relevant information with colleagues involved in your patient’s care” and “when you do not provide your patients’ care yourself... be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient”<sup>3</sup>. If the consultant considers that an emergency NHS prescription is required it is important that they contact the GP to share this information and to gain the agreement of the GP. Patients should be informed that unless it is an emergency prescription requests would be subject to the usual delay for routine prescription requests as specified by the practice.

For a specific condition, where a private consultant recommends a medication that is more expensive without good evidence that it is more effective than that recommended by the NHS, health board prescribing advice should be followed by the GP. This advice should be explained to the patient, who will retain the option of obtaining a private prescription from the consultant.

#### 4.2 For NHS patients

A GP may issue a private prescription for any item in circumstances where the medicine is not available on the NHS. These circumstances are where:

- The item is listed in [Schedule 1](#) of the National Health Service (General Medical Services Contracts) (Prescription of Drugs Etc.) (Wales) Regulations 2004 as amended (the so called “blacklist”)<sup>17</sup>. This list of products may also be found in part XVIII A of the NHS Drug Tariff<sup>16</sup>.
- The item is listed in [Schedule 2](#) of the National Health Service (General Medical Services Contracts) (Prescription of Drugs Etc.) (Wales) Regulations 2004 as amended (the so called Selected List Scheme “SLS list”) and where its use is for persons or purposes other than those specified in the Schedule<sup>17</sup>.
- The product is a travel vaccine, not included in current public health policy e.g. Tuberculosis, Japanese encephalitis vaccine, rabies vaccine, yellow fever vaccine (if at a yellow fever vaccination centre) (see [section 15.1](#)).
- The product is being prescribed in connection with travel and is for an anticipated condition (e.g. antibiotics for travellers’ diarrhoea or acetazolamide).
- The product is being prescribed for malaria chemoprophylaxis (see [section 15.2](#)).

#### 4.3 For a branded product

Where NHS policy recommends that a generic medicine is used and a patient requests the branded equivalent, a private prescription cannot be issued if the patient is being treated within the NHS, unless the product cannot be prescribed on the NHS as specified above in the “blacklist”.

Whilst issuing an NHS prescription for patients who request a branded equivalent is not prohibited, practices should be aware that as a guiding principle, it is appropriate to prescribe the most cost effective medication for a patient<sup>18</sup>. Consistent prescribing of excessive amounts of high cost products where no clinical justification exists could be considered an example of inappropriate or excessive prescribing as stated in the GMS contract [Schedule 6, Part 3, paragraph 46](#)<sup>19</sup>.

### 5.0 PRESCRIBING OF MEDICINES FOR AN UNLICENSED USE

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The GMC defines ‘unlicensed medicines’ as medicines used outside the terms of their UK licence (marketing authorisation) (sometimes referred to as ‘Off Label’ use<sup>13</sup>) or which have no licence (marketing authorisation) for use in the UK<sup>20</sup>. However, there may be different considerations when prescribing off-label or unlicensed medicines as outlined by Aronson and Ferner (2017)<sup>21</sup>.

For non-medical independent prescribers, the distinction between these is particularly significant, as certain prescribing restrictions apply to medicines for which there is no UK marketing authorisation (unlicensed medicines).

- Pharmacist and nurse independent prescribers are able to prescribe unlicensed medicines subject to good clinical practice.
- Physiotherapist, chiropodist/podiatrist, optometrist, therapeutic radiographer and paramedic independent prescribers are only able to prescribe “off-label” medicines, and not those without UK marketing authorisation.

The prescribing rights of different professions have changed, and continue to change over time. For up to date advice please refer to the [Pharmaceutical Services Negotiating Committee website](#)<sup>4</sup>.

Although prescribing unlicensed medicines is not recommended, the GMC states that “you may prescribe unlicensed medicines where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient”<sup>20</sup>.

The following extract is from the GMC 'Good practice in prescribing and managing medicines and devices' (2013)<sup>20</sup>:

*"When prescribing an unlicensed medicine you must:*

- a. be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy.*
- b. take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow-up treatment, or ensure that arrangements are made for another suitable doctor to do so.*
- c. make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine"*<sup>20</sup>.

**Points for consideration:** (See GMC guidelines for full version<sup>20</sup>)

Prescribing unlicensed medicines may be necessary where:

- a. There is no suitably licensed medicine that will meet the patient's need.
- b. A suitably licensed medicine is not available.
- c. The prescribing forms part of a properly approved research project<sup>20</sup>.

### **Information for patients**

- a. You must give patients (or their parents or carers) sufficient information about the medicines you propose to prescribe to allow them to make an informed decision.
- b. Some medicines are routinely used outside the terms of their licence, for example in treating children. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population. You must always answer questions from patients (or their parents or carers) about medicines fully and honestly.
- c. If you intend to prescribe unlicensed medicines where that is not routine or if there are suitably licensed alternatives available, you should explain this to the patient, and your reasons for doing so.
- d. You should be careful about using medical devices for purposes for which they were not intended<sup>20</sup>.

Leaflet for unlicensed use of medications in children:

[www.medicinesforchildren.org.uk/unlicensed-medicines](http://www.medicinesforchildren.org.uk/unlicensed-medicines)

## **6.0 PRESCRIBING OUTSIDE NATIONAL GUIDANCE**

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NHS Wales prescribing advice is based on a rigorous decision-making process taking into account clinical and cost effectiveness. AWMSG advice has no impact on the licensed status of the technology and the inherent implications associated with this. A negative recommendation will not impact on the clinical freedom of the prescriber. However a positive recommendation by AWMSG, subsequently endorsed by Welsh Government, places an obligation on Health Boards to fund accordingly. AWMSG advice is interim to NICE guidance, should this be subsequently published. A prescriber must ensure the decision to prescribe a medication is made with consideration of patient equity and must be responsible, appropriate and in line with current prescribing practice for NHS Wales patients in accordance with AWMSG, NICE, and local formulary advice. Whilst issuing a WP10 in circumstances which fall outside of the national/local recommendations is not prohibited, practices should be aware that this could be considered an example of inappropriate or excessive prescribing as stated in the GMS contract<sup>22</sup>.

Medicines associated with a statement of advice in relation to the AWMSG appraisal process “cannot be endorsed for use” and therefore should not be prescribed routinely within NHS Wales<sup>23</sup>. Healthcare professionals should make clinical decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer and informed by the Summary of Product Characteristics of any medicine they are considering<sup>23</sup>.

National and local guidance will often clarify what prescribers should do for identified individuals, e.g. who to immunise against influenza. Prescribers may make a decision, on a case-by-case basis, to prescribe outside any national guidance or programme if there is a compelling clinical reason to do so.

If the case is made to immunise outside of the national programme, this is a GMS service. GPs should not offer their registered patients a private service.

## 7.0 PRESCRIBING DURATION

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People that are stabilised on their medicines and are suitable for longer prescribing intervals can be considered for repeat dispensing (28-day prescriptions for 6–12 months)<sup>24</sup>. The British Medical Association (BMA) notes that “Prescribing intervals should be in line with the medically appropriate needs of the patient, taking into account the need to safeguard NHS resources, patient convenience, and the dangers of excess drugs in the home.”

A 28-day repeat prescribing interval has been broadly recommended to synchronise medication repeat prescriptions, and reduce errors when medicines are stopped or changed. However, discretion should be used for individual patients or medicines, where a different duration may be appropriate<sup>2,24</sup>, and which may include patients with stable chronic conditions being treated in primary care<sup>25</sup>. This should be coupled with a rigorous and effective medication review process<sup>24</sup>. For controlled drugs listed in schedules 2, 3 and 4 of the Misuse of Drugs Regulations it is strongly recommended that prescriptions do not exceed 30 days<sup>26</sup>.

## 8.0 PRESCRIBING OF BORDERLINE FOODS AND DIETARY PRODUCTS

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In certain conditions some foods (and toilet preparations) have characteristics of drugs and the Advisory Committee on Borderline Substances (ACBS) advises as to the circumstances in which such substances may be regarded as drugs<sup>27</sup>.

Prescribing of borderline foods and dietary products should comply with the recommendations of the ACBS: ACBS recommends products on the basis that they may be regarded as drugs for the treatment of specified conditions. Prescribers should satisfy themselves that the products can be safely prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available<sup>27</sup>.

A complete list of products can be found in the British National Formulary (BNF)<sup>26</sup> or Part XV of the NHS Drug Tariff<sup>27</sup>. Most of the conditions for which they can be prescribed fall into the following categories:

- dysphagia
- gastrectomy
- inflammatory bowel disease
- liver disease
- malabsorption states
- malnutrition (disease-related)

- metabolic disorders
- renal failure
- specific skin disorders.

There are several areas where prescriptions for dietary products do not comply with the above recommendations, and the responsibility lies with individual GPs who may use their judgement to make exceptions to the above recommendations. This may occur following recommendations from a dietician, or for a medical condition requiring nutritional support for a defined period of time. An example of the latter would be a patient having had maxillofacial surgery, being discharged from hospital with a wired jaw and requiring nutritional support for six to eight weeks post-operation. Such a patient would be unlikely to receive adequate nutrition from a manageable volume of liquidised foodstuffs.

GPs are strongly advised against prescribing dietary products for patients (including in nursing or residential homes) outside the uses listed in this section, and using them as an alternative to liquidising/purchasing appropriate food.

AWMSG has resources to support [Prescribing Gluten-free Products](#) the [Prescribing and Supply of Sip Feeds](#), and [Vitamins for Babies, Children, and Pregnant and Breastfeeding Women](#). Advice on the use of vitamins and minerals is also available in the document [Items Identified as Low Value for Prescribing in NHS Wales – Paper 3](#).

## 9.0 COMPLEMENTARY MEDICINE AND ALTERNATIVE THERAPIES

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Complementary and alternative therapies include, but are not limited to:

- acupuncture
- Alexander technique
- aromatherapy
- herbal medicine
- homoeopathy
- hypnosis
- massage
- nutritional therapy
- reflexology.

Public Health Wales publication 'Complementary Therapies and Alternative Medicines' (2012) stated:

*"Complementary medicines/alternative therapies are generally NOT used by the NHS. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. On existing available evidence the LHB will not support referral outside of the NHS for these services. Prior approval is required on a case by case basis for any requests outside the above criteria. The request for referral would need to be supported by evidence of the clinical effectiveness of the treatment and be to appropriately trained and qualified practitioners with recognised qualifications."*<sup>28</sup>

*"The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up-to-date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of the NHS library."*<sup>28-30</sup>

Please note physiotherapists can decide to use certain alternative therapies (acupuncture, Alexander Technique, massage) as part of their NHS treatment plan if they consider it appropriate.

### 9.1 Herbal Medicines

Prescribers should be aware of patients taking herbal medicine. An IPSOS Mori poll in 2009 found 35% British adults have used herbal medicines<sup>31</sup>, and a separate study in 2011 suggested this was true of 19.7% of patients with cancer<sup>32</sup>. NICE have stated that prescribers should “be aware that some people may wish to try the following self-care treatments, which have limited evidence of some benefit for the relief of cough symptoms:... pelargonium (a herbal medicine; in people aged 12 and over)”<sup>33</sup>. Since 2004 the [MHRA](#) have licensed manufactured herbal medicines that can be purchased over the counter using the Traditional Herbal Registration (THR) scheme. The licensing process ensures the purity and safety of the herbal medicine but differs from conventional licensing in that evidence of efficacy is based on 15-30 years of traditional use (see [Herbal medicines granted a traditional herbal registration](#)). The summary of product characteristics for the different herbal preparations that have been granted a THR license can be found at [MHRA webpage](#). The European Medicines Agency (EMA) has developed [monographs](#) on herbal medicines, and prescribers should consider using either the [MHRA](#) or [EMA](#) sites to check on any herbal medicines patients are taking.

### 9.2 Homeopathy

Homeopathy isn't widely available on the NHS. In 2017, NHS England recommended that GPs and other prescribers should stop providing it. This is because they found "no clear or robust evidence to support the use of homeopathy on the NHS.

## 10.0 COMMON AILMENTS

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From 1 April 2007, prescription charges for drugs and appliances no longer applied in Wales. However, the Minister for Health and Social Services, Welsh Government, advised:

*“While [free prescriptions] will benefit everyone who currently pays for prescriptions in Wales, it should particularly benefit those people on modest incomes or who have chronic illnesses who may not have previously been eligible for free prescriptions under the complicated exemption system.*

*“This is the simplest and most effective way of resolving health inequalities and those inconsistencies in prescribing. The move removes all the unfairness surrounding the present outdated 1968 exemption system where, for example, a diabetes patient automatically gets all prescriptions free but a cystic fibrosis sufferer doesn't.*

*“It must be stressed though that the free prescription policy aims to provide medication for free that is only available with a prescription. Where patients already buy non-prescription medication over the counter they should continue to do so in the normal way. If patients change their behaviour radically this could have a detrimental impact on the NHS as a whole and indirectly on those patients who are in most need of the free prescriptions.”<sup>34</sup>*

The GMC advises that prescribers “should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs”<sup>11</sup>. Declining patient requests from the outset may deter patients from making similar future demands (e.g. requests for simple analgesia or for antibiotics for viral infections).

The community pharmacy Common Ailments Service provides NHS treatment and advice to patients for a number of common ailments, using the [Common Ailments Formulary](#), and is available to any patient registered with a Welsh GP.

## 11.0 FERTILITY TREATMENT

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There are three providers of specialist fertility services for Welsh patients. These are:

- Liverpool Women's NHS Foundation Trust
- Shropshire and Mid Wales Fertility Centre at Shrewsbury Hospital
- Wales Fertility Institute at Neath Port Talbot Hospital and Wales Fertility Institute at University Hospital Wales, Cardiff

It is not expected that GPs will prescribe treatments for these specialist fertility centres. For information on interface prescribing and private prescriptions, please see sections [2](#) and [4](#).

The latest policy in Wales for [Specialist Fertility Services](#) was issued by the Welsh Health Specialised Services Committee (WHSSC) in January 2017 and applies to residents of all seven health boards in Wales<sup>35</sup>. The document sets out the circumstances under which patients will be able to access specialist fertility services, clarifies the referral process, and defines the criteria that patients must meet in order to access treatment. The document also includes a generic referral form.

The criteria for treatment in this policy are as follows:

### **Female age**

*Criteria – Due to the associated risks with teenage pregnancies patients will need to be at least 20 years old to access IVF treatment. Women who are aged less than 40 years and who meet the access criteria are entitled to two cycles of in vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI). However, if the woman reaches the age of 40 during the first cycle of treatment they will not be entitled to a second cycle of IVF.*

*Women aged between 40 and 42 years (up to their 43<sup>rd</sup> birthday) who meet the access criteria are entitled to one cycle of IVF with or without ICSI provided the following three criteria are also fulfilled:*

- *They have never previously had IVF treatment.*
- *There is no evidence of low ovarian reserve.*
- *There has been a discussion of the additional implications of IVF and pregnancy at this age.*

### **Male age**

*Criteria – Men must be aged 55 years or younger in order to access IVF treatment.*

### **Existing children**

*Criteria – IVF on the NHS is available for:*

- (1) couples where one of the partners does not have any living children (biological or adopted)*
- (2) single women or men who do not have any living children (biological or adopted)*

### **Body mass**

*Criteria – Women accessing IVF treatment must have a body mass index (BMI) of between at least 19 and up to and including 30. Female patients with a BMI below 19 that are ovulating normally may be treated at the discretion of the treating clinician. Patients outside this range will not be added to the waiting list and should be referred back to their general practitioner for management where required.*

*Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility.*

### **Sterilisation**

*Criteria – Subfertility is not the result of a sterilisation procedure in either partner/single woman/single man (this does not include conditions where sterilisation occurs as a result of another medical problem). Couples/single women/single men who have undertaken a reversal should not be referred for treatment.*

### **Smoking**

*Criteria – Where either of the couple/single woman/single man smokes the patient is not eligible. Only patients who agree to take part in a supported programme of smoking cessation will be accepted on the IVF treatment waiting list and must be non-smoking at time of treatment.*

### **History of previous treatment**

*Criteria – For single patients, three or more IVF cycles by the patient will exclude any further NHS IVF treatment. For couples, three or more IVF cycles by either partner will exclude any further NHS IVF treatment. Previous cycles whether NHS or privately funded will be taken into account.*

### **Subfertility**

*Criteria – Subfertility must be demonstrated before there can be access to NHS funded IVF treatment. Subfertility for heterosexual couples is defined as inability to conceive after 2 years unprotected intercourse or a fertility problem demonstrated at investigation. Subfertility for same sex couples/single women/single men is defined as no live birth following insemination at or just prior to the known time of ovulation on at least six non-stimulated cycles or a fertility problem demonstrated at investigation.*

*For same sex couples/single women/single men, the non-stimulated cycles may be achieved through a private arrangement or through NHS-provided IUI with donor sperm. Intra-uterine insemination (IUI) is not funded by WHSSC. Funding for IUI is the responsibility of the health boards. Where donor sperm is needed to undertake IUI, the donated sperm will be funded by WHSSC, but not the IUI procedure.*

*In women aged 40–42 years there is also no evidence of low ovarian reserve.*

### **HFEA**

*Criteria – Patients not conforming to the Human Fertilisation and Embryology Authority (HFEA) Code of Practice will be excluded from having access to NHS funded assisted fertility treatment.*

### **Change of Partner whilst waiting for IVF treatment**

*Criteria – If a couple consent to treatment but during the waiting period for treatment the couple break up then treatment cannot commence. If one or both of the partners wish to proceed with treatment with either a new partner or by themselves then the clinic that is providing the treatment needs to be notified. The new couple/individual will need to attend a consultation where the fertility history of the couple/individual needs to be reviewed, treatment options explained and discussed and if the couple/individual still meet the eligibility criteria consent to proceed with treatment.*

### **IVF for veterans**

*Criteria – Armed Forces Personnel who have become infertile as a result of military action and are Armed Forces Compensation Scheme (AFCS) recipients are entitled to three full cycles of IVF treatment. All applications for this should be forwarded to Welsh Health Specialised Services via the All Wales IPFR process for consideration in line with guidance from the Independent Medical Expert Group.*

## 12.0 MEDICINES FOR THE TREATMENT OF ERECTILE DYSFUNCTION

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### 12.1 Treatment of erectile dysfunction

The information in this section relates to the prescribing of medicines for the treatment of erectile dysfunction in Wales. The regulations governing the NHS prescribing of these and other medicines differ between Wales and England. The relevant regulations in Wales are the National Health Service (General Medical Services Contracts) (Prescription of Drugs Etc.) (Wales) Regulations 2004 as amended, [Schedule 2](#) of which lists a number of medicines, which can be used only in specified circumstances<sup>17</sup>. Schedule 2 of the regulations is reproduced in Part XVIII B of the NHS Drug Tariff.

Alprostadil, sildenafil, tadalafil or vardenafil can be prescribed for the treatment of erectile dysfunction on NHS prescription in the following circumstances:

- A man who is suffering from any of the following:
  - diabetes\*
  - multiple sclerosis
  - Parkinson's disease
  - poliomyelitis
  - prostate cancer
  - severe pelvic injury
  - single-gene neurological disease
  - spina bifida
  - spinal cord injury.
- A man who is receiving treatment for renal failure by dialysis.
- A man who has had the following surgery:
  - prostatectomy
  - radical pelvic surgery
  - renal failure treated by transplant.
- A man who has been diagnosed as suffering severe distress resulting from erectile dysfunction where the assessment has been made by a specialist service or GP under arrangements made with a health board to provide such assessments.

Prescriptions must be endorsed 'SLS' (generic sildenafil should continue to be endorsed 'SLS' in Wales).

\*Note that the Association of British Clinical Diabetologists (ABCD) and the Primary Care Diabetes Society (PCDS) provide [advice](#) relating to the read coding of diabetes in remission<sup>36</sup>.

For full advice on preparations available for patients with erectile dysfunction and restrictions see the 'In Wales' section in Part XVIII B of the [Drug Tariff](#).

Additionally, men receiving a course of NHS drug treatment for erectile dysfunction on 14 September 1998 will continue to be eligible to receive treatment from their GP<sup>37</sup>.

Prescribing guidance relating to men whose impotence is causing severe distress has been updated in Wales, with AWMSG making the following recommendations<sup>38,39</sup>:

- *For patients who have been assessed as suffering from severe distress as a result of erectile dysfunction, guidance is amended to remove the restriction of specialist service supply, enabling GPs to prescribe the medication [for this indication].*
- *The assessment of severe distress resulting from erectile dysfunction may be undertaken by GPs or specialist teams. All health boards should have clearly defined commissioning arrangements for this assessment. A commissioned,*

*specialist-led service will support equality of access to therapy and minimise conflict in the doctor–patient relationship.*

- *Once-daily preparations should only be considered in patients who anticipate frequent use of single-dose preparations (i.e. at least twice-weekly). This should be based on the clinician’s judgement<sup>38</sup> [and in accordance with local formulary advice].*

The following criteria should be considered when assessing severe distress:

- Significant disruption to normal social and occupational activities;
- A marked effect on mood, behaviour, social and environmental awareness;
- A marked effect on interpersonal relationships<sup>38</sup>.

It should be noted that any patient who does not adhere to a category may have the treatment prescribed privately<sup>38</sup>.

The frequency of treatment will need to be considered on a case-by-case basis, but prescribers may find it helpful to bear in mind that the average frequency of sexual intercourse in the 40–60 years of age range has been estimated as once a week. Prescribers may also wish to bear in mind that some treatments for impotence have been found to have a ‘street value’ for men who consider, rightly or wrongly, that these treatments will enhance their sexual performance. Excessive prescribing could therefore lead to unlicensed, unauthorised and possibly dangerous use of these treatments<sup>37</sup>.

In 1999 the National Assembly for Wales (now the Welsh Parliament or Senedd) advised prescribers that one treatment a week is appropriate for most patients treated for erectile dysfunction<sup>37</sup>. If the GP, in exercising clinical judgement, considers that more than one treatment a week is appropriate, they should prescribe that amount on the NHS<sup>37</sup>; the GP should not write a private prescription.

## **12.2 Use in management of other clinical conditions**

Where a medicine has a UK or EU marketing authorisation both for the treatment of erectile dysfunction and for the treatment of another clinical condition, the medicine may only be prescribed for the treatment of erectile dysfunction in the circumstances described in 12.1. However, it may be prescribed to any patient for the treatment of any other clinical condition provided the product’s UK or EU marketing authorisation is also for that use.

## **13.0 PRESCRIBING FOR ONESELF OR FAMILY**

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The GMC states that ‘wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship’<sup>1</sup>. Ideally, doctors, family and staff from a practice should be registered with, and treated by, another practice. This gives the doctor and their family members access to objective advice and avoids the conflicts of interest that can arise when doctors treat themselves or those close to them.

The following guidance applies to all prescribers, not just GPs.

The GMC states:

- *Controlled medicines present particular dangers, occasionally associated with drug misuse, addiction and misconduct. You must not prescribe a controlled medicine for yourself or someone close to you unless:*
  - *no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient’s, life or health at risk or cause unacceptable pain or distress, and*

- *the treatment is immediately necessary to:*
  - *save a life*
  - *avoid serious deterioration in health, or*
  - *alleviate otherwise uncontrollable pain or distress.*
- *If you prescribe for yourself, or someone close to you, you must:*
  - *make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe.*
  - *tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object<sup>20</sup>.*

## 14.0 VISITORS

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### 14.1 Visitors from overseas

Overseas visitors who are entitled to NHS treatment in primary care include, but are not limited to:

- A person intending to be resident in this country for six months or more (registration with a practice is necessary).
- Patients from within the European Economic Area in possession of a European Health Insurance Card (EHIC).
- Patients who require immediate, essential treatment, which the treating doctor deems cannot reasonably be delayed until the patient returns home (EHIC not required).
- Patients holding an S2 form (previously an E112) for specific treatment of a particular condition (and prescriptions for this condition only).
- Patients allocated by the health board.
- Refugees (those whose applications to reside in this country have been approved) and asylum seekers (those who have submitted an application and are awaiting a decision).

This list contains the most common categories, but prescribers should check an individual's situation before providing or declining NHS care as special conditions may apply.

Patients who do not fall into these categories may be offered and charged for private care, including the provision of private prescriptions where necessary. Further advice for GPs on overseas visitors accessing NHS primary medical services is available from the [Overseas Visitors and the NHS](#) section of the NHS Wales website.

Where appropriate, patients should be encouraged to register, permanently or as temporary residents, with a general practice to receive NHS care.

### 14.2 Temporary patients

In line with the terms of The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004, any person requiring emergency necessary treatment can receive this from any GP if they have been in the practice area for a period of less than 24 hours ([Part 5, Regulation 15](#))<sup>19</sup>. Patients intending to reside in an area for more than 24 hours but fewer than three months should register as a temporary patient ([Schedule 6, Paragraph 16](#))<sup>19</sup>. Patients intending to reside in an area for more than three months should register with a GP at their new address as soon as possible.

Visitors are not encouraged to register as temporary patients simply to facilitate an ongoing supply of a repeat prescription. In an emergency, visitors can access the Emergency Medicines Supply service from a community pharmacy via the Choose Pharmacy platform. Alternatively, their own GP may be able to provide a prescription directly to a community pharmacy for dispensing.

Advice relating to repeat prescribing for temporary residents during the Covid pandemic can be found at: <https://gov.wales/getting-medicines-during-coronavirus-pandemic#section-43563>.

## 15.0 TRAVEL ABROAD

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Under NHS legislation, the NHS ceases to have responsibility for people when they leave the UK. For patients intending to be away from the UK for a period of at least three months, the health board can remove them from the contractor's list of patients as specified in the NHS General Medical Services Contracts Regulations ([Schedule 6, Paragraph 25](#))<sup>19</sup>. However, to ensure good patient care, the following guidance is offered.

Following Brexit, healthcare provisions akin to those provided by the European Health Insurance Card (EHIC) will continue. If an EHIC is still in date, it will remain valid for travel to an EU country. If an EHIC has expired, a new UK Global Health Insurance Card (GHIC) should be applied for. Patients should be advised that neither the EHIC nor the new GHIC is a replacement for travel insurance, and that they should have both in place prior to travel. Patients are advised to check specific details on the [UK Government website](#).

Guidance for GPs on risk assessment for travellers and appropriate advice is available from the [NaTHNaC](#) website<sup>40</sup>.

Medication required for a pre-existing condition should be provided in sufficient quantity to cover the journey and to allow the patient to obtain medical attention abroad. If the patient is returning within the timescale of a normal prescription (usually one and no more than three months) then this should be issued, providing it is clinically appropriate.

Patients carrying certain prescribed medication for their own personal use may require a doctor's letter or a personal licence<sup>40</sup>. This will depend on the duration of travel, the type of medicine (e.g. codeine, Sativex<sup>®</sup>) and the country of travel. More information on the carrying of prescribed controlled drugs abroad for personal use is covered in [section 15.3](#). Patients who require over-the-counter (OTC) medicines should check that the medicine is available OTC in the country of destination<sup>41</sup>.

For longer visits abroad (e.g. more than three months), the patient should be advised to register with a local doctor in the destination country for continuing medication; this may need to be paid for by the patient. It is wise for the patient to check with the manufacturer that medicines required are available in the country being visited.

GPs are not required to provide prescriptions for medication that is requested solely in anticipation of the onset of an ailment whilst outside the UK, but for which treatment is not required at the time of prescribing (e.g. travel sickness, diarrhoea). Patients should be advised to purchase these items in the UK prior to travel; advice is available from community pharmacists if required. A private prescription may be provided for any prescription-only medicines if deemed appropriate and necessary, such as ciprofloxacin for traveller's diarrhoea (for use outside Asia). Patients should be advised about the appropriate use of self-medication and when they would need to seek medical attention abroad.

Travellers should consider carrying a personal emergency medical travel kit tailored to their needs and their travel destination (advice on what to include is available from the [NaTHNaC](#) website). There are occasions where the traveller may wish to include prescription-only medicine (POM) items including plasma substitutes in their personal emergency medical travel kit. A private prescription is required for the former.

### 15.1 Immunisation for travel abroad

*Immunisation against infectious disease* (The Green Book)<sup>42</sup> gives recommendations for the use of vaccines, but does not identify those that are recommended to be NHS funded (see Appendix 1 for further information on NHS versus private supply options). Where no remuneration is available, either via the GMS contract or a local enhanced service for individual vaccines, NHS prescribing is generally discouraged in line with the intent of regulations, which enable GPs to charge their own patients for some immunisations requested/advised for the protection of their health when travelling abroad.

Immunisations that are reimbursable under the GMS contract must be provided free of charge to registered patients who require them<sup>43</sup>. These travel vaccines include (see [BMA](#) for further information):

- Hepatitis A
- Combined hepatitis A and B
- Typhoid
- Combined hepatitis A and typhoid – first dose (second dose is with Hepatitis A alone)
- Tetanus, diphtheria and polio as given in the combined Td/IPV vaccine
- Cholera
- Paratyphoid
- Smallpox<sup>43</sup>.

A number of other travel-related vaccines, including hepatitis B and meningococcal A, C, W135 and Y vaccine, are not remunerated by the NHS as part of additional services, although the vaccine costs may be reimbursable. The regulations do not impose any circumstances or conditions as to when these immunisations should be given on the NHS or as a private service<sup>43</sup>. Charging for these is at the discretion of each general practice. General Practitioners Committee (GPC) guidance states that:

*“This causes confusion, and the ambiguity stems from the regulations regarding the charging of patients that are registered with the practice. [Schedule 5 of The National Health Service \(General Medical Services Contracts\) Regulations 2004](#) states that: ‘The contractor may demand or accept a fee or other remuneration for treatment consisting of an immunisation for which no remuneration is payable by the [Local Health Board] and which is requested in connection with travel abroad’*

*This wording leaves the decision as to whether the practice levies a charge or not to the discretion of the practice, rather than the [health board].”<sup>44</sup>*

In the case of hepatitis B vaccination, which is also available as a combination product, the practice may charge any patient a private fee for hepatitis B for travel, as long as it is not combined with hepatitis A, which must be given on the NHS<sup>44</sup>. For more information on hepatitis B vaccination, see section [16.1](#).

The following travel immunisations are not generally prescribed as part of an NHS service nor are they remunerated by the NHS if given for pre-exposure to travel:

- Japanese encephalitis
- meningitis vaccines
- rabies
- tuberculosis

- tick-borne encephalitis
- yellow fever<sup>43</sup>.

Practices may charge for both the prescription and the administration of these vaccines at their discretion<sup>17</sup>.

No charge should be made to any NHS patient of the practice for providing advice.

### 15.2 Malaria chemoprophylaxis

There is no NHS Regulation that prevents a GP prescribing drugs for the prevention of malaria at NHS expense. However, Welsh Office guidance in 1995 encouraged general practitioners to prescribe privately<sup>45,46</sup>. A GP may provide medicines for malaria chemoprophylaxis via a private service and charge the patient for prescription and/or the supply of medication (pharmacy ['P'] medicines and POMs).

Patients can purchase 'P' medicines for malaria chemoprophylaxis directly from the community pharmacy. Local community pharmacists also have access to up-to-date advice regarding appropriate prophylactic regimes and can advise travellers accordingly.

Patients should be advised to purchase sufficient prophylactic medicines to cover the recommended period before travel, during time in the endemic area and after leaving the endemic area. Patients are advised to commence treatment one week before departure and continue treatment for four weeks after leaving the endemic area<sup>26</sup>.

Exceptions are:

- mefloquine (Lariam<sup>®</sup>), for which prophylaxis should be started 2–3 weeks before travel to the endemic area so that if adverse events occur there will be time to switch to an alternative<sup>47</sup>,
- proguanil/atovaquone (Malarone<sup>®</sup>), for which prophylaxis should be started 1–2 days before travel to the endemic area and stopped one week after leaving the endemic area<sup>47</sup>,
- doxycycline, for which prophylaxis should be started 1–2 days before travel to the endemic area<sup>47</sup>.

The importance of mosquito nets, suitable clothing and insect repellents to protect against being bitten should be stressed. Travellers should be directed to the Public Health England document: [Guidelines for malaria prevention in travellers from the United Kingdom 2019](#)<sup>47</sup>.

Remember the four steps to prevent suffering from malaria in UK travellers:

- **Awareness:** know about the risk of malaria.
- **Bites by mosquitoes:** prevent or avoid.
- **Compliance** with appropriate chemoprophylaxis.
- **Diagnose** breakthrough malaria swiftly and obtain treatment promptly.

### 15.3 Controlled drugs: implications for patients

Department of Health guidance recommends that, in general, prescriptions for controlled drugs in Schedules 2, 3 and 4 should be limited to a supply of up to 30 days treatment. Exceptionally (to cover a justifiable clinical need and after consideration of any risk) a prescription can be issued for a longer period, but the reasons for the decision should be recorded in the patient's notes<sup>26</sup>.

Patients who are travelling for fewer than 3 months and carrying fewer than 3 months' supply of prescribed controlled drugs listed under Schedules 2, 3, 4 Part I and 4 Part II to The Misuse of Drugs Regulations 2001, will not need a personal import or export licence to enter or leave the United Kingdom<sup>48</sup>. They should carry a letter from the prescribing doctor with the carrier's name, travel itinerary, names of prescribed controlled drugs, dosages and total amounts of each to be carried<sup>48</sup>.

Additionally, it is always advisable to contact the Embassy, Consulate or High Commission of the country to be visited regarding their policy on the import of controlled drugs, as the legal status of controlled drugs varies between countries. Controlled drugs should be:

- carried in original packaging;
- carried in hand luggage (airline regulations permitting);
- carried with a valid personal import/export licence (if necessary; see below).

Persons travelling abroad (or visitors travelling to the UK) in excess of three months and carrying controlled drugs, or carrying more than three months' supply of controlled drugs, will require a personal export or import licence<sup>48</sup>. A personal licence has no legal standing outside the UK and is intended to assist travellers passing through UK customs controls with their prescribed controlled drugs. Travellers are advised to contact the Embassy, Consulate or High Commission of the country of destination (or any country through which they may be travelling) regarding the legal status and local policy on the importation of controlled drugs<sup>49</sup>.

Prescribers are reminded of the guidance relating to controlled drug prescription duration above, and guidance provided in Section 15.0 relating to provision of an NHS prescription for patients travelling abroad:

Medication required for a pre-existing condition should be provided in sufficient quantity to cover the journey and to allow the patient to obtain medical attention abroad. With regard to supplies of controlled drugs, the BNF advises that, "*The Department of Health and the Scottish Government have issued a strong recommendation that the maximum quantity of Schedule 2, 3 or 4 Controlled Drugs prescribed should not exceed 30 days; exceptionally, to cover a justifiable clinical need and after consideration of any risk, a prescription can be issued for a longer period, but the reasons for the decision should be recorded on the patient's notes.*"<sup>26</sup>

#### 15.4 Medical tourism

In 2010 over 60,000 residents of the UK travelled abroad for medical treatment, despite the fact that the medical tourism industry is almost entirely unregulated, and has potential risks for those travelling out of the UK<sup>50</sup>. Costs of managing complications of cosmetic surgery received abroad may be significant. One study identified that the average cost for surgical treatment of patients with complications was \$16,292 per patient, with complications from abdominoplasty resulting in the highest average cost per patient of \$20,404<sup>51</sup>. Taking into account the exchange rate at the time of publication (August 2020), this would be equivalent to over £12,000 and over £15,000, respectively.

The National Institute for Health Research (NIHR) Health Services and Delivery Research programme-funded study "Implications for the NHS of inward and outward medical tourism: a policy and economic analysis using literature review and mixed-methods approaches" found that patients lacked consistent information on possible complications, long-term consequences of surgery and the maintenance requirements. The study concluded that there was a need for better information and a full understanding of risks amongst this group of medical tourists before they travel. Of the 13 bariatric patients interviewed, all had been in contact with the NHS before making their decision to travel for treatment. It is therefore important that practitioners take this opportunity to inform patients of the risks. Information for patients is available from the [Royal College of Surgeons](#) and the [British Association of Plastic Reconstructive and Aesthetic Surgeons](#).

When discussing treatment with patients, practitioners should ensure that patients are either offered any necessary aftercare services in the UK by their overseas provider, or, if this is not in place, patients should contact a consultant who can provide private care in the UK to provide any medications that are required post-operation and also

further follow-up. The British Association of Plastic Reconstructive and Aesthetic Surgeons advises that the NHS will provide emergency care for life threatening conditions, but will not usually fund treatment for less serious complications or for poor outcomes<sup>52</sup>.

## 16.0 VACCINES FOR OCCUPATIONAL HEALTH PURPOSES

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The provision of vaccines for occupational health reasons is the responsibility of the employer and not the patient's GP (unless private contractual arrangements have been made between the practice and the employer). The employer (not the patient) will have to make private arrangements for administration of the vaccine(s). This may be with a GP practice, an occupational health provider, or another provider such as a community pharmacy.

### 16.1 Hepatitis B vaccine

**Occupation** – Hepatitis B vaccinations for occupations as listed in the Green Book<sup>42</sup> and BNF<sup>26</sup> should normally be provided by the employer via their own occupational health provider or via private agreement with a practice. Categories are:

- NHS General Dental Practice employees\*
- Primary care employees†
- Other occupational groups considered at risk‡. These include:
  - NHS Trust, private and charity health workers,
  - nursing home and old peoples' home staff,
  - prison staff, police, ambulance officers, morticians and embalmers.

Special consideration may need to be given to a patient who is at risk where the employer refuses to provide the intervention, or no occupational health service is available.

There are occasions where the vaccine is for occupational health reasons and the patient is from a group of patients identified as 'at risk'; it is then the responsibility of the GP to provide the vaccine if necessary and appropriate. See *'At risk' patients* below.

**Students** – Prospective and current students of healthcare (e.g. medical, nursing, dental students) should be vaccinated by their educational organisation<sup>44</sup> and not in general practice, as, practically, the provision of vaccination might include prior blood screening to assess immunity status, and guidance from an appropriate specialist on whether vaccination is necessary. Students will also receive specific advice on how to avoid blood-borne infections, needle-stick injuries etc. If hepatitis B vaccination is given in general practice, it could deprive the students of the necessary and important occupational health induction they will get at their educational organisation prior to their hepatitis B immunisation. This will also include advice on hepatitis C, HIV etc.

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\* **NHS General Dental Practice employees** – Funding has been made available by the Welsh Government to reimburse the costs for the vaccination course for healthcare workers who may be at risk. Some areas may have NHS occupational health departments to assist making the vaccination available. Alternatively, where a dental employee is considered at risk following a risk assessment by their employer, a request for the vaccination should be given to the employee for the GP practice. A fee may be charged by the practice and the dental practice may claim the fee on presentation of a receipt to the health board.

† **Primary care employees** – Where a primary care employee is considered at risk following a risk assessment by their employer, a request for the vaccination should be given to the employee for the GP practice. The immunisation is free to the patient; the practice is asked to bear the service cost. A WP10 or WP34 can be used.

‡ **Other occupational groups considered at risk** – The patient should not be charged. The employer can be charged to include the cost of the drug (plus VAT and on cost), dispensing fee and service fee.

**'At risk' patients** – Where the patient is identified as being 'at risk', it is the responsibility of the GP to provide the vaccine if necessary and appropriate. The GP should use either WP10 for supply through community pharmacy or personally administered item (WP34) to reclaim vaccine cost. There is no item of service fee. Examples of patients 'at risk' are provided in the BNF<sup>26</sup> and Green Book<sup>42</sup> and include:

- parenteral drug users,
- patients with multiple sexual partners,
- close family contact of a case or carrier especially infants,
- people with learning disabilities living in residential care,
- patients and carers of patients receiving frequent blood transfusions,
- foster carers of children at increased risk.

**Travel** – If a patient requests hepatitis B immunisation for travel abroad to areas of high prevalence and may be at risk, this should normally be a private service to patient, but for patients 'at risk', hepatitis B immunisation may be given if appropriate. The patient may be charged a fee to include cost of drug (plus VAT and on cost), dispensing fee and service provision. There is no item of service fee.

Guidance on the provision of hepatitis B vaccinations is open to interpretation. To date, there is no definitive advice on the use of the hepatitis B vaccine for occupational health or travel purposes as part of the service provided by NHS under the GMS, and the decision as to whether or not an NHS prescription for the hepatitis B vaccine is appropriate should be made on an individual patient basis, taking into account their clinical and occupational situation, and may depend on the views of the medical practitioner involved.

For further advice contact your local occupational health or public health teams. [Guidance is also available from the BMA<sup>53</sup>](#).

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## APPENDIX 1: TRAVEL-RELATED VACCINES AND OPTIONS FOR PRIVATE OR NHS SUPPLY THROUGH GENERAL PRACTICE

Vaccine	Private	NHS		Comments
		WP34	WP10	
Cholera	X	X	✓	The vaccine is not indicated for most travellers, and should be advised following an individual risk assessment.
Hepatitis A	X	✓	✓	All doses provided on the NHS. Refer to the Green Book <sup>42</sup> for guidance.
Hepatitis B	✓	✓	✓	Private prescription for travellers, pre exposure, and for occupational health purposes, unless they are in an at risk category as documented in the Green Book <sup>42</sup> Check local policy.
Hepatitis A and B (combined)	X	✓	✓	All doses for the complete course are provided on the NHS. Regions of risk for hepatitis A apply, refer to NaTHNaC for further information.
Hepatitis A and typhoid (combined)	X	✓	✓	All doses provided on the NHS. Refer to the Green Book <sup>42</sup> for guidance.
Japanese B encephalitis	✓	X	✓	Only one vaccine is licensed for UK use: Ixiaro <sup>®</sup> (Novartis Vaccines). Not routinely available on the NHS for overseas travel. Should be advised after an individual risk assessment.
Meningococcal A, C, W135 and Y	✓	✓	✓	Not routinely available on the NHS for overseas travel.
Rabies	✓	X	✓	Pre-exposure immunisation is recommended for some travellers. For occupational risk and bat handlers, the vaccine is obtained from the Department of Health. For more details of this, and post-exposure information see the Green Book <sup>42</sup> . Not routinely available on the NHS for overseas travel.
Tetanus, diphtheria and polio	X	X	✓	This vaccine (Revaxis <sup>®</sup> ) is supplied centrally for the childhood vaccination programme but central stocks should not be used for adults.
Tick-borne encephalitis (TBE)*	✓	X	✓	TBE vaccine is used for the protection of individuals at high risk of exposure to the virus through travel or employment. Not routinely available on the NHS for overseas travel.
Typhoid	X	✓	✓	Refer to the Green Book <sup>42</sup> for guidance.
Yellow fever	✓	X	X	Only available at approved yellow fever vaccination centres (YFVCs): <a href="http://nathnacyfzone.org.uk/search-centres">http://nathnacyfzone.org.uk/search-centres</a> .

### Electronic multi-vaccine claims

GP practices who submit monthly claims for administering multiple-dose vaccines are now able to do so electronically via the NHS Wales Shared Services Partnership [intranet site](#). WP10 forms should not be submitted to Prescription Pricing Services in GP accounts for vaccines allowed via the WP34 claim form route.

**NB** GPs may prescribe privately and charge their registered patients for vaccine only if use is in association with pre-exposure related to travel abroad.