Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

Prescribing Dilemmas

A Guide for Prescribers

February 2021

(October 2025 – Removal of ‘Erectile dysfunction’ Section. References updated to reflect change in source material. Please see ‘Updates’ section at the end of the document for further details.)

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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Contents

1.0 Introduction

This document provides guidance for health professionals regarding clinical responsibility, prescribing duration, foodstuffs, complementary medicines and alternative therapies, common ailments, fertility treatment, 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

Whatever element of prescribing activity you are involved in, you are responsible for your decisions and actions, and the steps you take to ensure that prescriptions are appropriate, necessary and safe[1]. 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[2]. It is important that prescribers prescribe medicines or treatment, including repeat prescriptions, only when they have adequate knowledge of the patient's health, and are satisfied that the medicines or treatment serve the patient's needs[3].

Non-medical independent prescribers (nurse/pharmacist/optometrist/physiotherapist/ chiropodist/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. Optometrist independent prescribers cannot currently prescribe controlled drugs. Physiotherapist, chiropodist/podiatrist, therapeutic radiographer and paramedic 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 Community Pharmacy England website[4].

All prescribers are encouraged to report suspected adverse drug reactions using the Yellow Card reporting scheme[5]. 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[1].

At the interface between hospitals and primary care, 'prescribing responsibility will continue to be based on clinical responsibility. This is good medical practice and is in the best interests of the patient'[6]. 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 pressured 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 Proposing, Prescribing, Providing and managing medicines and devices' states[1]:

Paragraph 4 "Whatever element of prescribing activity you are involved in, you are responsible for your decisions and actions, and the steps you take to ensure that prescriptions are appropriate, necessary and safe."

Paragraph 92 "Whether you propose, prescribe or provide medications using repeat prescribing or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up and review. You should take account of the patients' needs and any risks arising from the medicines."

Paragraph 97. You must make sure that any repeat prescription you propose, or sign is safe and appropriate. You should consider the benefits of prescribing with repeats, and where possible, reduce repeat prescribing.

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 92 states that "You should take account of 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.

2.2 Prescribing of Valproate

AWTTC has developed a sodium valproate information hub to highlight the risks associated with valproate use in both males and females, and to provide links to useful sources of information for healthcare professionals and patients.

2.2.1 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[7].

The MHRA states "Valproate must not be used in any woman or girl able to have children unless there is a pregnancy Prevention Programme (PPP) in place."[7] Prescribing of valproate outside of the PPP is contra-indicated, and represents unlicensed use. Furthermore, valproate must not be used for the treatment of migraine or bipolar disorder during pregnancy and must not be used to treat epilepsy during pregnancy (unless no other effective treatment is available). Prescribing of valproate in these circumstances is also unlicensed. However, some 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 PPP through completion of an annual risk acknowledgement form[8]. Patients should be reviewed annually and have a completed risk acknowledgement form before receiving ongoing supplies.

2.2.2 Males

The MHRA has introduced additional safety measures to reduce the harms associated with valproate use in men. Findings from a retrospective observational study indicate a possible increased risk of neurodevelopmental disorders in children born to men treated with valproate in the 3 months prior to conception, compared with those born to men treated with other antiepileptic medicines.

The MHRA advises that male patients and their partner use effective contraception during valproate treatment and for at least three months after stopping valproate. Furthermore, patients should not donate sperm during treatment and for three months after stopping valproate. Valproate should not be started in new patients younger than 55 years unless two specialists document that there is no suitable alternative, or that the reproductive risks do not apply.

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, you still think the treatment or care would not serve the patient's needs, you should not provide or propose it. You should explain your reasons to the patient and explore other options that might be available, including their right to seek a second opinion."[1]

3.0 Private referral

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, medicines prescribed or treatment provided by a clinician in the course of a private consultation should be at the patient's expense[9]. 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[9] recommendations. The 'Medicines Funding in the NHS' report recommends that patients opting for top-up treatment should not lose their entitlement to NHS treatment[10]. However, health boards have the power to charge for associated monitoring and care (excluding unpredictable events)[9]. There are also recommendations relating to procedural issues that should be considered when top-up treatment packages are introduced[9].

4.0 Private prescriptions

4.1 Following a private consultation

A clinician (i.e. the person providing the private opinion, which may be a physician, dentist or other healthcare professional; henceforth referred to as 'the private clinician') may see a patient on a private basis in order to give an opinion to an NHS prescriber regarding diagnosis or further management. Alternatively, the private clinician may treat a patient privately for whom they will continue to have clinical responsibility and will personally determine the ongoing treatment for that particular condition. Until the private clinician discharges the patient, this remains an episode of care. In this case, the private clinician should prescribe privately for their private patient, and an NHS prescriber may refuse to prescribe for that condition on the

NHS. Once the private episode of care is completed, an NHS prescriber may consider providing an ongoing NHS prescription if required. In some limited circumstances an NHS prescriber may consider it appropriate to enter into a shared care agreement with a private clinician (see section 4.1.1 for further information).

If the medicine is not on the health board formulary for the relevant indication or, where applicable, has not been recommended by NICE or AWMSG, it would not be expected for the NHS prescriber to provide an ongoing supply on an NHS prescription. Private clinicians should keep this in mind when selecting treatment options. It is advisable that NHS prescribers inform patients of this possibility before referral and mention it in any referral letters. The NHS prescriber must, however, continue to provide NHS treatment and prescriptions for other conditions for which they retain clinical responsibility[10].

Situations where an NHS prescriber would not be expected to continue the ongoing prescribing on an NHS basis would be where:

- prescribing a medication would be outside the competence of the NHS prescriber, for example specialised medicines not suitable for prescribing in primary care,
- the NHS prescriber considers that the treatment would not be of overall benefit to the patient, in which case they must explain this to the patient and include the option to seek a second opinion[1];
- the medication is generally not provided within the NHS (e.g. a drug listed under Part XVIIIA of the NHS Drug Tariff[11]).

The GMC advises that it is good medical practice to “promptly share all relevant information about patients (including any reasonable adjustments and communication support preferences) with others involved in their care, within and across teams, as required” and “be confident that any person you delegate to has the necessary knowledge, skills and training to carry out the task you’re delegating.”[3]. If the private clinician considers that an emergency NHS prescription is required, it is important that they contact the NHS prescriber to share this information and to gain their agreement. Patients should be informed that unless it is an emergency prescription requests would be subject to the usual timescale for routine prescription requests.

For a specific condition, where a private clinician recommends a medicine 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. This advice should be explained to the patient, who will retain the option of obtaining a private prescription from the private clinician.

4.1.1 Sharing responsibility for prescribing between a private clinician and an NHS prescriber

Where a private clinician has requested treatment be continued by the NHS under a shared care agreement with an NHS prescriber and the NHS prescriber is considering this approach, they should be aware that circumstances where this is appropriate are likely to be limited and are likely to present significant governance challenges to the NHS prescriber (see below).

The decision of whether to accept the agreement lies with the NHS prescriber. When deciding whether or not to enter into a shared care agreement with a private clinician,

the following should be considered and addressed. Where it is not possible to address these points, entering into a shared care agreement would be inadvisable:

- If the patient were unable to obtain an ongoing supply of the medicine unless a shared care agreement were in place, what would be the consequences of stopping treatment?
- What are the professional credentials of the private clinician? For example, are they registered as a prescriber? Are they on the relevant GMC specialist register? Are they registered with Health Inspectorate Wales, or the Care Quality Commission?
- Is the diagnosis made by the private clinician appropriate? Has information about the assessment, diagnostic criteria or validated assessment tool been provided? Can the advice of an NHS specialist be sought?
- Is the proposed medicine appropriate for shared care? (Refer to the AWMSG shared care prescribing and monitoring guidance for further information).
- Has the medicine received a positive Health Technology Appraisal recommendation from NICE or AWMSG?
- Is the proposed medicine being used within the terms of its marketing authorisation, part XVIIIA of the NHS Drug Tariff, and relevant health board guidelines (including position on health board formulary for the relevant indication)?
- Is the NHS prescriber familiar with the prescribing of this medicine?
- Has the private clinician provided a comprehensive shared care agreement in line with the AWMSG shared care model available in the AWMSG shared care prescribing and monitoring guidance?
- Are the monitoring requirements and responsibilities clear, and have they been discussed with the private clinician?
- Is there an existing shared care protocol for the relevant medicine, which has previously been agreed by the health board? NHS prescribers should be aware that funding to manage the additional requirements of a shared care agreement with a private clinician may not be available from the heath board.
- Has the shared care agreement template received approval from the health board's drugs and therapeutics committee, local medical committee or equivalent? The AWMSG shared care prescribing and monitoring guidance states: '*Primary care prescribers are not expected to be asked to participate in a shared care arrangement where no national or locally approved protocol exists, or where the medicine falls outside the criteria defined as being suitable for inclusion in a shared care agreement.*'
- Prescribers are reminded that the person signing the prescription accepts responsibility for prescribing. Is the NHS prescriber willing to accept prescribing responsibility? This would include acting upon problems identified by any monitoring that is being managed.
- Are there clear guidelines on how to contact the private clinician in case of serious problem or an emergency? When entering into a shared care agreement, the role of a private clinician would be expected to be equivalent to that of an NHS specialist and specified in the Shared Care Protocol.
- In the event that the private clinician's involvement in the patient's care were to cease, is the NHS prescriber willing and do they have the required competencies to manage ongoing treatment whilst further specialist support is arranged? Where appropriate, referral to an NHS specialist should be made at the earliest opportunity to help mitigate this risk.

Indemnity considerations
If entering into agreements, prescribers should ensure that they have appropriate indemnity cover in place. Although any responsibility for ensuring safe treatment would be shared between the private clinician and the NHS prescriber, in the event of a claim being made it is possible that such a claim would be made solely against an NHS prescriber's indemnification. For GPs, prior review of any proposed shared care agreement at a senior level within the health board would likely be required for NHS indemnification to apply. Non-medical prescribers should seek advice from their indemnifier.
The Public Services Ombudsman for Wales has information explaining how complaints about healthcare delivered outside the NHS are investigated.

Where NHS healthcare professionals are involved in referring patients to private clinicians, expectation regarding future prescribing recommendations should be managed at the time of referral and documented in the clinical records. The patient should be advised that future access to treatment on the NHS may not be guaranteed (for example if an NHS prescriber does not agree with the treatment choice of the private clinician) and that the decision to enter into any shared care agreement lies with the NHS prescriber not the private clinician. Furthermore, the patient should be advised that should the involvement of the private clinician cease, this would terminate the shared care agreement and stop NHS prescribing of the associated medicines. In these circumstances, it would be the responsibility of the patient to obtain private prescriptions from a different private prescriber (if they wished to remain on the medicine) pending referral and assessment within the appropriate local NHS pathway.

Where private treatment has been initiated abroad, the BMA provides the following advice:

"*Patients can transfer their care from private to NHS as per the NHS Constitution. Thus, if a patient would normally receive follow up in general practice following specialist treatment, they should receive this if they transfer from private care, whether in the UK or not.*

However, if follow up is of a specialist nature, or not within normal general practice remit, the patient should be referred to the appropriate service in the UK for this follow up.

If an appropriate service is not available, or rejects the referral, this should be directed to the local commissioner whose responsibility it is to commission the service."

Further information relating to shared care can be found in the AWMSG shared care prescribing and monitoring guidance.

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[12]. This list of products may also be found in part XVIIIA of the NHS Drug Tariff[11].
- 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[12].
- 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 14.1).
- 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 14.2).

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 part XVIIIA of the NHS Drug Tariff".

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[13]. 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 3, Part 5, paragraph 58[14].

5.0 Prescribing of medicines for an unlicensed use

The GMC defines 'unlicensed medicines' as medicines used outside the terms of their UK licence (marketing authorisation) (sometimes referred to as 'Off Label' use[10]) or which have no licence (marketing authorisation) for use in the UK[1]. However, there may be different considerations when prescribing off-label or unlicensed medicines as outlined by Aronson and Ferner (2017)[15].

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 able to prescribe "off-label" medicines, but 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 Community Pharmacy England website[4].

Although prescribing unlicensed medicines is not recommended, the GMC states that prescribing of unlicensed medicines "may be appropriate 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[1].
The following extract is from the GMC 'Good practice in proposing, prescribing, providing and managing medicines and devices' (2021)[1]:
"*If proposing, prescribing or providing 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 make sure that arrangements are in place 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.*"[1]

Points for consideration: (See GMC guidelines for full version[1])
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.
d. There is a serious risk to public health and the MHRA has temporarily authorised the sale or supply of an unlicensed medicine.

Information for patients

- 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.
- 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.
- If you intend to prescribe unlicensed medicines where it's not routine or if there are suitably licensed alternatives available, you should explain this to the patient and give your reasons for doing so.

The AWMSG-endorsed document "Understanding unlicensed medicines" has advice for healthcare professionals, and patients.

Leaflet for unlicensed use of medications in children:
www.medicinesforchildren.org.uk/unlicensed-medicines

6.0 Prescribing outside national guidance

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 medicine 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[14].

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[16]. 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[16].

National and local guidance will often clarify what prescribers should do for identified individuals, e.g. who to immunise against influenza. Prescribers may decide, 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. General Practices should not offer their registered patients a private service.

7.0 Prescribing duration

The British Medical Association (BMA) states that “Doctors should provide prescriptions for intervals that they feel are clinically appropriate”, taking into account effects of the drug, stability of treatment, patient compliance and necessary monitoring.

Historically, a 28-day repeat prescribing interval has been broadly recommended, however a review by the Welsh Institute for Health and Social Care (WIHSC) concluded that, on balance, there would be a benefit to General Practices, patients and pharmacies if dispensing intervals were extended, where appropriate[17]. The AWMSG-endorsed document “All Wales Guidance for Prescribing Intervals” provides further advice[18].

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[19].

8.0 Prescribing of borderline foods and dietary products

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[20].

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[21].

A complete list of products can be found in the British National Formulary (BNF)[19] or Part XV of the NHS Drug Tariff[21]. 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 prescribers 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.

Prescribers 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

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."*[22]

"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."[22-24]

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[25], and a separate study in 2011 suggested this was true of 19.7% of patients with cancer[26]. 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)"[27]. 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

From 1 April 2007, prescription charges for medicines and appliances no longer applied in Wales. Where patients already buy non-prescription medicines over the counter they should continue to do so in the normal way.
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.

The Pharmacy Independent Prescribing Service: Common Ailments and Contraception service provides a mechanism for community pharmacist independent prescribers to diagnose and treat an agreed list of common ailments within their scope of practice. The scheme is funded by NHS Wales. As with the Common Ailments Service, patients must be resident or registered with a General Practice in Wales.

11.0 Fertility treatment

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 General Practices 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, now known as NHS Wales Joint Commissioning Committee [NWJCC]) in January 2017 and applies to residents of all seven health boards in Wales[28]. 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 considers factors including female age, male age, existing children, body mass, sterilisation, smoking status, previous treatment, subfertility, HFEA, change of partners and veterans. Full details can be found in the policy document.

12.0 Prescribing for oneself or family

The GMC states that 'wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with'[1]. 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.

Prescribing of controlled drugs presents particular challenges relating to misuse, addiction and misconduct. The following guidance applies to all prescribers, not just GPs.

The GMC states:

- *You must not prescribe controlled drugs for yourself or someone close to you unless:*
  a. *no other person with the legal right to prescribe is available to assess and prescribe without a delay*
  b. *emergency treatment is immediately necessary to avoid serious deterioration in health or serious harm.*

- *If you prescribe for yourself, or someone close to you, you must:*
  a. *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.*
  b. *follow the advice on information sharing and safe prescribing*[1]

13.0 Visitors

13.1 Visitors from overseas

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

- Patients who require emergency or immediately required treatment, which the treating doctor deems cannot reasonably be delayed until the patient returns home (this includes oxygen therapy and renal dialysis).
- A person intending to be resident in this country for six months or more (subject to paying an Immigration Health Surcharge where applicable, and registration with a practice is necessary).
- Patients from European Union member countries, Norway, Iceland, Liechtenstein and Switzerland holding an S1 or S2 form for specific treatment of a particular condition (and prescriptions for this condition only).
- Refugees (those whose applications to reside in this country have been approved), asylum seekers (those who have submitted an application and are awaiting a decision), and failed asylum seekers (those who have been refused leave to remain in the UK but are yet to return to their home country).

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

Patients may be assigned by a health board to a contractor whose list of patients is open or, in certain circumstances, a contractor who has closed its patient list. The procedures for this are outlined in Schedule 3, Part 4, Paragraph 43.

In relation to non-emergency treatment, Welsh Health Circular (WHC) WHC/2025/025[29] states that "…*it is for the GP to decide whether to accept that person onto his or her list for NHS treatment. If the GP wishes to accept the overseas visitor onto his or her list, he or she may treat the visitor as either a fully registered patient or as a temporary resident. Either way, if the GP accepts the patient onto his or her list, the normal contractual terms will apply and therefore the GP has to provide that treatment free of charge to the patient (except for special cases where the 2023 Regulations or equivalent legislation for APMS and LHBMS providers allow the GP to charge or accept a fee).*

If the GP does not wish to accept the overseas visitor onto his or her list, the GP may treat the patient on a private, paying basis (with the exceptions in paragraph 26 below). GPs are encouraged to do so on the grounds that eligibility to receive free medical treatment is intended to relate to whether a person is ordinarily resident in the UK."

13.2 Temporary patients

In line with the terms of The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, any person requiring emergency necessary treatment can receive this from the assigned contractor for up to 14 days. If the person is present in the contractor's practice area for less than 24 hours, they can receive treatment for 24 hours or for as long as the person is present in the contractor's practice area (Part 5, Regulation 17)[14].

Patients intending to reside in an area for more than 24 hours but fewer than three months should register as a temporary patient (Schedule 3, Part 2, Paragraph 25)[14]. 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.

14.0 Travel abroad

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 3, Part 2, Paragraph 34)[14]. 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 prescribers on risk assessment for travellers and appropriate advice is available from the NaTHNaC website[30].

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[30]. This will depend on the duration of travel, the type of medicine (e.g. codeine, Sativex®) and the country of travel. More information on the carrying of prescribed controlled drugs abroad for personal use is covered in section 14.3. Patients who require over-the-counter (OTC) medicines should check that the medicine is available OTC in the country of destination[31]. 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.

General practices 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 azithromycin for traveller's diarrhoea. 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.

14.1 Immunisation for travel abroad

Immunisation against infectious disease (The Green Book)[32] 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 General Practices 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[33]. 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

A number of other travel-related vaccines, including hepatitis B and meningococcal A, C, W135 and Y vaccine, are not remunerated by the NHS. The BMA states that "*The practice may therefore charge a registered patient if such a vaccination is requested for travel. The patient may either be given a private prescription to get the vaccines, or charged for stock purchased and held by the practice. Administration is also chargeable."* [34]

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[34]. For more information on hepatitis B vaccination, see section 15.1.

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[33].

Practices may charge for both the prescription and the administration of these vaccines at their discretion[12].
No charge should be made to any NHS patient of the practice for providing advice.

14.2 Malaria chemoprophylaxis

There is no NHS Regulation that prevents a GP prescribing medicines for the prevention of malaria at NHS expense. However, 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)[2].

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[19].
Exceptions are:

- mefloquine (Lariam®), 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[35],

- proguanil/atovaquone (Malarone®), for which prophylaxis should be started 1–2 days before travel to the endemic area and stopped one week after leaving the endemic area[35],
- doxycycline, for which prophylaxis should be started 1–2 days before travel to the endemic area and stopped one week after leaving the endemic area[35].

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 2024*[35].

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

- **A**wareness: know about the risk of malaria.
- **B**ites by mosquitoes: prevent or avoid.
- **C**ompliance with appropriate chemoprophylaxis.
- **D**iagnose breakthrough malaria swiftly and obtain treatment promptly.

14.3 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[19].

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[36]. 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[36]. 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[36]. 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[37].

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;* e*xceptionally, 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.*" [19]

14.4 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[38]. 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[39]. 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[40].

15.0 Vaccines for occupational health purposes

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 General Practice, an occupational health provider, or another provider such as a community pharmacy.

15.1 Hepatitis B vaccine

Occupation – Hepatitis B vaccinations for occupations listed in the Green Book[32] and BNF[19] should normally be provided by the employer via their own occupational health provider or via private agreement with a practice.

Pre-exposure immunisation is recommended for groups at increased risk including healthcare workers, laboratory staff, staff working in accommodation for those with learning disabilities, and other at risks groups such as morticians, tattoo artists, and prison service staff who are in regular contact with prisoners.

For other groups such as police and rescue services, post-exposure prophylaxis may be more appropriate based on occupational health risk assessment.

The BMA considers that there is no obligation for practices to provide occupational health services for patients[41]. Under health and safety legislation, employers have a responsibility to protect their workforce. Special consideration may need to be given to a patient who may be at risk but does not have an employer (e.g. self-employed workers). In these cases, the patient may be referred to another practice where they can receive occupational care as a private patient. Alternatively, their own practice may treat them as an NHS patient and claim reimbursement for the vaccine cost.

Students – Prospective and current students of healthcare (e.g. medical, nursing, dental students) should be vaccinated by their educational organisation[34] 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.

'At risk' patients – Where the patient is identified as being 'at risk', it is the responsibility of the General Practice to provide the vaccine if necessary and appropriate. The General Practice 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[19] and Green Book[32] 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 the medicine (plus VAT and on cost), dispensing fee and service provision. There is no item of service fee.

For further advice contact your local occupational health or public health teams. Guidance is also available from the BMA[41].

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Updates

Date of update publication	Details of update
November 2024	Throughout: Word ‘drugs’ replaced with ‘medication’ where it is not a direct quote from alternative source. Section 2.0: Amendment to list of prescribers who can prescribe controlled drugs to reflect changes from the Community Pharmacy England website. Section 2.1: Quoted text and paragraph numbers from GMC Good Practice in Prescribing and Managing Medicines and Devices updated to reflect current version of the source guidance. Section 2.2: Updated to reflect the MHRA guidance on valproate use in women of childbearing age and their pregnancy prevention programme. Section 2.3: Updated the quoted text to reflect new wording in the GMC Good Practice in Prescribing and Managing Medicines and Devices guidance. Section 4.1.1: Added a new section on ‘Sharing responsibility for prescribing between a private clinician and an NHS prescriber’ Section 5.0: Addition of another point for consideration to reflect new wording in the GMC Good Practice in Prescribing and Managing Medicines and Devices document. Link added to AWMSG-endorsed ‘Understanding unlicensed medicines’ document. Section 7.0: Update to quote on prescribing duration from the BMA Prescribing in General Practice. Link added to AWMSG-endorsed ‘All Wales guidance for prescribing intervals’ document. Section 10.0: Text edited to be more succinct and to add information on ‘Pharmacy Independent Prescribing Service: Common Ailments and Contraception’. Section 11.0: Updated ‘WHSSC’ to ‘NWJCC’ following organisation name change. Also reduced the direct quotation from the document and instead included a referral link to the specialist fertility service document. Section 13.0: Updated the quoted text to reflect new wording in the GMC Good Practice in Prescribing and Managing Medicines and

Date of update publication	Details of update
	Devices guidance. Section 15.0: Updated links to NaTHNaC website. Section 16.1: Updates to section following a withdrawal of previous resource and replacement with new reference source from the British Medical Association.
April 2025	Minor updates to text and references including in sections 2.0, 2.1, 2.3, 4.1, 4.1.1, 4.2, 4.3, and 5.0 to reflect changes in GMC guidance and other sources.
October 2025	Section 12 ‘Erectile dysfunction’ removed following the retirement of the All Wales Guidance on prescribing for erectile dysfunction. Minor updates to text and source references in sections 13.1 ‘Visitors from overseas’ and 13.2 ‘Temporary patients’.

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[32] 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[32] 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[32] for guidance.
Japanese B encephalitis	✓	X	✓	Only one vaccine is licensed for UK use: Ixiaro® (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[32]. Not routinely available on the NHS for overseas travel.
Tetanus, diphtheria and polio	X	X	✓	This vaccine (Revaxis®) 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[32] for guidance.
Yellow fever	✓	X	X	Only available at approved yellow fever vaccination centres (YFVCs).

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.