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**Process for Approval of Allocation of a New Primary Care**

**Virtual Practice Code**

Virtual practice codes:

* Are designed for teams of independent prescribers working across a number of practices / HSCP areas, where they are not linked to a single practice.
* Allow prescribing activity and spend to be linked to a virtual practice and thereby a group of practitioners providing a specific service on and outreach/locality basis
* Are not designed for individual practitioners or groups of practitioners with no common service theme

Requests for a new virtual practice will follow the process below:

The proposal form should be completed by the lead professional for the service e.g. the nurse/manager responsible for the day to day running of the service. The following details must be included:

* Description of the service in terms of pathway, clinical governance and corporate (financial) governance.
* The independent prescribers (names, registration numbers and confirmation of IP status) who will be part of the virtual practice.
* The following individuals are required to sign the form indicating their support for the proposed virtual practice:
	+ The named Head of Service / professional lead (i.e. the lead professional with overall accountability for the service, usually at least one grade above the service lead).
	+ The named operational / management lead for the service. This is likely to be a HSCP manager.
	+ The finance officer responsible for finance issues in the HSCP / service that the prescribing spend will be allocated / recharged to.

Once completed, the form should be sent to the Primary Care Prescribing Group via the Medicines Management email gram.medicinesmanagement@nhs.scot

Proposals will be considered at the next available meeting and written feedback will be given to the requestor within 30 days of a decision

NB Ordering of prescription pads will be an operational responsibility once the virtual practice is approved i.e. Responsibility sits with the virtual practice service lead.

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| **Request for Allocation of a New Primary Care Virtual Practice Code** |
| **Name of Professional Lead completing request** **(Block Capitals): Signature:****Date:****Email:** |
| **Name of Service:** |
| **HSCP / Locality:** |
| **Service Description:** *Include details on the following:*Why is a Virtual Practice Code required?To what population will the service prescribe – define HSCP/Practice/cluster & condition(s)/pathway?Is there a formulary for items that may be prescribed by this service? Is this in line with NHS Grampian Area Formulary?Describe the range of medicines/items that may be prescribed.Will there be any remote prescribing?Will there be any prescribing of controlled drugs?How will prescribing be documented?How will prescribing be communicated to appropriate individuals e.g. GP practice? |
| **Clinical Governance**: *Include details on the following:*Describe who will review professional practice of practitioners involved / be organisationally accountable for the professional practice in the service?How frequently and by whom will prescribing be reviewed? |
| **Corporate / Financial Governance:** *Include details on the following:*Describe who will hold budgetary responsibility and provide oversight of spend within the virtual practice |
| **\*List below each independent prescriber to be involved in prescribing from the virtual practice** |
| Name | Registration Number | IP Number (if applicable) |
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| \*If unable to name individual prescribers e.g. rotational/multiple practitioners involved in delivery of service ensure this is detailed below: |
| **This proposal is supported by the following in terms of clinical and financial governance** |
| Professional Lead DateName (Block Capitals) Signature |
| Operational / Management Lead DateName (Block Capitals) Signature  |
| Finance Officer DateName (Block Capitals) Signature  |
| **Completed form to be emailed to –** gram.medicinesmanagement@nhs.scot |
| ***Primary Care Prescribing Group – Medicines Management Team Completion Only*** |
| Received Date: Scheduled Primary Care Prescribing Group Date:Feedback Provided Date: |
| **Primary Care Prescribing Group Comments:** |
| **Primary Care Prescribing Group Approval/Non-Appro*val (delete as appropriate*) Date****Chair Name (Block Capitals) Signature** |