DRAFT

MINUTES OF THE MEETING OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND DISORDERS OF THE NERVOUS SYSTEM

Thursday 27 October 2016

Present:

Professor G Cruickshank	Chairman
Dr Paul Reading	
Professor P J Hutchinson	
Mr R Nelson	
Dr C Tudur Smith	
Professor R Al-Shahi Salman	

Lay Members:

Ex-officio:

Dr S Mitchell	Civil Aviation Authority
Dr N Delanty	National Programme Office for Traffic Medicine, Dublin
Dr S Bell	Chief Medical Officer maritime and Coastguard Agency
Dr Clive Beattie	OHS(NI)
Dr B G R Wiles	Panel Secretary, DVLA
Dr P Prasad	Medical Adviser, DVLA
Dr N Jenkins	Medical Adviser, DVLA
Mr J Donavan	Medical Licensing Policy, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Mrs Sian Taylor	Communication and Engagement Representative, DVLA

1. Apologies for absence

Professor A Marson, Mr R Macfarlane, Dr D Shakespeare, Professor J Duncan, Mr C Jones and Dr A R Gholkar.

2. Chairman's remarks

2.1 There have been a number of members leaving over the past 12 months. Thanks were given to those and to those who are still supporting the Panel. The fact that the meeting fell during half-term for schools was noted and had depleted the attendance.

2.2 There had been no panel chairs' meeting over the summer, but it is expected that there will be one reorganised soon.

2.3 There is an ongoing review into the working of panels and their recruitment. This has yet to report and is a limiting factor for recruitment to replace those members who have moved on.

2.4 There has been a well published PHSO report regarding the working of DVLA.

2.5 The DVLA response is that the report was based on 8 cases between 2009 and 2014. During that time DM processed 4.5 million cases.

2.6 There has been an article in The Times regarding issues regarding licensing. The Chair has written to the paper to correct the article. The article was one-sided and the chair acknowledged that there are issues on all fronts regarding making licensing decision: that doctors can be delayed in responding to DVLA requests and that there are a limited number of people in DVLA to deal with the cases. There was a suggestion that Panel as a whole write to The Times regarding this.

2.7 The Chair of the Cardiology Panel has concerns regarding the syncope standards. These were changed as part of the response to the Glasgow Bin Lorry FAI. It was not clear as to what the actual concerns are. It was felt that inviting the Chair of the Cardiology Panel to the next Neurology panel meeting to set the agenda for any such joint meeting would be appropriate. It must be noted that the Neurology panel have tacitly approved the new guidelines.

3. Matters arising

3.1 **Item 6.1 -** It was again confirmed that there are currently no plans to increase the age of relicensing from 70 to 75. However, the independent Older Drivers Task Force made a series of recommendations, including increasing the age to 75 but only in conjunction with mandatory eyesight testing, in its Supporting Safe Driving into Old Age report which was published in July. The Government is considering the recommendations carefully.

3.2 **Item 8 -** A detailed discussion ensued regarding head injury and seizure risk.

3.2.1 A number of issues were raised.

3.2.2 There is a general lack of up to date research which is restrictive.

3.2.3 There is an issue regarding at what point to notify DVLA. The issue of the spectrum of head injuries was noted.

3.2.4 The Royal College of Surgeons has given guidance regarding severity of head injuries.

3.2.5 The need for better guidance was noted. The issue is regarding markers of severity.

3.2.6 It was suggested that the need for a hospital admission for 48 hours or more could be used but this is dependent upon all clinicians (including from all specialities) having the same procedures. The need for a neurology/neurosurgery referral was also suggested but the same issues would apply.

3.2.7 It was suggested that a scan showing pathology (apart from a small subarachnoid haemorrhage that was discussed last meeting) could also be a trigger for referral.

3.2.8 Some imaging demonstrated pathology would not necessarily be linked to an increase in seizure risk. The lack of data to delineate these groups was noted.

3.2.9 Any attempt to put a size limitation on pathologies was not felt to be a viable stratifying technique as it couldn't be consistently applied across all cases.

3.2.10 It was noted that most of these cases would be dealt with by A+E departments and not neurosurgeons so any standards would have to be easily applicable across all specialties.

3.2.11 It was noted that the DMG have more operational problems with Group 2 drivers given the lower seizure risk allowable. Given the relatively short period of time off driving that Group 1 drivers may be subject to, the operational impact can be limited due to the drivers qualifying for reapplication.

3.2.12 It was suggested that discussing with A+E colleagues regarding whether or not this is an issue could be a way forward however it was noted that the practice in A+E may well not highlight such issues.

3.2.13 It was considered whether or not the time to clinical recovery could be used as a surrogate marker for seizure risk. It was mentioned that this can't be relied upon.

3.2.14 It was noted that specialties allied to neurosurgery may see the lower risk head injuries but there is no available evidence to support this.

3.2.15 The previously documented research proposal was discussed again. There is no current funding available however given the recent PHSO report, the climate regarding this may have changed.

3.2.16 The study would require 4000 Head injury patients with CT head scans to be followed for 5 years. Allowing for multicentre participation, the recruitment for the data could be quite quick. There are about one million head injuries reported via A&E departments in the UK per annum.

3.2.17 It was acknowledged that the Panel needs better data in the current clinical setting to be of more direct benefit.

3.2.18 It was noted that whilst a 5 year follow up of the above study would be required to obtain the data for Group 2 licensing, some useful data for Group 1 licensing may be available at 1 year.

3.2.19 It was noted that there are about 20 factors that are of relevance to seizure risk but there is no current data (and hence the requirement for the study outlined above) to quantify the absolute impact.

3.2.20 Various sources of funding and institutions that could benefit from this data was discussed.

3.2.21 The chair will discuss the above issues with Prof Peter Hutchinson to come up with a policy statement regarding what data is required, how to research this and to develop better guidance regarding notification.

3.2.22 The Chair stated that more data is needed to guide DVLA's standards to avoid further public concerns as to the basis for decision making on licensing as noted in the recent press articles.

3.2.23 One member raised concerns regarding the standards based upon 2 cases he had in his NHS practice.

3.2.24 There are potential inconsistencies between the head injury standards and others such as subdural haematomas.

3.2.25 The current clinical approach in A+E departments is to have an early CT scan with the intention of bringing forward the discharge. The

statistical papers originate from a time before this practice came into being and therefore it is more difficult to apply the data to current clinical practice for the purposes of driver licensing. Some of the imaging may not be necessary based upon the previous clinical guidance and be revealing pathology that wouldn't have otherwise been discovered and with no impact upon seizure risk.

3.2.26 The issue of MRI scanning as opposed to CT scanning was raised.

3.2.27 There is no evidence regarding MRI findings and seizure risk as there is for CT finding.

3.2.28 It was therefore decided that where the standards quote pathology in head injuries, these apply to CT scan results only. It was noted that the incidence of individuals only having an MRI is currently very low in clinical practice.

3.2.29 It was clarified that Post Traumatic Amnesia in the standards refers to Post Traumatic Amnesia for more than 24 hours.

3.2.30 It was recognized that there are some individuals who could drive sooner than are allowed under the current standards but the problem is how to identify them. Discussion regarding whether or not to reduce the minimum period of time off driving to 3 months revealed the operational issue of how to identify these cases.

3.2.31 The CAA have a system for assessing head injury risk which involves clinical findings as well as imaging findings. They have found it equally difficult to extrapolate the statistical findings to a cut off point for seizure risk.

3.2.32 In order to reduce the number of unnecessary referrals to DVLA, a new category for Group 1 licences will be introduced:

- Traumatic Brain Injury- in the absence of seizures, Post Traumatic Amnesia >24 hours, a dural tear, the presence of intracranial haematoma or contusions, driving must cease for 3 months and then can recommence if there is clinical confirmation of full clinical recovery. In these cases DVLA need not be notified.

3.3 **Item 13 -** The psychiatry panel have an issue with recruitment and membership. This has had an effect upon a joint meeting.

3.4 The chair has spoken to the psychiatry panel chair at a chairs' meeting and will endeavour to do so again but this may have to wait until the recruitment hiatus is finished.

4. OSAS

4.1 DVLA has had discussions and a meeting with some stakeholder groups regarding OSAS and the new legislation.

4.2 The understanding of the Annex was clarified.

4.3 The guidance has been redrafted and is awaiting legal advice/confirmation.

4.4 The major issue is regarding the application of the guidance given the fact that clinically the sleepiness is the major issue not the objective severity of the OSA which is what the Annex focuses upon.

4.5 It was noted that the Chair of the Working party whose report was used as a basis for the Annex has said that the main factor should be the sleepiness.

4.6 The question of why the Chair hadn't requested a review of the Annex if it misrepresented the report was raised.

4.7 The definition of the sleepiness was discussed. The Epworth is objective self assessment. There are other more objective assessments.

4.8 Obviously if the European Commission changes the Annex then the guidance could be altered.

5. Professor Duncan's comments on the previous meeting minutes

5.1 Professor Duncan was unable to be present at the meeting but sent various pieces of statistical data for consideration.

5.2 These will be considered at the next panel meeting.

5.3 **Section 6.4 -** I think there has been some misunderstanding of some details.

5.3.1 It is Queen Square, not Queen's Square.

5.3.2 Approximately 50-60 patients per year have resections, not 300.

5.3.3 The database, kept prospectively following surgery includes over 900 patients and started in 1990.

5.3.4 Virtually all patients had seizures with impaired awareness prior to surgery: usually focal with impaired awareness and some also with secondarily generalized seizures.

5.3.5 The comparison of relapse rates of seizures with loss of awareness following surgery was made between two groups: those who were entirely seizure free for a year, and those who continued to have auras.

a. In individuals who were entirely seizure free for a year, the risk of a seizure with loss of awareness in the next year was 4.85% (95% CI 4.25-5.45%)
b. In Individuals who had auras (only) for 1 year, the risk of a seizure with loss of awareness in the next year was 11.35% (95% CI: 9.27-13.43%)
c. In individuals who had auras (only) for 2 year, the risk of a seizure with loss of awareness in the next year was 8.75% (95% CI: 6.5-11%)
d. In individuals who has auras (only) for 3 years, the risk of a seizure with loss of awareness in the next year was 7.61% (95% CI 5.15-10.07%)

5.3.6 Further analysis will follow and be discussed with professor Marson and Dr Tudur-Smith, and brought back to a future meeting of the panel.

5.3.7 **Item 6 -** We completed the analysis of aura after epilepsy surgery and the risk of disabling seizures in the next year.

5.3.8 With the added sophistication of clustering.

5.3.9 Due to clustering in the data, to take into account the impact of varying lengths of follow-up, we created a logistic regression model to further assess the validity of the preliminary results:

In summary:

	Chance of Seizure in the next year (%)	95% Confidence Intervals	Patient years analysed
Highest grade in previous 1 year			
1	16.4	± 3.01	4,888
2	21.8	± 3.50	891
≥3	54.8	± 4.60	2,725

Grade 1 = seizure free

Grade 2 = auras in the preceding year. The critical figure for this group is the 21.8% risk of a seizure with loss awareness in the next year.

Grade 3+ seizures with loss of awareness.

This then would not argue for a change in the law.

6. Subdural empyema and abscesses

6.1 Given the reduction in time off driving for isolated seizures and that the logic for the period of time off driving in these conditions is the seizure risk and that this has been challenged, it was asked of panel if the standards should remain.

6.2 The opinion was that these conditions are highly epileptogenic and the standards should remain as they are.

6.3 Discussion ensued regarding whether or not infratentorial pathology could be considered less stringently.

6.4 This had been discussed in 2014 and due to the difficulty in delineating the supratentorial extent (if any), there couldn't be a lowering of these standards.

6.5 The panel members noted the rarity of an isolated infratentorial abscess/empyema in clinical practice.

6.6 If there is clinical evidence to absolutely exclude supratentorial extension of infratentorial disease, licensing can be considered earlier than currently.

6.7 A draft addition to the standards will be prepared for the next meeting.

7. Chronic subdural haematoma

7.1 The Group 2 criteria indicate that a period of 6 or 12 months off driving is required depending upon features without specifying those features.

7.2 Panel agreed that 6 months off driving applied if:

- The condition is uncomplicated.
- There is only 1 drainage procedure.
- There is no recurrence.
- There are no multiple membranes seen in the haematoma.

7.3 All other cases require 1 year off driving.

7.4 The current clinical process is to make 2 Burr holes when draining the haematoma.

7.5 This practice, if taking place during 1 one operation, is to be considered, for the purposes of driver licensing, as one drainage procedure.

8. Acute subdural haematoma and seizures.

8.1 A seizure at the time of, or with 24 hours of, a stroke or TIA can (depending upon clinical factors that apply to all potentially provoked seizures) be considered as a provoked seizure.

8.2 The question was put: should this be extended to acute subdural haematomas?

8.3 Given the variability in this pathology, it is difficult to come up with standards for all cases.

8.4 In the case of a spontaneous acute subdural haematoma, seizures can be considered as provoked depending upon the clinical factors for all potentially provoked seizures.

8.5 If the haematoma is associated with a head injury, the head injury guidance would apply.

9. Assessing Fitness to Drive and At a Glance

9.1 Earlier in 2016, the medical standards were re formatted into AFTD.

9.2 Panel were asked to confirm whether or not they felt the new version of the standards accurately reflected the medical standards.

9.3 As indicated earlier, the Cardiology Panel have concerns regarding the syncope standards.

9.4 It must be pointed out that in AAG, "prodrome" in the standards for blackouts with no prodrome was not defined.

9.5 These events were felt to represent episodes which may turn out to be seizures and hence the standards reflected the seizure/epilepsy standards.

9.6 In AFTD, "prodrome" has been defined regarding the ability to safely stop a vehicle.

9.7 As this is a significant change to the intention, it will be discussed at the next meeting when the epilepsy specialists are present.

9.8 It was noted that some discretion regarding whether or not to notify/drive has appeared due to the wording "should" when the previous version of the standards used the general instruction that notification was required unless otherwise stated.

9.9 Where this discrepancy occurs, it will be corrected.

9.10 Regarding infratentorial cavernomas, it was noted that cerebellar and brain stem cavernomas may have different risks of impairment.

9.11 This will be discussed at the next meeting when the statistical evidence will be available to review.

9.12 The anomaly of the standards for untreated incidental aneurysms needing to have demonstrated clinical recovery was raised. This will be changed to "Providing there is no other relevant condition, driving may continue and DVLA need not be notified".

9.13 In addition to the changes quoted in other sections, the layout of the section regarding chronic subdural haematomas will be changed to be more clear regarding the applicability of the general information box.

9.14 It was noted that some of the errors are due to combining the notification and driving advice into one traffic light grading.

10. Cases discussed

10.1 Five cases were discussed.

10.2 The following general points were noted:

- Neurosyphilis presents with insidious onset cognitive/personality changes. These are covered under the psychiatry standards.

- For ruling out epilepsy and confirming NEAD, video EEG monitoring is considered the Gold standard.

11. Any Other Business

11.1 The brain tumour charity (Brain Tumour Trust) has been in contact with the Chair regarding the long time it can take for licensing decisions.

11.2 This is for the same reasons as other cases (mentioned in Chair's remarks).

11.3 The Brain Tumour Trust is visiting DVLA in the near future.

11.4 An individual has written to panel members asking for assistance.

11.5 Panel members were advised that DVLA has written to him (11.4) and all correspondence received by members should be forwarded to DVLA.

12. Date of next meeting

12.1 To be confirmed but March 2017 likely. Members to inform DVLA if there are any dates to avoid.

DR B G R WILES
Panel Secretary

31 October 2016