NHS England

Responsibility for prescribing between Primary & Secondary/Tertiary Care

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Responsibility for prescribing between Primary & Secondary/Tertiary Care

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1.0 Introduction

1.1 Good organisation of care across the interface between primary and secondary/tertiary care is crucial in ensuring that patients receive high quality care – and in making the best use of clinical time and NHS resources in all care. Good professional practice requires care for patients to be seamless; patients should never be placed in a position where they are unable to obtain the medicines they need, when they need them. Lack of communication between primary and secondary/tertiary care and misunderstandings around the responsibilities of the professionals involved are often cited as reasons for patients not being able to get their medicines in a timely manner, despite effective collaborative working and communication being an important part of patient-centred professionalism.

1.2 Many people are living with long-term conditions, some with multi-morbidities requiring multiple medicines as part of their treatment plan. The requirements for those professionals responsible for prescribing medicines therefore need to consider the whole needs of the patient, and care should be provided where it can be most appropriately monitored and reviewed in the best interest of the patient.

1.3 Patients have the right to access NHS services and to receive care and treatment that both meets their needs and takes account of their preferences. They have the right to be treated with a professional standard of care. The NHS Constitution contains a number of pledges, which include the following commitments:

- To provide convenient, easy access to services
- To make the transition as smooth as possible when referring patients between services, and to place patients at the centre of decision-making where the outcomes affect them
- To ensure those involved in patient care have access to the patient's health information, so they can care for them safely and effectively

1.4 Patients want to get their medication when they need it and health professionals from both secondary and primary care want clear and easy ways of providing seamless care for patients. This is particularly relevant for patients receiving shared care between their hospital consultant and their GP, and also when care is being transferred to the GP from their hospital consultant.

1.5 This guidance aims to provide clarity on the responsibilities of all professionals involved in commissioning and prescribing across primary, secondary and tertiary care (and includes community and specialised services, and care for those patients in secure residential settings) and to provide support in developing shared care agreements and in the transfer of care.

The guidance covers:

- Supply of medicines
- In-patient and day cases

- Patients attending urgent and emergency care centres
- Out-patients
- People at risk of self-harm
- Shared care

1.6 The guidance additionally reflects ambitions around medicines optimisation, as well as the changing landscape of healthcare provision.

2.0 Background

2.1 The previous guidance (EL 91 (127) 'Responsibility for prescribing between hospitals and GPs') was issued in 1991, and the issues identified in that guidance included:

- Patients being caught in the middle where there is lack of agreement over prescribing responsibilities and the risk that they might be left without the medication they need
- Perverse cost incentives to shift responsibility for medicines between secondary care and primary care
- GPs' concerns over taking responsibility for unfamiliar treatment
- Lack of consultation between professionals over the transferring of prescribing responsibilities
- Hospitals providing insufficient quantities of medication on discharge, or following out-patient or emergency treatment
- Patients having to make a special trip to their GP to obtain a prescription immediately after a hospital visit

2.2 Some of these issues have been addressed through new measures in the NHS Standard Contract for 2017/19 (see section 4.2). However, there is still a need to ensure that professionals are clear about their clinical responsibilities with regard to prescribing, are supported to carry out these responsibilities, and that patients are never left in a position where they are not able to get the medication they need.

2.3 This guidance is not intended to undo or undermine existing prescribing arrangements that have been deemed to be working well across health communities by primary and secondary care, but it does aim to reduce the level of variation and to improve the quality of patient care.

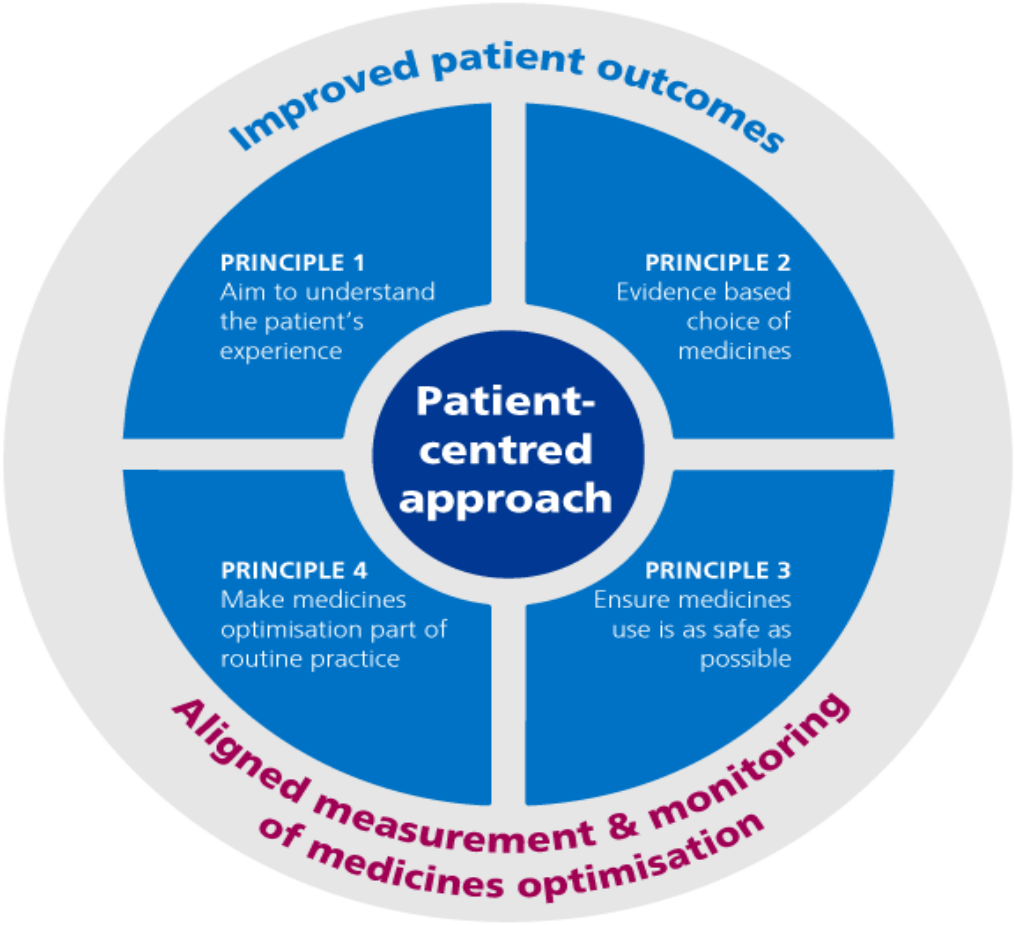
2.4 This guidance has been developed in collaboration with a representative stakeholder working group chaired by the Chief Pharmaceutical Officer for England.

3.0 Medicines Optimisation

3.1 Since the previous guidance was written, the role of medicines optimisation has become better understood in helping patients make the most of medicines and improve their health outcomes. The responsibilities around prescribing and the decisions that are made by healthcare professionals

and patients therefore need to reflect the seven elements of medicines optimisation, to deliver improved patient outcomes, and to be supported by appropriate measurement and monitoring.

The seven elements of medicines optimisation



Principle 1 – aim to understand the patient's experience To ensure the best possible outcome from medicines, there is an ongoing, open dialogue with the patient and/or their carer about the patient's choice and experience of using medicines to manage their condition; recognising that the patient's experience may change over time even if the medicines do not.
Principle 2 – evidence-based choice of medicines Ensure that the most appropriate choice of clinically and cost-effective medicines (informed by the best available evidence base) is made, and which can best meet the needs of the patient.
Principle 3 – ensure medicines use is as safe as possible The safe use of medicines is the responsibility of all professionals, healthcare organisations and patients, and should be discussed with patients and/or their carers. Safety covers all aspects of medicines usage, including unwanted effects, interactions, safe processes and systems, and effective communication between professionals.
Principle 4 – making medicines optimisation part of routine practice Health professionals routinely discuss with each other and with patients and/or their carers how to get the best outcomes from medicine throughout the patient's care.

(Reference: *'Medicines Optimisation: Helping patients make the most of medicines'* Royal Pharmaceutical Society, May 2013)

4.0 Clinical responsibility and the prescribing of medicines

4.1 General Principles

4.1.1 Clinical responsibility for prescribing should sit with those professionals who are in the best position and appropriately skilled to deliver care which meets the needs of the patient. In many cases it will be the GP who is the most appropriate clinician to provide continuing care. In terms of patient experience, those patients who are on long-term medication or are less well may prefer to avoid unnecessary hospital appointments by receiving their prescriptions closer to home. The use of the Electronic Prescription Service by hospitals should be encouraged to allow the efficient provision of prescriptions from secondary care where this is required. Greater collaboration between GPs, hospital consultants and other prescribers is essential to ensuring these principles are considered in decision-making.

4.1.2 However, when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs. If the GP considers him- or herself unable to take on this responsibility, then this should be discussed between the relevant parties so that additional information or support can be made available, or alternative arrangements made. When drawing up shared care agreements, or where there is a lack of clarity about prescribing responsibilities, it may be necessary for local discussion to take place between hospitals, commissioners, the Area Prescribing Committee, and the relevant Local Medical Committees (LMCs) as a prelude to establishing agreement with individual GPs. GPs would only be obliged to provide treatment consistent with current contract requirements.

Because patients' healthcare needs are constantly changing, doctors will need to adapt their practice through continuing professional development ('CPD') so they can continue to best serve the needs of their patient population (please see the General Medical Council's *'Good Medical Practice'* for more information).

4.1.3 Commissioners have a role in ensuring that they commission services which cover the prescribing needs of their population and make the best use of available resources; particularly in the case of medicines suitable for shared care. In doing so, commissioners should identify, and take into account, operational and resource requirements of all hospitals and general practice so that patient care remains safe and effective.

4.1.4 CCG medicines optimisation teams, working with clinical pharmacists in GP practices, can support joint working and collaboration with hospital chief

pharmacists to ensure that GPs and other primary care prescribers have access to information on new or less familiar medicines, and the related prescribing policies. The NHS Specialist Pharmacy Service, through its Medicines Information Centres, is able to provide support. Contact details are provided in the British National Formulary (BNF) or via www.sps.nhs.uk.

4.1.5 The expansion of clinical pharmacists as independent prescribers in general practice also provides an opportunity to build stronger links between hospitals and general practice. Clinical pharmacists in general practice are experts in optimal medicines use, monitoring, and review; and so will provide good support to all general practice staff. They are a good point of contact for hospitals for all medicines-related matters, including when designing and implementing shared care arrangements.

4.1.6 Legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence. Further advice on this is contained within the General Medical Council's (GMC) core guidance; *Good Medical Practice (GMP)* is recommended.

4.2 Supply of medicines

4.2.1 In all cases, it is essential for good patient care that there is prompt and clear communication on the transfer of care between hospital and primary care, and also at key stages during the outpatient pathway.

4.2.2 The NHS Standard Contract (available at https://www.england.nhs.uk/nhs-standard contract/) sets out specific requirements for providers of secondary and tertiary care in relation to the supply of medicines to patients. The Contract requires the provider to supply medicines, where clinically appropriate:

- on discharge from inpatient or day case care;
- following clinic attendance (where a patient has an immediate need for medication, for example, where treatment is expected within 7 days);
- in accordance with local policy agreed with its commissioners, but subject to covering a minimum period.

The specific current requirements are set out in Service Conditions 11.9 and 11.10 of the NHS Standard Contract 2017/19 and are summarised in paragraphs 4.2.3-4.2.5 below. NHS England periodically updates the terms of the Contract, and readers of this guidance will need to refer to future Contract conditions for any changes to these.

4.2.3 In-patients and day cases

4.2.3.1 When a patient is discharged from inpatient or day case care in hospital, sufficient medication must be supplied by the hospital pharmacy for a minimum period of 7 days after discharge; unless a shorter period is more clinically appropriate, or the patient has an adequate supply, or will receive such a supply through an existing repeat prescription. The minimum period of time covered by the prescription should take into account bank holidays and weekends, to allow patients sufficient time to contact staff at their general practice.

4.2.3.2 The GP to whose care the patient is being transferred should receive notification, via a Discharge Summary within 24 hours of discharge, of the patient's diagnosis and medication; so that any necessary ongoing treatment can be maintained.

4.2.4 Out-patients

4.2.4.1 Where a patient has an immediate clinical need for medication as a result of attending an outpatient clinic, the secondary care provider must supply medication sufficient to last at least until the point at which the outpatient clinic's letter can reasonably be expected to have reached the patient's GP, and when the GP can therefore accept responsibility for subsequent prescribing. Consideration should be given to providing a minimum of 7 days' supply to allow patients sufficient time to contact staff at their general practice (or shorter if medicines are not required for that length of time).

4.2.5 Patients attending emergency departments

4.2.5.1 Although these are not specific requirements within the Contract, patients attending an urgent and emergency care setting should also receive from the emergency department a supply of prescription medicines for 7 days, or shorter if medicines are not required for that length of time. Again, any appropriate prescribing after that period will then rest with the GP responsible for the patient's continuing care.

4.3 People at risk of harm

4.3.1 When making arrangements for the prescribing of medicines for someone who may be at risk of self-harm or have the potential to misuse the medication, the arrangements should fit within the overall care plan for the individual service user. In addition, the safe use of some medicines requires specific information resources; such as the patient guide, prescriber checklist and patient card for girls and women of childbearing age who may be taking or considering taking certain medicines such as valproate.

4.4 Shared care

4.4.1 Shared care agreements are a specific approach to the seamless prescribing and monitoring of medicines which enables patients to receive care in an integrated and convenient manner. Shared care is a particular form of the transfer of clinical responsibility from a hospital or specialist service to general practice in which prescribing by the GP, or other primary care prescriber, is supported by a shared care agreement.

4.4.2 When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP concerned (and the patient) to share their care. In proposing shared care agreements, a specialist should advise which medicines to prescribe, what monitoring will need to take place in primary care, how often medicines should be reviewed, and what actions should be taken in the event of difficulties.

4.4.3 At a system level, medicines and conditions suitable for shared care are usually identified through a traffic light system determined by an Area Prescribing Committee (APC). Shared care typically applies to medicines for which a shared care agreement must be in place before prescribing responsibility is transferred. This contrasts with medicines which are categorised as suitable for routine prescribing in primary care, or those that should remain the responsibility of specialist prescribers only. All prescribers have a responsibility to be aware of medicines identified through the traffic light system, so that prescribing decisions can be made most effectively.

4.4.4 At an individual patient level, patients themselves and/or carers must be centrally involved in any decision-making process. They should be supported by good quality information that helps them to both come to an informed decision about engagement in a shared care arrangement and sets out the practical arrangements for ongoing supplies of medicines. Given the increasing use of, and benefits derived from, the Summary Care Record and other digital innovations, it is important that a comprehensive primary care record is in general practice, particularly in situations where not all medicines for a patient are prescribed by their GP and supplied by their community pharmacy.

4.4.5 When clinical responsibility for prescribing is transferred to general practice, it is important that the GP, or other primary care prescriber, is confident to prescribe the necessary medicines. Shared care agreements play a key role in enabling primary care prescribers to prescribe medicines with which they may not initially be familiar. For this reason it is important that agreements reflect the principles set out in **Annex 1**, and are agreed locally through an APC or an equivalent authoritative committee.

4.4.6 Prescribers are responsible for the prescriptions they sign and they must be prepared to explain and justify their decisions and actions. Service Condition 11.4 of the NHS Standard Contract 2017/19 makes clear that when a shared care protocol exists and where the GP has confirmed willingness to accept the transfer of care, the hospital must initiate and abide by that agreement.

4.4.7 When a GP accepts responsibility for prescribing medicines which are not usually dispensed in the community, and where the patient is stabilised on a particular medication, there should be liaison with the transferring hospital and if appropriate the relevant community pharmacist to ensure continuity of treatment.

4.4.8 To overcome some of the challenges associated with shared care agreements, this guidance is accompanied by ‘Shared Care Prescribing Guidelines’ – local policies which enable GPs to agree to the prescribing and monitoring of medicines/treatment in primary care, in agreement with the specialists and patient.

4.4.9 The purpose of these guidelines is to provide a framework for seamless transfer of care for a person from a hospital or specialist service setting to general practice, where it is appropriate and in their best interest. These are set out in **Annex 1**, and form part of this guidance. It is recommended that

all professionals from primary and secondary care follow these principles when developing shared care agreements in collaboration with patients.

4.5 Retaining responsibility for prescribing

4.5.1 **Table 2** in **Annex 1** highlights possible circumstances where shared care may not be the most appropriate mechanism, and where specialists would therefore normally retain responsibility for prescribing. This determination is usually made under an APC traffic light system, and may include medicines:

- undergoing or included in a hospital-based clinical trial
- requiring specialist monitoring and ongoing specialist intervention
- that are unlicensed; or are used off-label without an associated evidence base or being recognised as standard treatment
- that are only available through hospitals

5.0 Non-Medical Prescribing

5.1 The range of healthcare professionals now authorised to prescribe medicines has broadened and continues to expand. This guidance therefore relates to all those professionals with responsibility for prescribing. CCG medicines optimisation teams will be able to help with the current list of those registered healthcare professionals who can prescribe.

6.0 Role of Regional Medicines Optimisation Committees (RMOCs)

6.1 RMOCs have recently been established to provide advice and make recommendations on the optimal use of medicines for the benefit of patients and the NHS. They bring together decision-makers and clinicians across the four regions of England to understand the evidence base, share best practice, and coordinate action in order to reduce variation and improve outcomes and value.

6.2 The RMOC system is well-placed to facilitate developments that better integrate medicines optimisation activities, and to ensure the safe and effective transfer of medication-related responsibilities between hospitals and primary care. In particular, RMOCs should stimulate through Area Prescribing Committees and Drug and Therapeutics Committees collaboration between primary and secondary care health professionals on medication-related care.

6.3 RMOCs can also play a role in facilitating a review of current systems and processes, and standardising across regions.

ANNEX 1 : A template of principles for shared care between primary and secondary care/tertiary care

1.0 Introduction

1.1 Shared Care Prescribing Guidelines are local policies to enable General Practitioners to accept responsibility for the prescribing and monitoring of medicines/treatments in primary care, in agreement with the initiating specialist service.

1.2 The purpose of this template of principles for shared care is to provide a framework for the seamless transfer of care for a person from a hospital or specialist service setting to general practice, where this is appropriate and in their best interests. People should never be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary/tertiary care.

1.3 The General Medical Council guidance on “Good practice in prescribing and managing medicines and devices” states that doctors are responsible for the prescriptions they sign, and their decisions and actions when they supply and administer medicines and devices; or authorise or instruct others to do so. They must be prepared to explain and justify their decisions and actions when prescribing, administering and managing medicines.

1.4 Where possible, shared care will be ‘disease specific’ rather than ‘medicine specific’, and will link into and complement local integrated care pathways and shared care policies. Medicines and conditions suitable for shared care will be identified by local medicines committees and will be classified as “Amber” through the traffic light system. Shared care will ensure that the potential dangers of prescribing specific medicines in high risk clinical situations are reduced through appropriate monitoring, co-operation, communication and resourcing, thereby reducing the chance of harm. Application of the following principles will facilitate effective shared care. However, it should be remembered that the provision of shared care prescribing guidelines does not necessarily mean that the GP has to agree to and accept clinical and legal responsibility for prescribing; they should only do so if they feel clinically confident in managing that condition.

2.0 Principles of Shared Care

2.1 Best interest of the patient

2.1.1 The best interest, agreement and preferences of the patient should be at the centre of any shared care agreement and their wishes followed wherever possible. Patients should be able to decline shared care if, after due consideration of the options, they decide it is not in their best interests. Involvement of carers may be critical, especially in circumstances when it is not possible for the patient to make a decision e.g. mental capacity; where appropriate they should be included in discussions about shared care.

2.2 Individual, patient by patient arrangements

2.2.1 Patients should be at the centre of any shared care arrangements. Individual patient information and a record of their preferences should accompany shared care prescribing guidelines, where appropriate.

2.3 Reasonably predictable clinical situation

2.3.1 Transfer of clinical responsibility to primary care should only be considered where the person's clinical condition is stable or predictable.

2.4 Agreement of shared care between consultant and GP

2.4.1 Referral to the GP should only take place once the GP has agreed to this in each individual case, and the hospital or specialist will continue to provide prescriptions until a successful transfer of responsibilities. The GP should confirm the agreement and acceptance of the shared care prescribing arrangement and that supply arrangements have been finalised. The secondary/tertiary provider must supply an adequate amount of the medication to cover the transition period. The patient should then be informed to obtain further prescriptions from the GP.

2.5 Involving the patient in shared care arrangements

2.5.1 Clinicians should clearly explain what a shared care arrangement means for the patient and why it might be an option in their case. The patient or their carers should have the opportunity to ask questions and explore other options if they don't feel confident that shared care will work for them. They should be fully involved in, and in agreement with, the decision to move to a shared care model for their ongoing care. Importantly, patients should never be used as a conduit for informing the GP that prescribing is to be transferred.

2.5.2 The shared care agreement should state how often the patient will be reviewed and provide a 'route of return' should their condition change (such as a return of symptoms, or a development of adverse effects). As part of the consent process, patients must be made fully aware of all monitoring requirements, in line with national guidance.

2.6 Willing & informed consent of all parties

2.6.1 This includes patients, carers and all clinicians involved in their care. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily.

2.7 Clear definition of responsibility

2.7.1 The areas of care for which each clinician has responsibility should be clearly defined.

2.8 Clinical responsibility

2.8.1 Clinical responsibility for prescribing is held by the person signing the prescription, who must also ensure adequate monitoring.

2.9 Communication network & emergency support

2.9.1 Telephone details and (if appropriate) secure email addresses of both parties should be exchanged and recorded. This will enable the practice to access timely advice, guidance and information if problems arise, and also enable secondary care clinicians to easily contact the GP if necessary. This should include out-of-hours contact numbers, e.g. how to access the on-call duty doctor. Patients and their carers should also be provided with contact details for support and help if required; both in and out of hours.

2.9.2 People who are being treated on the advice of the secondary care team, but are no longer being seen in that setting, may still need review should problems arise. The appropriate level of care and/or advice should be available from the secondary care team in a timely manner without necessarily requiring a new referral.

3.0 Clinical information

3.1 This should include a brief overview of the disease and more detailed information on the treatment(s) being transferred (see **Table 1**). Written information should be provided as well as a verbal explanation of this.

4.0 Training

4.1 The commissioner of the service pathway should, in liaison with the secondary care provider, ensure that adequate training and educational support is in place for the primary care multidisciplinary team, e.g. managing the disease, administration of the medicine etc. Information on how to access this support should be provided in the shared care prescribing guidelines.

5.0 Resources

5.1 It should be recognised that resources available in practices are not uniform, and there may be impacts on both primary and secondary care. Commissioners should take account of the operational and resource implications of shared care, and of the fact that this should also extend to the requirements and sustainability of hospitals in situations where shared care is not accepted. If ongoing monitoring and prescribing are part of the shared care agreement, then the resources and capacity to ensure consistent delivery need to be determined before any shared care prescribing is implemented.

6.0 Monitoring

6.1 All appropriate monitoring requirements must be fulfilled. The person delivering that aspect of the shared care agreement should ensure that the resources to do this are in place in the clinical setting in which they are delivered.

7.0 Circumstances where shared care is not appropriate

7.1 Issues which may make this necessary are listed in **Table 2**.

Adapted from ‘Effective Shared Care Arrangements’, Midlands Therapeutic Review & Advisory Committee

http://ccg.centreformedicinesoptimisation.co.uk/files/MTRAC_ESCA_2009.pdf

Table 1

Clinical information should include a brief overview of the disease and more detailed information on the treatment(s) being transferred including (as a minimum):

Summary of NICE, BNF, SPC or other guidance, where applicable (and a web link to access the full guidance)
Licensed indications & therapeutic class
Dose, route of administration and duration of treatment
Adverse effects (incidence, identification, importance and management)
Cautions and contra-indications
Monitoring requirements and responsibilities
Clinically important drug interactions and their management
Peer-reviewed references for product usage
Contacts for more detailed information

Table 2

Possible circumstances where it may not be appropriate for a shared care agreement to be agreed, or where an exception to an agreement may be appropriate, so that the hospital/specialist retains responsibility for prescribing:

Medicines requiring ongoing specialist intervention and specialist monitoring.
Patients receive the majority of ongoing care, including monitoring, from the provider and the only benefit of transferring care would be to provider costs.
Medicines, which are unlicensed and/or are being used outside of product license (e.g. licensed medicine used for unlicensed indication or at an unlicensed dose) unless there is a recognised evidence base and/or it is standard treatment. In terms of paediatric medicines, that inclusion of dosage guidance in the Children's BNF provides a suitable evidence base.
Medicines, which are only available through the provider, i.e. are not available on FP10, including any 'borderline' products when used outside approved indications.

Medicines used as part of a provider-initiated clinical trial or the continuation of a provider initiated clinical trial or compassionate use, where no arrangement has been made in advance with the commissioner to meet the extra cost of treatment.
The GP has insufficient information to participate in a shared care prescribing arrangement where applicable.
No shared care prescribing agreement exists.
The GP does not feel competent in taking on clinical responsibility for the prescribing of a specialist medicine.
Medicines and other prescribable products, which have not been approved for addition to the provider's formulary.
Medicines subject to High-tech Hospital at Home guidance (EL(95)5).
All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement, or other process as agreed by the local APC.
Without collaboration and agreement with the patient and/or carer.

Glossary

BNF	British National Formulary
Continuing Care	Continuing Care applies to medicines requiring initiation for clinical reasons by a specialist, but which do not require regular blood monitoring and review over and above that which is usually provided by a GP, and where the GP accepts continuing prescribing responsibility as part of usual transfer of care arrangements.
EL (95) 5	DH NHS Executive letter with recommendations on purchasing high-tech healthcare for patients at home.
FP10	Prescriptions form used by GPs.
NICE	National Institute for Health and Care Excellence.
Non-NHS/Private Treatment	Treatment which is **not funded** by the NHS. Note that under the patient choice agenda many private hospitals, hospices or clinics offer NHS-funded treatment.
PbR excluded medicines	There are a number of high-cost medicines that are excluded from the Payment by Results (PbR) tariff. They are typically specialist, and their use is concentrated in a relatively small number of centres, rather than evenly across all trusts that carry out activity in the relevant HRGs. These medicines would therefore not be fairly reimbursed if they were funded through the tariff.
Person	Patient and/or their carers.
Primary care	Includes General Practitioners (GPs), practices, practice staff.

Secondary care	Includes hospitals, providers, tertiary care, specialists, secondary teams, and specialist departments.
Shared Care	Shared Care applies to higher risk medicines requiring initiation for clinical reasons by a specialist, which also require regular blood monitoring and review over and above that which is usually provided by a GP, and where the GP has agreed to take on prescribing responsibility under a written agreement with the specialist for each patient. It should be noted that different organisations may use different terminology to describe the different levels of shared care.
SPC	Summary of Product Characteristics is a legal document approved as part of the marketing authorisation of each medicine.
Specialist service	This may include Mental Health, Tertiary care, Community providers, Private providers, GPs with a specialist interest.
Stable Patients	A patient who has been prescribed the medication for at least 3 months and monitored to demonstrate the treatment has been optimised and the response is consistent.
Traffic light system	This is a process of assessing a medicine and a condition by local medicines committees to establish whether it is safe and appropriate for GP prescribing (usually designated green), appropriate for shared care guidelines (usually designated amber) or for hospital only prescribing (usually designated red).
Unlicensed	There are clinical situations when the use of unlicensed medicines or use of medicines outside the terms of the licence (i.e. ‘off-label’) may be judged by the prescriber to be in the best interest of the patient on the basis of available evidence.