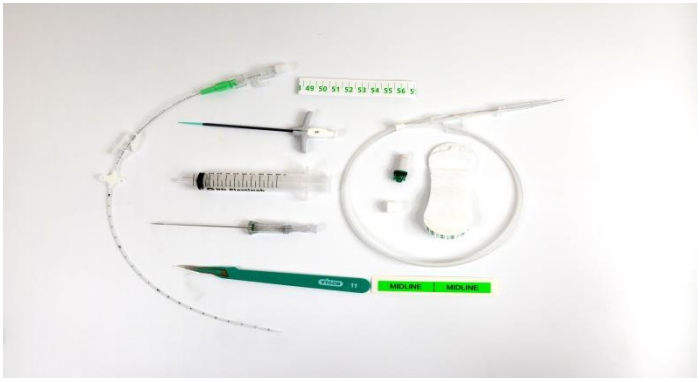
INSERTION OF MIDLINE GUIDELINE FOR PATIENTS ON ARU

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

This guideline focus on the management of patients who require Midline insertion on the acute respiratory unit (WRH)



Lead Clinician(s)

Heather Lloyd	Pleural Lead Nurse
Approved by Respiratory Directorate Meeting:	7th March 2022
Approved by DMB:	11th May 2022
Approved by Medicines Safety Committee:	13th July 2022
Review Date: This is the most current document and should be used until a revised version is in place	13th July 2025

Key amendments to this guideline

Date	Amendment	Approved by:

Background

This document sets out the guidance for the insertion of a Midline using the Seldinger Technique for Nurse practitioners on the respiratory ward. The patient group may include those with difficult IV access who are requiring IV therapy for more than 5 days.

A midline is a device inserted peripherally into the basilic, median, cubital or cephalic veins and is approximately 20-30 centimetres long. The tip sits in a large axillary vessel but does not go into the central circulation. It is used for longer term intravenous access for the administration of chemotherapy, antibiotic therapy, IV fluids and to take blood samples from. It can be sited under direct vision of the vein or under ultrasound guidance. Midlines should be used for approximately 6 weeks duration.

Purpose

Identify the procedure for the assessment and insertion of a midline.

To ensure competency of the Nurse Practitioner to insert Midlines

Improve personal care for the patient and reduce the risks associated with having a midline sited by identifying evidence based safe systems of work.

Contraindications

- **Patients requiring over 6 weeks of therapeutic intravenous medication should be considered for a PICC line.**

To reduce the length of stay for this patient group who require long term intravenous therapy treatment.

Scope

This guideline relates to the following staff groups who may be expected to assess and insert a midline and should be used in conjunction with standard operating procedures which refer to the administration of injectable medications and the management and maintenance of a midline:
Nurse Practitioners on the respiratory unit.
Staff undertaking this procedure must be able to demonstrate attendance at relevant training and be assessed as competent as per local competency assessment and must demonstrate the following:

- Nurse Practitioners are educated, trained and competent to undertake insertion of Midlines.
- Nurse practitioner are educated, trained and competent to explain and discuss insertion of Midlines and obtain informed written consent from the patient
- Nurse practitioner demonstrates appropriate level of knowledge in the theory and practice of the insertion of Midlines
- Nurse practitioner demonstrates knowledge of the relevant anatomy and physiology of the upper limb and thoracic venous system.
- Nurse practitioner can describe the functions of the venous system and use of a midline.
- Nurse practitioner ensures patient and staff safety is met throughout the procedure.

- Nurse practitioner demonstrates appropriate Infection Control practices (See WAHT-INF-050).
- Nurse practitioner understands and demonstrates the importance of accurate and concise documentation.
- Nurse practitioner demonstrates an understanding of informed patient consent, and ensures a process is in place for gaining written consent

A chest x-ray is not required following midline insertion as the tip ends in the axillary vein and does not enter the central system.

Location

This Procedure can be implemented in a setting where competent staff are available to perform this skill and asepsis maintained (ideally a dedicated procedure room).

Midline Insertion Procedure

1. **Patient**
   - Give the patient information leaflets.
   - Check patient medical history and notes for reason for midline request and check medications for anticoagulant therapy and allergies.
   - Counsel the patient re need for the midline and the risks and benefits and gain consent.
2. **Collect the equipment required**:
   - Portable Ultrasound machine (if ultrasound guided procedure)
   - Ultrasound conduction gel
   - Disposable tourniquet
   - Vygon Midline kit
   - Sterile gloves x 3
   - Filter needle x 1
   - ChloraPrep 2% lolly pop X2
   - 10ml luer-lock syringe
   - 5ml luer-lock syringe
   - Semipermeable IV Transparent Dressing

   Sterile sodium chloride 0.9% posiflush device (10mls) and Lidocaine 1% (5mls)

3. **Non-sterile vessel assessment with ultrasound.**
   - Instruct the patient on the purpose of the ultrasound procedure.
   - Position the patient with the arm supported.
   - Ensure that the Ultrasound machine is in a suitable location for optimum visualisation by the placer
   - Scan the patient with a non-sterile technique to determine the size, location, depth and patency of the veins and location of nerves and arteries
   - Identify insertion site.
   - Choose appropriate size and length of Midline

4. **Preparation**
   - Prepare the sterile field:
   - Put on apron and mask.
   - Wash hands
   - Open sterile midline pack, gown and gloves maintaining sterility

- Wash hands and arms using a surgical scrub technique.
- Dry hands using sterile towels and apply 1st pair of sterile gloves.
- Open remaining sterile items onto the trolley in a manner that maintains strict asepsis.
- Open outer Midline pack and place on sterile pack.
- Remove the gloves and then gel hands with alcohol gel
- Put on sterile gown & sterile gloves
- Draw up lidocaine injection (in 5ml syringe) and place an orange needle onto the filled syringe – only a 5ml syringe and a 10ml sodium chloride posiflush device are permitted onto the sterile field in order to clearly distinguish between the lidocaine and the sodium chloride 0.9%
- Ensure all lines are flushed with sodium chloride 0.9%.

5. Prep the patient

- Cleanse the skin thoroughly using Chloraprep 2% using a friction scrub technique for at least 30 seconds, allowing to air dry for at least 30 seconds. Place sterile drape underneath the arm and across the body.
- Cleanse the skin thoroughly once more using Chloraprep 2% using a friction scrub technique for at least 30 seconds, allowing to air dry for at least 30 seconds.
- Change sterile gloves.
- Drape the insertion site with fenestrated sterile drape.
- Drape the probe for sterile use:
- Apply a layer of sterile ultrasonic gel on the acoustic window of the probe. You will require an assistant to do this.
- Place the sheath over the probe head, being careful not to wipe off the gel Cover the probe and cable with the sheath without contamination
- Smooth the sheath over the acoustic window of the probe head and remove any air bubbles
- Use a sterile elastic band to hold the sheath in place.
- Place the probe safely onto the sterile drapes.
- Ask assistant to apply tourniquet.

6. Insertion of the Midline

- Apply sterile gel onto the skin at the intended site of cannulation
- Locate the site of a suitable vein for venepuncture using the ultrasound machine, measure and mark insertion site.
- Prepare catheter, flush and trim if necessary.
- Administer subcutaneous/intradermal lidocaine at the proposed venepuncture site. The dosage of local anaesthesia should be adjusted according to the response of the patient and the site of administration. The lowest concentration and smallest dose producing the required effect should be given. No more than 5mls of lignocaine 1% should be required.
- Place the probe on the skin at the intended access site and hold the probe perpendicular to the vein. Realign the vein on the centre dot marker (if using, on the ultrasound screen).
- If the vein is superficial, a longitudinal method can be used to place the needle into the vein
- When the vein is successfully accessed blood return will be observed in the needle. If cannulation is unsuccessful after 2 attempts, consider seeking assistance from another equally competent practitioner.
- Introduce the soft tip of the guide wire into the needle and into the blood vessel and advance to required depth.

- The wire should never be forced.
- Take extreme care not to lose the wire into the bloodstream, allow at least 10cm of wire outside the sheath and dilator (if using).
- Remove the needle over the guide wire holding the guidewire securely.
- Remove tourniquet.
- Make a small incision in the skin to allow the introducer to enter the vein through the skin
- Using 4fr midline kit thread the peel away introducer over the guide wire, through the subcutaneous tissues and into the vein and remove the guide wire holding the end of the introducer to minimise bleeding and prevent air entry. Then remove the white dilator situated within the introducer slightly rotating to unlock it and again covering the end of the introducer to prevent bleeding and air entry.
- Thread midline to position the tip in the axillary vein through the peel away catheter. Do not force the midline if it does not feed in smoothly.
- Once in position hold the midline securely and gently withdraw the peelable introducer slightly and begin peeling the introducer away from the catheter in several movements gently advancing the catheter in to the right position as the introducer is pulled back.
- Remove the inner stylet and place a needle free device on the end of the catheter.
- Secure the Midline with the midline skin locking device, cover with waterproof translucent dressing.
- Ensure you can aspirate the line and then flush the line with 10mls sodium chloride 0.9% posiflush device with a push pause technique.
- Safely dispose of sharps and correctly dispose of the insertion packs.

7. Documentation

4. Document the procedure in the medical notes ensuring the pack sticker with all of the product information is included in the notes. Clearly document:

   Insertion date
   Type, length and guage of catheter.
   Where it was inserted
   Any problems
   How it was secured
   Date for next dressing and bionector change.

8. Maintenance of Midline

Following device insertion, it is important that the device is managed correctly to prevent post insertion complications. Staff working with central venous access devices must have undergone training and education as stipulated by the Trust.

General guidance on catheter care:

5. Always determine if the device is needed and remove if it is no longer required or is causing harm to the patient.

Dressing regimens:

The function of dressings is multiple and includes providing security for the catheter to prevent dislodgement. They also provide a barrier impermeable to water and bacteria. They protect the catheter site from extrinsic contamination and discourage bacterial production at the insertion site (Gillies 2003).

6. Aseptic non-touch technique or an aseptic technique should be used when accessing venous access devices.
7. Dressings should be transparent to allow visual inspection of the site, they should be self adhesive and provide stability thus reducing the risk of vein intima trauma, phlebitis and contamination.
8. The dressing should be semi-permeable to protect the site from bacteria and liquid while still allowing the skin to breathe (NICE 2003).
9. Dressings should be inspected at each shift change
10. Dressings should be changed at least every 7 days or sooner if no longer intact or if moisture collects under the dressing
11. If a patient has profuse perspiration or if the insertion site is bleeding or oozing a sterile gauze dressing can be used. This will require daily inspection and replacement if it becomes damp, loose or soiled (NICE 2003).
12. A gauze dressing should be changed to a transparent dressing as soon as possible (NICE 2003)
13. Use a 'grip lok' device to stabilise the device.

Procedure for dressing change

- Wash and dry hands and put on a pair of clean gloves
- Prepare the patient, explain the procedure and gain consent
- Clean and set dressing trolley
- Remove old dressing and discard immediately
- Observe the exit site
- Wash and dry hands again or use an alcohol rub and put on a new pair of sterile gloves
- Clean the exit site with chlorhexidine 0.05% or above and 70% alcohol (chloroprep) for at least 30 seconds and allow to dry completely.
- Apply new securement device (grip-lok)
- Secure the catheter with a new dressing.

Maintaining catheter patency

It is important that the function of the catheter is maintained to prevent disruption in patient treatment.

Occlusions can be mechanical. These types of occlusion are caused by inadequate function of some part of the administration set up, the dressing or the catheter that interrupts the flow. Some of these occlusions are easily identified such as kinks or closed clamps. Others are less obvious and can be caused by the internal positioning of the catheter (RCN 2010). Mechanical occlusions can be ruled out by checking the following:

- IV tubing – is it clamped or kinked?
- Are all connections tight with no air leaks?
- Is the catheter kinked, twisted or misplaced?
- Does the changing of patient position improve the situation?

If these strategies do not allow the aspiration or delivery of medication the patient should be referred for further investigation of their device.

Blood occlusions occur when a clot completely occludes the lumen of the catheter. Blood occlusions can occur suddenly or over time. Failure to flush a device is a common cause of catheter occlusion.

Persistent withdrawal occlusion (PWO) The body reacts to any irritant in the vascular system by depositing fibrin around the irritant. In vascular access devices the body sees the catheter as a foreign object and deposits fibrin and thrombus around it (Santilli 2002). The first sign of a fibrin sheath is the inability to withdraw blood from the catheter. The vacuum created by negative pressure of withdrawal pulls back a flap, which is formed by the fibrin sheath, against the catheter opening and this prevents blood from entering the lumen. Fluids however can be delivered freely.

The catheter must be aspirated to ensure blood return prior to the delivery of medications or solutions (INS 2016). However according to the RCN (2010) there is no requirement to routinely withdraw blood and discard it prior to flushing (except prior to blood sampling, although the first sample can be used for blood cultures).

Catheter clearance

Flushing of catheters is important for maintaining catheter patency (Loveday et al 2014)

- Catheters should be flushed with sodium chloride 0.9%
- Devices should be flushed prior to and following each infusion (INS 2016)
- A turbulent flush should be used by using a push/pause/stop/start positive pressure technique. This will help remove debris from the internal catheter wall.
- Catheters are designed to withstand venous infusion pressures but typically infusion pressures should never exeed 25-40 pounds per square inch. Therefore syringes used for flushing central venous access devices should be no smaller than 10mls. Smaller syringe sizes will generate excessive pressures and could lead to catheter fraction (Hadaway 2010).
- Flushing should be performed weekly when the device is not in regular use (Loveday 2013)
- Heparin is not required to ‘lock’ Midlines.

Procedure for catheter clearance

- Check patient identity, explain procedure and gain consent
- Wash hands and apply clean gloves. ANTT method should be employed.
- Draw up sodium chloride 0.9%
- Remove old gloves, rewash hands or apply alcohol rub and apply new sterile gloves
- Use a sterile swab to pick up the catheter end and use an alcohol swab to ‘scrub the hub’ for at least 15 seconds. Allow to dry completely.
- Place the end of the catheter onto a sterile drape.
- Attach the 10ml sodiym chloride 0.9% syringe, unclamp catheter.
- Aspirate gently to ensure catheter patency then using a positive pressure ‘push/pause’ technique flush the catheter
- Clamp the catheter or remove the syringe during delivery of the last 1ml of sodium chloride 0.9%

- If there is difficulty aspirating or flushing use the techniques detailed above and if necessary refer the patient for further investigations if problems persist.
- Never force solution into the catheter
- If a needle-free device is in place and requires changing, the end of the catheter should be cleaned with alcohol for 15 seconds, allowed to dry and a new needle free device attached.

9. Removal of Midline.

Midline devices should be removed as soon as they are no longer required or if they are causing the patient harm (Loveday 2014). Vascular access devices should only be removed by competent practitioners. The patient should be prepared for the procedure, the procedure explained and consent gained.

Collect the equipment required

- Dressing trolley
- Plastic apron
- Sterile basic dressing pack
- Sterile gloves
- Skin cleaning product
- Transparent, semi- permeable, occlusive dressing (e.g.IV3000)

Procedure for catheter removal

- Check patient identity
- Explain procedure to patient
- Gain informed consent
- Establish appropriate position (exit site below heart level)
- Ensure patient comfort
- Support arm with pillow
- Wash hands
- Open sterile pack onto clean dressing trolley
- Drop all necessary equipment onto pack
- Decontaminate hands with alcohol rub and put on clean gloves
- Remove old dressing from the bottom up to avoid inadvertent device removal
- Remove stabilising device with the use of an alcohol swab
- Remove and dispose of gloves
- Clean hands using alcohol gel
- Put on sterile gloves
- Place sterile sheet under the line
- Clean exit site with chloroprep using back and forth, up and down motions
- Position a swab just above the insertion site
- Apply traction and gently pull the catheter out in a steady, even manner
- Always pull from near the insertion site
- Apply gentle pressure to the area whilst removing the catheter and following complete removal
- Ensure haemostasis before reducing pressure
- Apply either a gauze and bioclusive dressing or bioclusive dressing alone

Potential complications during removal

During catheter removal the tunica media is stimulated. This can lead to venospasm. This will result in difficulty in catheter removal and will feel as if the catheter is stuck. To reduce spasm, hot and cold compresses used alternatively can be useful (Dougherty 2006). Often it is worth waiting and retrying after a short time. If the problem persists contact an Interventional radiologist for advice and assistance.

Monitoring Tool

How will monitoring be carried out?	Reflective Audit of all patients with pin sites / external fixators to ensure Policy met
When will monitoring be carried out?	Ongoing for all patients with Midlines
Who will monitor compliance with the Guideline?	Ward Manager/ Matron

Standards:

Item	%	Exceptions
All patients will be given a Midline Patient information leaflet	100	None

References

Dougherty, L (2006) Central Venous Access Devices, Care and Management, Blackwell Publishing, Oxford

Gilies, D et al (2003) Central venous catheter dressings: a systematic review. Journal of Advanced Nursing 44(6) 623-632

Hadaway L (2010) Technology of flushing vascular access devices. Journal of Infusion Nursing 29 (3) 137-145

https://www.medicines.org.uk/emc/product/4781/smpc#gref

Infusion Nurses Society, policies and practices for infusion therapy (available online):http//ins.tizrapublisher.com/hha7v4/

Loveday HP et al (2013) epic3:NationalEvidence-based guidelines for preventing healthcare-associated infections in NHS Hospitals in England. London: Elsevier Ltd

National Institution for clinical excellence (NICE) (2014) Infection prevention and control, NICE Quality Standards – Vascular access devices https://www.nice.org.uk/guidance/qs61/chapter/quality-statemnt-5-vascular-access-devices.

Royal College of Nursing (2010) Standards fot Infusion therapy. RCN Intravenous therapy forum, London

Santilli J (2002) Fibrin sheaths and central venous catheter occlusions:diagnosis and management. Techniques in vascular and Interventional radiology:5 (2) 89-94

WAHT–INF-050 Infection prevention procedure and practice guideline for intravenous access devices (IVAD)

CONTRIBUTION LIST

Key individuals involved in amending this guideline

Name	Designation
Heather Lloyd	Pleural Lead Nurse

Circulated to the following individuals for comments

Name	Designation
Clare Hooper	Respiratory Lead Consultant
Bethan Barker	Respiratory Consultant
Stephen O'Hickey	Respiratory Consultant
Kate Cusworth	Respiratory Consultant
Amanda James	Respiratory Consultant
Jamie Johnstone	Respiratory Consultant
Sarah Deacon	Respiratory Consultant
Abhi Lal	Respiratory Consultant
See Ling Tan	Respiratory Consultant

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Dr Will Foster	Respiratory Clinical Director
Sue Smith	Director of Nursing
Clare Alexander	Matron Respiratory Worcester
Marian Freeman	Matron Respiratory Alex
David Whitelock	Anaesthetist

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Dr Hugh Morton	Infection Control

Supporting Document 1 – Equality Impact Assessment form

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.

Please complete assessment form on next page;

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	**Corinna Winkworth**

Details of individuals completing this assessment	**Name** / **Job title** / **e-mail contact** **Heather Lloyd** / **Pleural Lead Nurse** / **Heather.lloyd5@nhs.net**
Date assessment completed	**02/03/2022**

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Insertion of Midline guideline
What is the aim, purpose and/or intended outcomes of this Activity?	Guideline to focus on the insertion and management of patients who require midlines.

Who will be affected by the development & implementation of this activity?	❑ ✓❑ ❑ ❑	Service User Patient Carers Visitors	✓❑ ❑ ❑ ❑	Staff Communities Other _____	
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.	Peer Consensus. Literature review. Manufacturer Literature
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Circulated to wider group for comments
Summary of relevant findings	Comments received were actioned.

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		✓	✓	The guideline takes age in to account. The guideline is for all nurses who have been trained appropriately to Insert Midlines. Elderly patients may have difficulty noting problems with midlines. If a patient is unable to monitor problems from a midline, a district nurse / home OPAT team would be arranged.
Disability		✓	✓	The guideline takes disability in to account. The guideline is for all nurses who have been trained appropriately to insert midlines. Patients with a disability may have difficulty managing their midline, If a patient is unable to manage their midline, a district / practice nurse would be arranged or a carer taught how to manage.
Gender Reassignment		✓		The guideline takes gender reassignment in to account. The guideline is for all nurses who have been trained appropriately to insert midlines.
Marriage & Civil Partnerships		✓		The guideline takes marriage and civil partnerships in to account. The guideline is for all nurses who have been trained appropriately to insert midlines
Pregnancy & Maternity		✓		The guideline takes pregnancy and maternity in to account. The guideline is for all nurses who have been trained appropriately to insert midlines
Race including Traveling		✓		The guideline takes Race including traveling communities in to account. The guideline is for

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Communities				all nurses who have been trained appropriately to insert midlines
Religion & Belief		✓		The guideline takes Religion and Belief in to account. The guideline is for all nurses who have been trained appropriately to insert midlines
Sex		✓		The guideline takes sex in to account. The guideline is for all nurses who have been trained appropriately to insert midlines
Sexual Orientation		✓		The guideline takes sexual orientation in to account. The guideline is for all nurses who have been trained appropriately to insert midlines
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓	✓	The guideline takes other vulnerable and disadvantaged groups in to account. The guideline is for all nurses who have been trained appropriately to insert midlines. If a patient is unable to care for their midline a district / practice nurse would be arranged or a carer taught what to do.
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)		✓	✓	The guideline takes health inequalities in to account. The guideline is for all nurses who have been trained appropriately to insert midlines. If patient unable to care for their midline a district / practice nurse would be arranged / home Opat team

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
	Elderly / vulnerable	*Involvement of patient / carer/*	all nurses who have	ongoing

	patients may have difficulty caring midline	*district / practice nurse / home opat team if needed*	been trained appropriately to insert midline	
How will you monitor these actions?	Reflective audit of all patients with midlines can be carried out to ensure care reflects Midline Insertion policy			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	At next review of guideline October 2023			

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	Heather Lloyd
Date signed	02/02/2022
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
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	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
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	
	Other comments:	

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