Worcestershire Acute Hospitals NHS Trust

Guidelines for Clinical Neurophysiology Referral

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guidelines for the requesting investigations in Clinical Neurophysiology

This guideline is for use by the following staff groups:

Health Care Science Neurophysiology
All professionals that refer for Neurophysiology investigations

Lead Clinician(s)

Kelly Bill / Dr Sarah Green — Clinical Service Manager, Neurophysiology /Consultant Clinical Neurophysiologist

Approved by Neurophysiology Governance Meeting Board on: 21st October 2025

Review Date: 21st October 2025
This is the most current document and should be used until a revised version is in place

Key amendments to this Document:

Date	Amendment	By:
23/08/17	Document Approved at Key Document Approval Group	KDAG
05/12/2017	Sentence added in at the request of the Coroner	
18/8/2019	Document updated Inclusion of QIP data for EEG referral Updated reference list Updated information on In- patient referral Addition of link to new request forms	KB
05/10/2022	Update – to add in vide	Specialty Medicine DMB
	Updated – to include national guidance on referral process	

Introduction

The Department of Clinical Neurophysiology at Worcestershire Acute Hospitals covers a wide range of routine and specialist investigations. These investigations are usually performed by scientists, medical consultants and practitioners (Clinical Physiologists). Ordinarily these are clinically interpreted by medical consultants, consultant Scientists or Clinical scientists/physiologists.

The growing demand for healthcare services, particularly in specialised areas, has led to significant challenges in ensuring that patients receive timely and appropriate investigations. As patient numbers increase, healthcare systems are increasingly facing the dual pressures of rising demand and limited capacity. This imbalance often results in delays, misallocation of resources, and referrals which have a low probability of contributing usefully to patient management. To address these challenges, it is essential to explore innovative approaches to working practices that can make best use of available resources and improve patient outcomes.

By using recommendations as outlined in these guidelines it is anticipated that there will be a reduction in the number of inappropriate referrals therefore having a positive effect on waiting times. The primary objective of this guideline is to improve clinical practice for the best outcome of the patient.

Users

This document is intended for use by all referring practitioners, in particular extended scope practitioners and newly qualified doctors. For all neurophysiology investigations an appropriate referral is required.

This referral should be made using the Neurophysiology request form.

This can sent via email:wah-tr.NeurophysiologyElectronicReferrals@nhs.net

All primary care referrals should be made via the ERS system.

Link to referral form:
http://nww.worcsacute.nhs.uk/EasysiteWeb/getresource.axd?AssetID=120807&type=Full&servicetype=Attachment

http://nww.worcsacute.nhs.uk/EasysiteWeb/getresource.axd?AssetID=120808&type=Full&servicetype=Attachment

Rationale

It is deemed that a useful investigation may have a positive or negative result, but it must either alter the clinical management of the patient or add to the confidence of the clinician's diagnosis. Some of the causes of wastefulness in neurophysiology investigations are;

- Investigations where the result is unlikely to affect the patient management.
- Failing to provide appropriate clinical information with a question that the investigation should answer.
- Relying on investigations more than clinical assessment/examination (i.e. over investigating)
- Un-necessary repeating of investigations

Referral rejection

Referrals deemed inappropriate or which fall outside our referral criteria will be rejected. Referrals with limited or unclear clinical history will be returned, requesting either further information or clarity on the referral information or query.

Reason for rejection	Actions
Inadequate: History / Clinical Details / Examination Findings	Ask to re-refer with further information
Suspected diagnosis / differential diagnosis not clear	Ask for clarity on diagnosis
Neurophysiological investigation is unlikely to be helpful in this scenario	Explain why
Requires input from a specialist prior to referral	Explain that need specialist input, e.g. evidence of onward referral, advice and guidance etc.

Electroencephalography (EEG)

The electrical activity of the brain (EEG) can be recorded using scalp (surface) electrodes or in specialist circumstances depth electrodes (intercranial) electrodes. At Worcestershire Acute Hospitals Trust (WAHT) surface electrodes are used. For the purpose of these guidelines 'EEG' will refer to surface EEG.

Types of EEG currently available at WAHT are:

- Routine (with video)
- Sleep (deprived, sedated, natural)
- Ambulatory
- Video home Ambulatory
- Multiple sleep latency test (MSLT)

Routine

Outpatient Routine EEG recordings are taken from 20 minutes to several hours' dependent on clinical circumstances. Therefore, they are not deemed to be a 'quick' test even though they are relatively inexpensive and are not invasive. They will include

hyperventilation and photic stimulation as standard activation procedures, unless contraindicated (EEG guideline WAHT 2021)

Inpatient EEGs – will be adapted to each individual case and may be shorter in length and activation techniques are usually omitted. It is therefore important to ensure only medically urgent/acutely ill patients receive an inpatient EEG that will have a direct impact on care, treatment and management at that time. All other patients should be seen as an outpatient where appropriate.

Sleep EEG

Sleep deprivation is evidenced to increase the sensitivity of abnormality in the EEG (Giorgi et al., 2014, Meritam 2018). There are a number of different approaches to obtaining a sleep recording. These are: sleep deprivation, partial sleep deprivation, sedated sleep or natural sleep. The clinical scientist/physiologist will help determine the best approach in triaging, however, please include Melatonin prescription for all children under 3.

Ambulatory EEG /Home VT

These will be performed on an outpatient basis usually after routine EEG's have already been performed. However, to aid in the diagnosis of juvenile myoclonic epilepsy an ambulatory EEG may be performed in the first instance.

Recommendations for standard EEG

An EEG should be performed only to support a diagnosis of epilepsy in adults in whom the clinical history suggests that the seizure is likely to be epileptic in origin. (NICE 2004, 2018, 2023). A single routine EEG can be used to determine seizure type and classify epilepsy syndromes when the clinical features are highly suggestive of epilepsy (NICE, 2018, 2022). This enables children, young people and adults to be given the correct prognosis. In children, young people and adults presenting with a first unprovoked seizure, unequivocal epileptiform activity shown on EEG can be used to assess the risk of seizure recurrence (NICE 2004, 2018, 2022).

A single routine EEG can be used to determine seizure type and classify epilepsy syndromes when the clinical features are highly suggestive of epilepsy (NICE, 2018). However, the sensitivity of a routine EEG is around 50% (Smith, 2005), meaning that the EEG may be normal in many people with epilepsy. The specificity of inter-ictal abnormalities in an EEG is 70-90% (Smith, 2005).

Using EEG to assess cerebral function or diagnose and evaluate neurological conditions apart from epilepsy has widely been evidenced with varied sensitivity and specificity. When used in conjunction with a clear clinical history EEG can be used to aid diagnosis in the following circumstances:

When to refer for an EEG

Where seizures or non-convulsive status epilepticus (NCSE) may be a contributing to acute confusion

- Classification of epilepsy/seizures
- Record Non epileptic attack
- Clinical seizure in neonates
- Seizure control in children and neonates
- Assessment of ESES in hypsarrhythmia
- To detect focal or lateralised abnormalities which could suggest a structural basis for an encephalopathy
- To identify diagnostic EEG patterns in appropriate clinical settings, such as sporadic Creutzfeldt-Jakob disease (CJD), Herpes Encephalitis (HSV).
- Prognostication after hypoxia due to cardiac arrest or in neonates and children.

Circumstances where EEG is unlikely to be helpful

- Possible epilepsy or to rule out epilepsy - where there is a low suspicion of epilepsy, except if querying Non-Epileptic Attack Disorder (NICE, 2022; Kou et al, 2019; Smith, 2001)
- Likely syncope (Dantas et al. 2012; NICE 2023)
- Typical febrile seizures in children (Harini et al. 2015; Kuturec et al. 1997; ANZCS, 2018)
- Known epileptic – unless significant change in seizure semiology or recurrence after prolonged seizure freedom, or doubt about previous diagnosis, also subacute cognitive dysfunction and suspicion of superimposed toxic/metabolic encephalopathy or subclinical seizures
- Migraine (de Tommaso, 2019)
- Slowly progressive cognitive decline / dementia (AAN, 1994)

Recommendations for use of Home Video telemetry/Ambulatory (adults and children)

The department has the facility to offer home long-term monitoring with video. This is limited due to equipment constraints. Simultaneous video and EEG is proven to

increase the diagnostic yield of epilepsy classification (Cascuno 2022).
The referral should be made to the department. These cases will be assessed based on frequency of events and reasoning for video monitoring. Reasons for referral would include:

- Nocturnal events (frequent 3 plus per week)
- If routine and sleep-deprived EEG results are normal and diagnostic uncertainty persists (NICE guideline, 2022)
- Increased frequency in events
- Multiple types of events
- To capture a non-epileptic event
- Where there is difficulty in determining the semiology i.e. focal or generalised.

Recommendations specific for children and young people

An electroencephalogram (EEG) should be performed only to support a diagnosis of epilepsy in children and young people. If an EEG is considered necessary, it should be performed after the second epileptic seizure but may, in certain circumstances, as evaluated by the specialist, be considered after a first epileptic seizure (NICE 2004, 2018 2023).
In children and young people, a sleep EEG is best achieved through sleep deprivation or the use of melatonin. (NICE 2017 2023)

If diagnosis is still unclear after a standard EEG

If epilepsy is suspected, other specialist neurophysiological investigations are available, such as sleep EEGs or ambulatory EEGs.

Repeated standard EEGs may be helpful when the diagnosis of the epilepsy type or the syndrome is unclear. However, if the diagnosis has been established, repeat EEGs are not likely to be helpful (NICE 2004, 2018).

Do not use repeated standard EEGs in preference to sleep or sleep-deprived EEGs. When a standard EEG has not contributed to diagnosis or classification of epilepsy, a sleep EEG may be performed (NICE 2004). In children and young people, this is best achieved through sleep deprivation or the use of melatonin (NICE 2012).

Do not use repeated standard EEGs if the diagnosis has been established (NICE 2018 2023).

Nerve conduction study/EMG referrals

Appropriate NCS/EMG referrals with caveats

Clinically indicated	Caveats
Polyneuropathy – diabetic, chemotherapy related, critical illness or unspecified	Clinically isolated small fibre neuropathy as NCS can only assess large fibres (Raasing et al. 2021; Hovaguimian and Gibbons, 2011)
Mononeuropathy: Median CTS Ulnar (elbow or wrist) Radial (wrist drop) Fibular (fibular head) Long thoracic	For suspected CTS, refer to our ICB guidance before considering referral. Mild to moderate cases should be managed for at least a minimum of 6 weeks with a wrist splint or steroid injection, and urgent cases should be referred to the hand surgeon urgently for consideration of surgery
Nerve injuries Median (and distal branches) Lateral cutaneous nerve of the forearm Ulnar (and dorsal ulnar cutaneous) Medial cutaneous nerve of the forearm Radial Saphenous nerve Musculocutaneous Medial plantar nerve Spinal accessory Lateral plantar nerve Femoral Sciatic Sural Superficial fibular Axillary nerve	Vague sensory symptoms that do not map to an individual peripheral nerve distribution, as these are unlikely to have a peripheral nerve cause. Please note that we are unable to diagnose piriformis syndrome; this is a clinical diagnosis.
Mononeuritis multiplex	Small patches of numbness not in a peripheral nerve distribution. Symptoms should be in the distribution of at least 2 peripheral nerves. (Does not have to be simultaneously).
Cervical and lumbosacral radiculopathy	Radiculopathy when the diagnosis is secure based on clinical imaging findings (with the exception of a spinal surgeon querying active denervation). Cervical radiculopathy: note that EMG is not mentioned anywhere in the NICE guidance. They recommend conservative management for 4-6 weeks, and

	an MRI in cases where the symptoms do not improve. Lumbosacral radiculopathy: note that EMG is not mentioned anywhere in the NICE guidance. Sciatica should resolve over weeks to months with conservative management in the majority of cases. Specialist referral is recommended if pain is non-tolerable at 6 weeks.
Brachial or lumbosacral plexopathy, including. thoracic outlet syndrome, brachial neuritis etc.	Neuralgic amyotrophy/brachial neuritis: where this is suspected, please consider urgent referral for rehabilitative physiotherapy
Disorders of the neuromuscular junction – MG, LEMS. (Antibody testing should be first line, unless clinical urgency, e.g. bulbar symptoms)	. If there is a clear clinical response to pyridostigmine or antibodies are positive, testing is not indicated. Testing will be considered where there is diagnostic uncertainty, i.e. negative antibodies and no clear treatment response. All cases should be discussed with Neurology prior to referral.
Disorders of the anterior horn cells - MND	AHCD/MND: note that where these conditions are suspected, you should be discussing urgently with a Neurologist Not appropriate if no motor weakness/wasting/abnormal neurology (Ramahi et al. 2014; Kaufman, 2007), such as in benign fasciculation syndrome, unless FH of MND or high level of anxiety surrounding symptoms.
Disorders of the muscles – myositis, myopathy	Myalgia without weakness
Specialist NCS/EMG - pudendal studies. Cases must have been discussed with neurology before referral.	

Inappropriate NCS/EMG referrals with caveats

Not clinically indicated	Caveats
Length dependent neuropathy in the >70's; interpretation of abnormalities is limited as the distal responses may be diminished due to age.	Unless you are trying to distinguish between peripheral neuropathy and an alternative cause (i.e. radicular or focal entrapment). Clinical correlation is required; peripheral neuropathy tends to present with length-dependent symmetrical symptoms.
Recent relevant study performed	Unless significant clinical change since study
Symptom duration less than 10-14 days for NCS and 2-3 weeks for EMG (Kamble et al. 2019; Parry, 1992)	Please see point above regarding CTS referrals.
Intermittent paraesthesia relating to position, e.g. leaning on elbow	
Tarsal tunnel syndrome.	
Pain as a stand-alone symptom	Unless clinical signs on examination, or radicular query
Muscle aches/ myositis /myopathy where there is no significant weakness	
Jerks / myoclonus / tremor / spasms without other neurological abnormality. These should be discussed with Neurology.	Cases of tremor may be considered on an individual basis, e.g. confirmation of rate of orthostatic tremor, or clinical suspicion of psychogenic tremor.
Clinically sound Meralgia Paraesthetica. (Scholz et al. 2023; Hui and Peng, 2006)	Unless clinical history is more suggestive of radiculopathy
Piriformis syndrome	Unless differential is radicular
Unsteadiness / poor balance	Unless the clinical examination supports length-dependent peripheral neuropathy, e.g. absent ankle jerks and reduced sensation in the feet.
Small fibre neuropathy (Raasing et al. 2021; Hovaguimian and Gibbons, 2011)	Alternative testing not available in Worcestershire Acute Hospitals Trust
Fasciculations without weakness (Ramahi et al. 2014; Kaufman, 2007)	Unless abnormal neurology / family history of MND / significant anxiety over symptoms

Abnormal speech / swallowing	Unless abnormal cranial nerve examination
Breathlessness	Unless limb weakness or proven type 2 respiratory failure
Thoracic sensory symptoms	
Long standing nerve palsies (> 5 yrs)	Unless recent clinical change
Central lesions (e.g. Multiple Sclerosis)	Unless also symptoms/signs of peripheral nerve pathology
Small areas/patches of numbness/paraesthesia not involving an entire peripheral nerve distribution	

Visual Evoked Potentials

Type of test	Query diagnosis
VEP/PERG	Optic nerve/macula dysfunction
Half field VEP	Visual field defect
Onset/offset VEP	Albinism or poor visual acuity/compliance
Flash VEP	Poor visual acuity/compliance
VEP/PERG/ERG	Retina +/- optic nerve
VEP/PERG/ERG/EOG	Retina +/- optic nerve and EOG requested or ?Best's disease

Visual electrodiagnostic investigations should be performed as an outpatient. Inpatient consideration may be given to patients with acute visual loss, where the cause is unknown.

Inpatient Referrals (all investigations)

As a standard the department aims to see each inpatient, where clinically appropriate, within 24hours of receipt of referral. When taking into consideration the content of this document, referrals will be accepted into the department. It may be necessary to suspend a referral until further information is available. Where possible all referrals should be discussed with a member of the Neurophysiology clinical team. There will be variation and adaptation to the outpatient process to allow inpatients to be seen in a timelier manner. There may be adaptations to the procedure of the investigation for differing clinical circumstances.

Electroencephlogram (EEG)

The majority of inpatients will be seen at the bedside for their EEG – therefore activation procedures are not routinely performed. The length of the EEG recording will be adapted depending on the clinical circumstances.

Indications for inpatient EEG (without activation)
Supporting the diagnosis of subclinical seizure *if* the patient has not come back to baseline within 24 hours of admission
Status epilepticus (clinical or subclinical) or uncontrolled seizures
Suspected NEAD with ongoing episodes
Support the diagnosis of Encephalopathy/unexplained rapid cognitive decline
Unexplained confusion/reduced GCS
Support the diagnosis of Encephalitis, e.g. HSV
HIE or seizures in ITU
Infantile spasms
Seizures in neonates
Referrals considered on a caseby-case basis, if deemed urgent and may have an effect on management

Nerve conduction Studies (NCS)

The majority of nerve conduction patients will need to be seen in the department due to the nature of the investigation and the need for electrical interference to be minimal for optimal results.

Electromyography (EMG)

These patients will have to be seen in the department due to the nature of the investigation and to limit electrical interference and gain optimal results.
These investigations are currently largely performed by the Clinical Consultant within the department. At the time of writing this document, this is a single-handed consultant

with no cover for EMG services This limits the availability of these investigations. If this investigation is required at a time when the Consultant Neurophysiologist is on leave, the referring doctor may have to consider having the investigation elsewhere or transferring the patient if clinically necessary.

Indications for inpatient NCS/EMG
Guillain Barre Syndrome (≥10 days post onset of Neurological symptoms)
Acute Myasthenic crisis
Motor Neurone Disease
Myositis (if >2 weeks post symptom onset)
Significant nerve injury if >3 weeks post onset
Mononeuritis multiplex secondary to possible vasculitis
Paraneoplastic neuropathy
Referrals considered on a case-by-case basis, if deemed urgent and would have an effect on management

Evoked Potentials (EP's)

It is not usual practice to perform evoked potentials on inpatients. However, individual clinical cases can be discussed with the clinical team within the department.

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Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Kelly Bill – Clinical Service Manager Neurophysiology
Dr Alison Blake – Consultant Neurophysiologist
Neurophysiology clinical staff
Neurophysiology department

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Divisional management Committee – Speciality medicine
Neurophysiology governance group

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Appropriateness of referral	Triage of referral by clinical staff	Every day	Clinical Staff	All non –appropriate referrals will be highlighted to the referring physician – documented on the audit sheet	Report to head of department on a monthly basis
	Change in national and regional guidelines	Bi-annual checks are carried out to ensure compliance with current guidelines	Bi-annual	Head of department	Any change in clinical guidance will go through a review process of the policy.	Bi-annually and reported at review of policy date

Worcestershire Acute Hospitals NHS Trust

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	#	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Kelly Bill**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Kelly Bill	**Clinical Service Manager Neurophysiology**	**k.bill@nhs.net**
Date assessment completed	**5/10/2022**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Policy – Guideline for Neurophysiology Referrals			
What is the aim, purpose and/or intended outcomes of this Activity?	To give guidance for referral process and acceptance of referals.			
Who will be affected by the development & implementation of this activity?	❑#	Service User	❑#	Staff
	❑#	Patient	❑	Communities
	❑	Carers	❑	Other _____
	❑	Visitors	❑	

Is this:	❑ #Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	This policy has been in use since 2019 – there have been no complaints or incidents related to the use of the policy. There has been an update in 2020 based on a QIP related to continued improvements of the policy. On this review of the policy staff within the department were consulted and contributed to the review.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	This policy has been reviewed by the neurophysiology department. The policy has been successfully in place since 2019 – based on no complaints, or incidents relating to the policy. Updated references have been used to support he policy and its continued use.
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		*		
Disability	#			By using this policy it ensures that all patients have equal access to the appropriate neurophysiology investigations by following the standards of referral within the policy.
Gender Reassignment		*		
Marriage & Civil Partnerships		*		
Pregnancy & Maternity		*		
Race including Traveling Communities		*		

Religion & Belief		*		
Equality Group	**Potential positive impact**	**Potential neutral impact**	**Potential negative impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**
Sex		*		
Sexual Orientation		*		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		*		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		*		

Section 4

What actions will you take to mitigate any potential negative impacts?	**Risk identified**	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Timeframe**
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**Annually or when any identified incident or complaint has arisen.**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Kelly Bill
Date signed	30/10/2025
Comments:	
Signature of person the Leader Person for this activity	Kelly Bill
Date signed	30/10/2025
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

If the response to any of the above is yes, please complete a business case which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval