SHARED CARE GUIDELINE FOR THE TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILDREN (UNDER 18 YEARS OF AGE)

1. Aim/Purpose of this Guideline
   1.1. This guideline applies to medical, nursing and pharmacy staff in the safe and appropriate prescription and administration of methylphenidate, atomoxetine or lisdexamfetamine when used in ADHD.

2. The Guidance
   2.1. See below for the Shared Care Guideline.
TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

This shared care guideline sets out details for the sharing of care of patients aged between 6 and 18 years with ADHD prescribed methylphenidate, atomoxetine or lisdexamfetamine. These guidelines provide additional limited information necessary to aid in the treatment of these patients. As with all shared care guidelines they highlight relevant prescribing issues but should be used in conjunction with relevant NICE guidance, the BNF, ABPI summary of product characteristics and do not replace them.

INDICATIONS FOR THE PURPOSES OF THIS GUIDELINE
Methylphenidate, atomoxetine or lisdexamfetamine are indicated as part of a comprehensive treatment programme for attention-deficit hyperactivity disorder (ADHD) in children aged 6 years of age and over when remedial measures alone prove insufficient. Diagnosis should be made according to DSM-IV criteria or the guidelines in ICD-10. Treatment must be under the supervision of a specialist in childhood behavioural disorders (eg Consultant Child Psychiatrist or Consultant Paediatrician, Staff Grade or Associate Specialist medical staff or ADHD Advanced Practitioner).

Methylphenidate, atomoxetine and lisdexamfetamine are not licensed for children less than 6 years of age. Methylphenidate is not licensed for adults over 18 years. Methylphenidate and lisdexamfetamine are controlled drugs (CD schedule 2) and are subject to the regulations for CDs e.g. requirements for safe custody, prescriptions stating the quantity to be dispensed in both words and figures, and duration of treatment not normally to exceed 30 days.

PREPARATIONS AND DOSAGE
Methylphenidate is available as an immediate release preparation (given in two or three daily doses) or long acting preparation (e.g. Concerta XL, Matoride XL tablets (12 hours duration of action), Equasym XL, Medikinet XL capsules (8 hours duration of action)). Long acting methylphenidate tablets are suitable for once daily dosing and due to greater cost are reserved for:

- school children where multiple daily dosing causes significant problems
- children whose symptoms are difficult to maintain on immediate release tablets.

Different versions of modified release preparations may not have the same clinical effects, hence prescribers should specify the brand to be dispensed.

Atomoxetine is available as an immediate release preparation (Strattera). Unlike stimulant medication, atomoxetine usually takes 4-6 weeks to work effectively. The total dose may be given either as a single dose in the morning or in two divided doses with last dose no later than early evening.

Lisdexamfetamine is available as a slow release preparation (13 hours duration of action) and should be given once daily in the morning (Elvanse).

When initiating medication the patient will have received a minimum of one month’s treatment, been shown to respond to the treatment and the dosage stabilised before prescribing responsibility is transferred to the GP. There is an expectation with such medication that doses may be titrated upwards slightly due to normal increases in weight and height without this meaning that treatment has become unstable.

CONTRAINDICATIONS AND PRECAUTIONS
Methylphenidate and lisdexamfetamine are contra-indicated in patients with:

- marked anxiety disorders, agitation, hyperthyroidism, severe angina pectoris, cardiac arrhythmias, glaucoma, and thyrotoxicosis,
- diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder.
- during treatment with non-selective, irreversible monoamine oxidase (MAO) inhibitors, or within a minimum of 14 days of discontinuing those drugs, due to risk of hypertensive crisis
- stimulant products are not recommended in children and adolescents with known structural cardiac abnormalities.

Atomoxetine is contra-indicated in patients with:

- hypersensitivity to atomoxetine.
- narrow-angle glaucoma
- monoamine oxidase inhibitor (MAOI) or within a 2 week period.
- phaeochromocytoma

Methylphenidate and lisdexamfetamine should be used with caution in patients:

- with a history of epilepsy and emotionally unstable patients, such as those with a history of drug dependence or alcoholism.
- with motor tics, tics in siblings, or a family history or diagnosis of Tourette’s syndrome
- with underlying medical conditions which might be compromised by increases in blood pressure or heart rate, e.g., those with pre-existing
hypertension, heart failure, recent myocardial infarction.

Atomoxetine should be used with caution in patients:
- cardiovascular disease including a family history of QT prolongation
- history of seizures.

Methylphenidate m/r (Concerta XL) should not be used in patients with severe gastrointestinal tract narrowing or dysphagia or significant difficulty with swallowing tablets.

**MONITORING SPECIALIST TEAM:**
- Prior to prescribing, it is necessary to conduct a baseline evaluation of a patient's cardiovascular status, including blood pressure and heart rate. A comprehensive history will document concomitant medications, past and present co-morbid medical and psychiatric disorders or symptoms, family history of sudden cardiac/unexplained death and accurate recording of pre-treatment height and weight on a growth chart.
- Responsible for baseline monitoring of height, weight, appetite as well as ongoing monitoring every six months. Undertake baseline blood pressure and heart rate monitoring as well as ongoing monitoring every six months. See attached monitoring checklist (a copy of which will be sent to the GP at least annually).
- Regular monitoring for psychiatric symptoms during treatment (e.g. at dose adjustment and every six months).
- There is a lack of information on the long-term effects of methylphenidate. The need to continue drug treatment for ADHD should be reviewed at least annually; this may involve suspending treatment.

**GENERAL PRACTICE:**
- There are no specific biochemical monitoring requirements for the GP to undertake.
- Patients should be monitored for the risk of diversion, misuse and abuse of methylphenidate and lisdexamfetamine.

**SIDE EFFECTS**
Methylphenidate and lisdexamfetamine:
- insomnia
- anxiety
- decreased appetite,
- occasional abdominal pain,
- nausea and vomiting (alleviated with concomitant food intake), headaches,
- emotional lability,
- temporary growth retardation may occur during prolonged therapy (monitor height and weight),
- changes in blood pressure and heart rate (usually increased).
- patients who develop symptoms such as palpitations, exertional chest pain, unexplained syncope, dyspnoea, or other symptoms suggestive of heart disease during treatment should undergo prompt specialist cardiac evaluation.

Atomoxetine
- headache
- abdominal pain
- decreased appetite

**COMMON / SIGNIFICANT DRUG INTERACTIONS**
- Alcohol can exacerbate adverse CNS effects.
- Methylphenidate may inhibit the metabolism of coumarin anticoagulants, some anticonvulsants, phenylbutazone and tricyclic antidepressants and SSRIs.
- Caution with sympathomimetic agents and MAOIs (also see contraindications). Hypertensive crisis can occur as a result of taking cough and cold cures or decongestants containing sympathomimetics (e.g. pseudoephedrine, phenylpropanolamine, phenylephrine).
- Clonidine: Concomitant use with clonidine has been associated with serious adverse events, though causality has not been established.

The above details are not a complete list and the BNF and SPC remain authoritative.

Parents will be advised by the Specialist to monitor any increase in liability to infections or increases in bruising and bleeding. This advice will be backed up by a written patient-handout on the effects of methylphenidate, atomoxetine and dexamfetamine. GPs, the parents and Specialist should all be aware of the risk of leucopenia and if there is an increase in infections or apparent difficulty in shaking off normal minor infections a full blood count should be performed immediately.

Atomoxetine.

Hepatic disorders: Following rare reports of hepatic disorders, patients and carers should be advised of the risk and be told how to recognise symptoms; prompt medical attention should be sought in case of abdominal pain, unexplained nausea, malaise, darkening of the urine or jaundice.

Suicidal ideation: following reports of suicidal thoughts and behaviour patients and their carers should be informed about the risk and told to report clinical worsening, suicidal thoughts or behaviour, irritability, agitation or depression.
SUPPORT

- Contact the CAMH’s Consultant Psychiatrist who can be contacted via Bodmin Hospital Switchboard 01208 251300.
- Medicines for Children website has information leaflets for parents and carers on methylphenidate, atomoxetine and lisdexamfetamine for ADHD.

Request for other formats
Please ask if you would like to receive this leaflet in large print, braille, on CD or in any other languages. If you would like the leaflet in an alternative format please contact the NHS Kernow communications Team at communications@kernowccg.nhs.uk or call 01726 627800

AREAS OF RESPONSIBILITY FOR THE SHARING OF CARE
These are suggested ways in which the responsibilities for the management of patients with ADHD who are prescribed methylphenidate, lisdexamfetamine or atomoxetine can be shared between the specialist and the general practitioners. The expectation is that these guidelines should provide sufficient information to enable GPs to be confident to take clinical and legal responsibility for prescribing these drugs. If a specialist asks the GP to prescribe this drug the GP should reply to this request as soon as practical. Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient and be accepted by them.

In its guidelines on responsibility for prescribing (circular EL(91)127) between hospitals and GPs, the DH has advised that legal responsibility for prescribing lies with the doctor who signs the prescription.

Referral criteria
- A full diagnostic assessment will have taken place under the specialist’s care – this will always involve independent reports on the child’s behaviour as well as direct observation of the child and parental reports. Schools are closely involved and will have provided detailed reports on the child’s behaviour in this setting. Assessment will have included psychological, social and family dynamic factors influencing the child’s concentration and impulsivity and hyperactivity. Where appropriate, cognitive and behavioural therapy will have been offered.

Specialist:
- The patient and carers will have received information on the medication from Choice and Medication website. www.choiceandmedication.org/cornwall/
- The specialist service will provide regular monitoring of the psychological and behavioural effects of treatment through reviews of the child with their family and liaison with school. The specialist service will organise any other psychological therapies such as parenting groups, cognitive therapy, social skills training as appropriate and either provide these directly or through partner organisations
- The specialist service will work with colleagues in Education and provide advice, for example, for individual education plans and statements of special educational need as necessary.
- Undertake baseline evaluation of a patient’s cardiovascular status for presence of heart disease, including blood pressure, heart rate and ECG on indication. The family history of cardiovascular problems should also be checked. Complete an assessment & continue to assess any environmental and family considerations that would mitigate against the use of methylphenidate and lisdexamfetamine – e.g. abuse potential within the family.
- Initiation of ADHD medication and implementation of the appropriate package of care to include cognitive and behavioural components. The patient will receive supplies of ADHD medication from secondary care-initiated prescriptions until the GP formally agrees to shared care. After initiating medication the patient will have received a minimum of one month’s treatment, been shown to respond to the treatment and the dosage stabilised, before prescribing is transferred to the GP. Drug titration, in response to changes in weight and height will be expected throughout the patient’s therapeutic journey and is not considered to be a sign that the patient is no longer stable on their medication. Dose increases for this reason will be clearly communicated to the patient’s G.P.
The specialist service will give advice to the family and the general practitioner regarding the appropriateness of the medication within the family setting, the effectiveness of medication and any advised changes to the dose regime.

Advising the GP when ADHD medication should be temporarily discontinued and providing the necessary supervision and assessment of the child’s condition during these “medication holidays”

Advising the GP when ADHD medication treatment should be discontinued for children receiving the drug long-term. This will generally be towards the end of their treatment until the end of the school year in which the child turns 18. If the patient has had a documented unsuccessful trial without medication and the specialist feels specialist input is needed beyond the patients 18th birthday, the CAMHS service will advise the G.P. on what drug and dosage to prescribe until such time as the patient is ready to reduce or discontinue their medication. The GP will not be expected to increase medication beyond the age of 18.

Development of de novo or worsening of pre-existing psychiatric disorders should be monitored at every adjustment of dose and then at least every 6 months and at every visit.

With ADHD treatment the advised monitoring includes six-monthly monitoring of height, weight and appetite because of the potential for appetite suppression leading to delayed growth, and six-monthly monitoring of blood pressure and pulse because of the cardiac effects of methylphenidate, atomoxetine and lisdexamfetamine and doing any further investigations as indicated by symptoms. A copy of the monitoring checklist will be sent to the G.P. at least annually. Routine monitoring for the effects of leucopenia and thrombocytopenia is unnecessary but will involve asking specific direct questions to establish whether these very rare side effects are likely and proceeding to blood tests if there are positive responses.

Liaise with the GP with respect to the monitoring of physical and psychological effect.

**General Practitioner:**

- Reply to request for shared care as soon as practical.
- Adverse drug reaction / interaction monitoring
- The general practitioner will prescribe the medicine in consultation with, and receiving advice from, the specialist service. Repeat prescriptions should be issued for a maximum of one month’s treatment.
- Monitoring the patient’s overall health and well being, and checking and acting upon the results communicated by the specialist.
- Monitoring of any environmental and family considerations that would mitigate against the use of methylphenidate and lisdexamfetamine e.g. abuse potential within the family.
- Inform the Specialist team if treatment is stopped for any reason.

**Patient / parent / guardian / carer:**

- Report any adverse effects to their GP and/or specialist.
- Safe storage of the ADHD medication in the home.
- Ensure that they/their parents/guardians/carers have a clear understanding of their treatment and ensure they attend for monitoring requirements as per shared care guideline and be aware that treatment will be stopped if patient does not attend for monitoring.

**BACK-UP ADVICE AND SUPPORT IS AVAILABLE FROM THE RELEVANT CLINICAL TEAM**
# METHYLPHENIDATE AND Lisdexamfetamine Monitoring Checklist

Name of child: ____________________________  DOB: _________________

B No: ___________________  ICS No: ____________________________

<table>
<thead>
<tr>
<th>Date</th>
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<th>Date</th>
<th>Date</th>
</tr>
</thead>
</table>

### Methylphenidate TDD

### Family History of sudden death in young adulthood (assessed at baseline)

### ECG if indicated (assessed at baseline)

### Blood Pressure

#### Pulse / minute

### Abuse potential

### Weight (kg / percentile)

### Height (cm / percentile)

### Appetite loss

### Sleep disturbance

### Psychiatric symptoms
- Mood
- Suicidal ideation
- Agitation
- Mania
- Psychosis

### Tics or other movements

### Less spontaneity

### Allergic rash

### Jaundice

### Aching joints

### Nausea/abdominal pain

### Dizziness/Fainting

### Palpitations

### Exertional chest pain

### Unusual breathlessness

### Headache

### Blurred vision

### Signs of leucopenia

### Signs of thrombocytopenia

### Hair loss

### Interactions

### Other

### Signed by:

---

_TDD = Total Daily Dose_
# ATOMOXETINE MONITORING CHECKLIST

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS No:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
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<th>Date</th>
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<tbody>
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<td>…/…/…</td>
<td>…/…/…</td>
<td>…/…/…</td>
</tr>
</tbody>
</table>

| Atomoxetine TDD | Blood Pressure | Pulse | Appetite decreased | Abdominal pain | Vomiting | Influenza | Anorexia (loss of appetite) | Early morning wakening | Irritability | Mood swings | Dizziness | Somnolence | Mydriasis | Constipation | Dyspepsia | Nausea | Dermatitis | Pruritis | Rash | Fatigue | Weight decreased | Palpitations | Sinus tachycardia |
|----------------|----------------|-------|-------------------|----------------|----------|----------|-----------------------------|------------------------|-------------|------------|-----------|-----------|----------|----------|----------------|----------|--------|-----------|---------|------|---------|----------------|-------------|----------|

**Signed by:**

TDD = Total Daily Dose
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance with prescribing and administration in accordance with this guideline (or other safe practice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Head of Prescribing Support Unit</td>
</tr>
<tr>
<td>Tool</td>
<td>No specific tool</td>
</tr>
<tr>
<td>Frequency</td>
<td>As required according to clinical incident reports</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Via Medicines Practice Committee</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Relevant Clinical Staff</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Relevant Clinical Staff</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Shared Care Guideline for the treatment of Attention Deficit Hyperactivity Disorder in children under 18 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>May 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>May 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>May 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>M Wilcock, Head of Prescribing Support Unit, Pharmacy Department, RCHT</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 253548</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Some clinical issues and details of prescribing responsibilities for GP and specialists</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Methylphenidate, atomoxetine, lisdexamfetamine</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT  CFT  KCCG</td>
</tr>
<tr>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>March 2016</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Shared Care Guideline for the treatment of Attention Deficit Hyperactivity Disorder in children under 18 years of age v2.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Cornwall Area Prescribing Committee</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Divisional Director CSSC</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Karen Jarvill, Associate Director CSCS</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Janet Gardner, Governance Lead CSCS</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>None</td>
</tr>
</tbody>
</table>
Signature of Executive Director giving approval | {Original Copy Signed}
---|---
Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet ✓ Intranet Only
Document Library Folder/Sub Folder | Clinical, pharmacy
Links to key external standards | Governance Team can advise
Related Documents: | BNF, Summary of Product Characteristics
Training Need Identified? | No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Nov’ 2012</td>
<td>V1.0</td>
<td>New guideline</td>
<td>M Wilcock, Head of Prescribing Support</td>
</tr>
<tr>
<td>23 Mar’2016</td>
<td>V2.0</td>
<td>Addition of lisdexamfetamine and associated text</td>
<td>M Wilcock, Head of Prescribing Support</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th>Shared Care Guideline for the treatment of Attention Deficit Hyperactivity Disorder in children under 18 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Dan Thomas, Pharmaceutical Services Contracting Team, NHS Kernow</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01726 627953</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   - **Who is the strategy / policy / proposal / service function aimed at?**
     - To provide information on prescribing of methylphenidate, lisdexamfetamine or atomoxetine to enable General Practitioners to take over prescribing responsibility from secondary care.

2. **Policy Objectives**
   - **To promote a consistent level of shared care between primary and secondary care (in relation to RCHT catchment area)**

3. **Policy – intended Outcomes**
   - **Confident and competent prescribers, enabling medicines to be access in a primary care setting.**

4. **How will you measure the outcome?**
   - If the guideline is not well received, publicised and adopted, then some GPs may not enter into shared care arrangements.

5. **Who is intended to benefit from the policy?**
   - General practitioners, hospital specialists and community pharmacists – from understanding local guidance around use of these medicines. Patients/carers, from being able to access medicines from their GP.

6a) **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**
   - **No**

   b) **If yes, have these *groups been consulted?**

   C). **Please list any groups who have been consulted about this procedure.**

7. **The Impact**

   Please complete the following table.

   Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. **Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):**

   **Shared Care Guideline for the treatment of Attention Deficit Hyperactivity Disorder in children under 18 years of age.**
<table>
<thead>
<tr>
<th>Race / Ethnic communities /groups</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>no</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>no</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>no</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>no</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>no</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | No |

9. If you are not recommending a Full Impact assessment please explain why.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dan Thomas</td>
</tr>
<tr>
<td>2. Mike Wilcock</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ____________________

Date ____________________

All or part of this document can be released under the Freedom of Information