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

Held on 9th October 2013

Present:

Professor Garth Cruickshank	(Chairman)
Professor Philip Smith	
Professor Anthony Marson	
Professor Susan Short	
Professor Paula Williamson	
Professor Peter Rothwell	
Dr Paul Reading	
Mr Robert Macfarlane	
Mr Peter Hutchinson	
Dr David Shakespeare	
Dr Anil Gholkar	
Dr Huw Morris	
Ms Rona Eade	

Ex-officio:

Dr Norman Delanty	National Programme Office for Traffic Medicine, Dublin
Dr C Beattie	Occupational Health Service, Northern Ireland
Dr Stuart Mitchell	Civil Aviation Authority
Ms Jan Chandaman	Policy Branch, DVLA
Ms Julie Lewis	OS&DD Products & Services, DVLA
Ms Sue Charles	Medical Business Change, DVLA
Dr Ben Wiles	Senior Medical Adviser, DVLA

1. **Apologies for Absence**

Mr Richard Nelson
Mr Charlie Jones
Dr Nerys Lewis

Item 2 – Chairman's Remarks.

Congratulations were given to Dr Lewis on the recent birth of her child.

The Chairman extended thanks to Professor Short and Professor Williamson on completion of their tenure on the Panel.

The Chairman recently attended the Panel Chairmen's meeting but was unable to attend the Government's Scientific Advisory Committee meeting and he is grateful for the report by Dr Mike Griffiths of the Cardiology Panel. The new Chief Scientific Officer for the Government is Sir Mark Walport. Concerns were raised at this meeting regarding budget cuts to scientific advisory committees in the future and concerns were also raised regarding higher education and university costs. It was noted that Government departments willingly accept the advice given to them by these committees under the COPSAC agreement.

Item 3 – Matters Arising from the Minutes of the Meeting of 14th March 2013.

Professor Susan Short indicated that she was present at that meeting and she has been added to the list of attendees.

Item 4 – Minutes of the Panel Chairmen's Meeting of 20th June 2013.

The following issues were discussed.

1. The driving assessment centres.

   The Panel was reassured that the motoring services consultation was regarding DSA and VOSA. It was indicated that there would continue to be a role for driving assessment, however, as part of the managed service contract this would be open for tender and it is not guaranteed that it would be the FORUM assessment centres who would be performing the driving assessment.

2. Financial pressures that DVLA as part of central Government is under.

3. Managed service contract was discussed.

4. The Chair indicated that fact that the Medical Advisers at DVLA do a good job in minimising the number of cases needing to be referred to Panel members and brought to the Panel emphasising that he was reassured that the Medical Advisor role was not under threat given items 2 and 3 above.

5. Sue Charles gave an update to the Panel regarding the review of the DVLA database of cases. This process is currently ongoing. The issue for DVLA is that of resources. The information held on the system allows ready access to total numbers of cases, however, in order to obtain any more detailed information a manual check of individual cases is required. A fuller report should be available for the next meeting.

6. The Panel Chairs were requested to provide details of research proposals. Discussions regarding these took place at the Chairmen's panel. The Neurology Panel put forward suggestions regarding analysing the data available for stroke and research regarding head injuries. As the DVLA is keen to increase cross panel working, the research funding has been allocated to topics regarding multiple medical conditions and to police incidents. It was suggested that the Panel could approach the National Institute of Health Research for potential funding for further research.

7. The issue of DVLA gold plating in the UK standards was commented upon. The issue of the length of time taken to process cases was discussed. It was suggested that for certain conditions a form could be sent to the customer for their doctor to sign to confirm fitness to drive. It was indicated that this is not always possible as the delays in getting the form signed may not be due to the customer's actions and therefore it would be difficult to serve compliance for this. Doctors in general don't always have training in 'fitness to drive'.

Item 5. Update on funding for Stroke/TIA data research project.

5.1 There is a need to further analyse this data in order to provide DVLA with the information in a form that can be used. As indicated the DfT funding will go towards multiple medical conditions and road traffic incidents and medical conditions. The research proposals are currently being drafted will be forwarded to the Chairs for consideration.

5.2 Professor Williamson indicated that she would like to continue to be involved with the research on the stroke/TIA data, despite completing her tenure as a Panel member. She did raise the issue of data sets that are freely available. She referred to the four e.health centres in the UK as well as drug trial data. It was noted that the quality in the e.health centre data can be variable as well as there being some possible pre-selection bias for drug trail data. Other possible data sets were the HES data set and the GPRD data set. The Farr Institute was also commented upon.

5.3 Professor Williamson is also a member of the MRC Methodology Research Committee.

5.4 It was noted by the Panel that there is an issue with the information that DVLA uses to make the medical decisions and the medical standards themselves not always being evidence based from lack of data. This would be indicative of there being 'patient benefit' from having further research performed. The NIHR may be a viable option for sourcing further funding. It was also noted that there is some data available regarding head injuries which could be similarly further analysed in order to guide the medical standards of fitness to drive.

5.5 It was indicated that there may have to be approval from the Minister to go externally for research funding. This will need clarifying with DfT.

Item 6. GP Survey regarding DVLA form about cognition.

6.1 This survey was sent to the GPs via the BMA. Unfortunately there were only 7 respondees. It was noted that there is a potential conflict between being the patient's doctor and giving an opinion which could be conceived as adverse, i.e. removing the driving licence. It was also noted that GPs may not pick up the cognitive issues of relevance to driving such as visuospatial issues. It should be stressed that third-party reports regarding driving should be quoted. It is noted that one of the respondees indicated that they would not provide hearsay evidence. It was discussed that such

information is important as the individual may not either remember or have insight into a dangerous driving event.

6.2 Alternative methods of performing such a survey were discussed, however these would involve commercial organisations and there would be financial implications.

6.3 It was stressed that it is important that doctors in general are aware of what DVLA do and how our processes work. It must be noted that DVLA have been approached by BMJ to write an article regarding medical fitness to drive and are currently awaiting details of what format the article would take.

6.4 It was suggested that consideration should be given to having a GP on the Panel, given the issues noted. There would have to be Ministerial approval to increase the size of the Panel and an appropriate justification would have to be put forward. Given that 2 of the current Panel members will have to be replaced shortly the request for a GP to be on the Panel can be made at the same time as replacements for the 2 current Panel members.

6.5 The possibility of having a smart phone app for "At a Glance to the Current Medical Standards of Fitness to Drive" was raised. The suggestion was that this would be automatically updating when "At a Glance" changes. The suggestion of having links through various Royal College websites was also raised.

6.6 The new GOV.UK website was commented upon. It is more difficult to find the "At a Glance" on the website, however it was noted that searching through Google for "DVLA At a Glance" provides the relevant information. It was noted that "At a Glance" is becoming a more complex document even for medical practitioners however at the moment the panel concluded that this is unavoidable given the changes in the medical standards, which are becoming more subdivided and specific for different conditions.

Item 7. Feedback to Panel about new Parkinson's disease questionnaires.

7.1 The main concern with the previous questionnaires related to the problems with motor control not being fully assessed. This has been addressed in the new questionnaires. One of the Panel members indicated that he had performed a brief survey of his colleagues regarding these forms, they felt that the forms take longer to fill in but have more relevant information. He is going to continue surveying his colleagues.

7.2 It was noted that there is some evidence that Parkinson's disease patients have a lower risk of accidents than the general population as they tend to be more cautious and stop driving early in the disease process.

7.3 Question 5c on the PK1 will be altered to include the words, "likely to affect driving" to mirror the rest of the questions. Similarly question 7d on the PK2 form regarding inappropriate impulsive behaviour will be likewise altered to include the phase, "likely to affect safe driving". The Panel was advised that whilst there are certain questions on the forms that would lead to an automatic refusal or revocation of a licence, there are other aspects that would be considered along with the rest of the information presented.

Item 8. Recurrent Grade III Gliomas, clarification of current standards.

8.1 The Panel Chair, along with Dr Jeremy Rees, has started a data analysis of individuals with Grade III gliomas. This follows on from the discussions in the Panel minutes over the last year to 18 months. The preliminary data suggests that a sub-set of Grade III glioma patients are free from adverse events after one year from diagnosis and that the risk of events over the following year is less than 20% per annum. It would appear that for these individuals survival for one year confers a survival benefit over the next 3 to 5 years or longer (8.2 below).

8.2 The 1p19q codeletion was discussed. Currently DVLA ask for information regarding this for all customers. To date a very small number of cases have been documented by DVLA. The 1p19q codeletion confirms a better prognostic outcome for Grade III tumours and following treatment individuals with a Grade III tumour with this codeletion would follow a clinical course more similar to that for a Grade II tumour. The question of the epilepsy risk was raised. It was noted that Grade III tumours tend to present more with clinical disease than epilepsy, which is the converse for Grade I and Grade II tumours.

8.3 The issue of the quality assurance of the original analysis was raised. The genetic marker typing has been assessed and reviewed by many different centres and is deemed to be accurate. The original study data comes from 2 large studies which indicate that the codeletion confers a 7 year increase in medium survival lifespan. The data did not provide any clear information regarding the risk of seizures and it must be noted that the "At a Glance" standards were written using prognosis as a surrogate for adverse events.

8.4 Currently the medical standards are not changing regarding Grade III gliomas, however as more data is collected these standards may well change.

Item 9. Medical standards update from ongoing discussion topics.

9.1.1 Incidental glioma.

When a low grade glioma is an incidental finding on imaging and asymptomatic the case may be considered on an individual bases for Group 1.

The Panel confirmed that this was appropriate. There would have to be clear evidence that the Glioma was a genuine incidental finding. The licensing decision would usually be a one year licence for 4 years.

For Group 2 licensing the licence would have to be revoked or refused for a period of one year and then licensing may be considered if there is favourable clinical assessment and the actual diagnosis is indicated as unlikely to be a glioma. There would be annual licensing thereafter.

9.1.2 Group 2 medical standards after a cranioplasty.

The Panel advise that the same standards as for an intraventricular shunt should apply, i.e. a minimum period of 6 months off driving and then licensing dependent upon the individual assessment of the underlying condition.

9.1.3 Licensing standards for Group 1 and Group 2 customers who have had a biopsy only and the histology is insignificant.

The Panel felt that as this involved a Cortical assault the same standards as for intraventricular shunt should apply for both Group 1 and Group 2, i.e. for Group 1 a period of 6 months off driving and then relicensing when there is no debarring residual impairment likely to affect safe driving, and for Group 2 a minimum period of 6 months off driving then licensing dependent upon individual assessment of the underlying condition.

Item 10. Standards for Group 1 drivers and Group 2 drivers who have had craniotomy for an AVM with no bleeding vs craniotomy for an aneurysm with no bleeding.

The Panel considered the difference between the two medical standards. Given the different nature of the pathologies as well as the general site within the cranial cavity that the pathologies tend to exist, the Panel felt that there was a different risk profile for the two pathologies and therefore the Panel was satisfied that the standards to remain as they are.

Item 11. Isolated seizures with underlying liability.

11.1 Two operational questions were put to the Panel: Once a customer is eligible for a licence what duration of licence should be issued and does the affect of medication on risk reduction alter DVLA's operation stance?

11.2 Regarding the duration of a licence, the Panel felt it appropriate to defer to the underlying liability. Essentially, after a period of one year off driving, the duration of the driving licence should depend upon the underlying liability rather than the fact that the individual has had an isolated seizure.

11.3 It was generally accepted that anti-epileptic medication would only be issued to individuals who are higher risk patients and therefore the use of anti-epileptic medication would not reduce the period of time off driving in cases of an isolated seizure with underlying liability to further seizures to anything less than one year.

Item 12. Does Panel advice from 1998 regarding seizures during transition between sleep and wakefulness still apply since new epilepsy regulation.

The Panel discussed whether or not the previous advice regarding the definition of "asleep" for the purposes of the sleep concession in the new epilepsy regulations should apply. The Panel agreed that the previous advice should still hold.

Item 13. Provoked seizures now defined in regulation with broad scope – review of list in "At a Glance Guide to the Current Medical Standards of Fitness to Drive".

13.1 Prior to the Motor Vehicle (Driving Licences) Amendments Regulations 2013, there was no specific legal definition of a provoked seizure. The new legislation would at first glance allow for more provoking factors than DVLA has previously accepted. The Panel felt that in their specialist medical opinion the list of provoking factors should remain as it is currently as they offered an effective framework for definition. It must be noted that the UK is allowed to apply higher medical standards than the EU Directive if there is specialist medical opinion to back this up. The Panel felt that other provoking factors could not be reliably identified and therefore the list of provoking factors that are accepted for driver licensing could not be increased.

13.2 The Panel did feel that symptomatic seizures in exacerbation of multiple sclerosis could not be considered as a provoking factor and therefore the section regarding seizures occurring during the acute exacerbation of multiple sclerosis or migraine has been removed from the list of provoking factors.

13.3 The standards regarding seizures occurred with migraine is delineated further in the section on cases discussed.

Item 14. Are drivers with a previous history of epilepsy (>5 years since last seizure) with/without abnormal EEG necessarily considered to have an underlying causative factor that may increase future risk?

The question was put to Panel regarding whether or not individuals who have a history of epilepsy and then present with a seizure more than 5 years after the last seizure should be considered as having an isolated seizure for the purposes of driver licensing. The Panel opinion was that for an individual who has a seizure more than 5 years after the last seizure could be considered for the purposes of driver licensing as having an isolated seizure and not a further seizure as part of their epilepsy. For other clinical situations it would need further consideration. Reference was made to the MESS data which indicates that this category of person would fall into the medium or high risk category for further seizures.

Item 15. Points for clarification.

15.1 The Panel was asked whether or not there should be a new standard for Group 2 drivers who have recurrent episodes of altered awareness with seizures markers to mirror the standards for Group 1. The Panel agreed that for recurrent episodes of loss of

consciousness with seizure markers a period of 10 years off driving using a Group 2 licence would be required.

15.2 The Panel accepted that infratentorial Grade 2 meningiomas to be considered in the same way as Grade 1 meningiomas, i.e. to drive on clinical recovery for Group 1 and Group 2 provided there is no residual impairment that affects safe driving. This is because of the low epilepsy risk based upon the site and pathology.

Item 16 – Cases for Discussion.

16.1 The Panel considered 6 cases. One was regarding a metastatic brain tumour and seizures, one was regarding a static meningioma, one was regarding a VP shunt, one was regarding an isolated seizure, one was regarding a metastatic brain tumours with no seizures and one was regarding seizures due to migraine.

16.2 General discussion points from the cases:

16.3 It was noted that migraine provoking epilepsy is not necessarily the same condition as migralepsy. Migraines provoking epilepsy can be considered for licensing with ongoing migraine symptoms in cases where the epilepsy regulations regarding seizures can be met.

16.4 Regarding infratentorial metastatic disease, it is difficult to gather enough data to provide any details regarding good prognostic factors in cases of this condition.

16.5 Gamma knife surgery has not demonstrated any significant reduction in seizure risk compared to formal craniotomy.

Item 17. Other updates.

For information the Panel was given details of the number of appeal cases under Section 100 of the Road Traffic Act, regarding neurological conditions in 2013 to the date of the Panel meeting.

Item 18. Any other business.

18.1 There was a request from one of the Panel members that when referring a case to a Panel member it would be very useful if a copy of the imaging could be provided on a CD disc.

18.2.1 The Chair read out a letter that he had received from Mr Nelson President of the SBNS. This letter was raising concerns regarding differing advice given to individuals from different neurosurgical centres. The difference in the advice pertains to whether or not the treating doctors decide to apply the standard as in "At a Glance" or refer the individual to notify DVLA. Following the second line can lead to delays whilst DVLA make their enquiries. The Chair's reply to Mr Nelson indicated that doctors should be

able to identify whether or not an individual has a condition that needs to be notified to DVLA and also be able to use "At a Glance" in order to advise the person accordingly.

Thus based on 'At a glance' a Doctor should:

a. Inform the Patient that they have a notifiable medical condition and that they, the patient, must report it to the DVLA
b. The Doctor can use ' At a Glance' to say when the patient can drive assuming no other factors and give a date from when this can take effect.
c. The Patient with a notifiable medical condition is legally required to notify the DVLA but would be eligible to drive from the date agreed with the advising doctor as long as no other debarring events occur in the period from seeing the doctor to the agreed date.
d. Where the doctor is unsure of recovery at the time, say at discharge, the doctor could reasonably defer formal advice until the next outpatient review advising cessation of driving until then

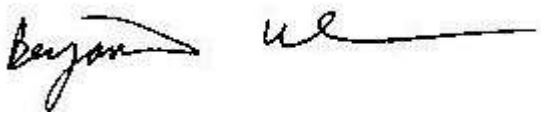
18.2.2 It was confirmed by Ms Charles that this advice is given out by DVLA and that individuals who notify DVLA during their current licence have cover to drive subject to having their doctors' approval. It was noted by one Panel member that some doctors may not be confident in making the assessment regarding fitness to drive and this may be causing some delays in individuals licensing decisions

18.2.3 The Chair will take this further with Mr Nelson.

18.3 The Sleep Apnoea Syndrome Working Party has drafted a report and hopes to present the final report before Christmas. There have been concerns within DVLA regarding the concept that individuals with sleep apnoea syndrome only needing to notify DVLA after control with treatment. This does mean that individuals would not have notified DVLA when they are at risk, i.e. before their condition is controlled. DVLA has arranged for communications to go out to the freight industry confirming that DVLA has to be notified on diagnosis or recognition of symptoms and that even if the licence is revoked, it generally is reissued after a short period of time when the condition comes under control. Assuming the report is published before the next Panel meeting it will be on the agenda for discussion. It was thought that it is not always clear for individuals and their doctors what to do with people who have mild symptoms of sleep apnoea. The Sleep Apnoea Department at Leeds has been surveying doctors attitudes towards notifying DVLA. They are due to publish this data towards the end of the year.

Item 19. Date and time of next meeting.

The next meeting will be held on 13th March 2014.



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