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, 22 October 2015

Present:

Professor G Cruickshank	Chairman
Professor A Marson	
Mr R Macfarlane	
Professor P Hutchinson	
Dr A Gholkar	
Dr C Tudur Smith	
Professor J Duncan	

Lay Members:

Mr C Jones
Ms R Eade

Ex-officio:

Dr S Mitchell	Civil Aviation Authority
Dr C Beattie	DVLNI
Dr N Delanty	National programme Office for Traffic Medicine, Dublin
Dr N Lewis	Panel Secretary, Medical Adviser, DVLA
Dr B Wiles	Medical Adviser, DVLA
Dr M Debritto	Medical Adviser, DVLA
Dr A Brown	Medical Adviser, DVLA
Mrs J Leach	Medical Licensing Policy, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Mrs R Cleal	Legal Adviser, DVLA
Mr A Burrows	Business Analyst, DVLA
Mr L Croucher	Common Services, DVLA

1. Apologies for absence

Dr P Reading
Dr D Shakespeare
Mr R Nelson
Professor H Morris
Professor R Al-Shahi Salman
Dr W Parry

2. Chairman's Remarks

New Panel members were welcomed.

Some of the issues raised at the Chairmen's meeting were reported back to the Panel. These included consideration of raising the age of renewal for all Group 1 licences from 70, possibly to the age of 75; ongoing issues relating to assessment of fitness to drive in patients with dementia; the likelihood that reporting by doctors to DVLA may be influenced by the Glasgow bin-lorry incident; and that changes to the At A Glance Guide to the Current Medical Standards of Fitness to Drive (hereafter referred to as At A Glance) are being considered. Members of the Panel wished to stress that they would encourage involvement of Panel members and lay members with any proposed changes (this was discussed further under Item 20, below).

3. Panel Recruitment

A suitable candidate is still being sought to fulfil the requirement for a Neuro-oncologist on the Panel. It is anticipated that a potential candidate(s) will soon be proposed.

4. Minutes of the Panel Meeting of 12 March 2015

The minutes were agreed as accurate and correct.

5. Fitness to Drive Project – Online Notifications

A presentation was given to the Panel to outline details of this project, which is building an electronic prototype to demonstrate how customers should, in future, be able to notify DVLA electronically of a medical condition. Consultation with customers has shown that the majority of customers would like to be able to notify DVLA of a medical condition

online. It is envisaged that the project could re-shape DVLA's Drivers' Medical Group in the future, removing the need for paper questionnaires and dramatically reducing the time taken to process information and make licensing decisions. The Panel was keen to be involved when it comes to finalizing the prototype for neurological conditions and wished to stress the importance of ensuring that customers not wishing/able to use online channels to communicate with DVLA should not receive a poorer service.

6. Minutes of the Chairmen's Meeting of 18th June 2015

Panel was advised that the Psychiatry Panel would be holding a symposium to discuss in further detail the issues relating to dementia and fitness to drive.

Research data is being collected and consultation will be made with all Panels and stake-holders in consideration of increasing the age of licence renewal from age 70.

7. Summary from the Working Group of the Vision Panel

A summary document written by Dr Shakespeare was discussed. It was noted by the Panel that it is not widely known by practising clinicians that 'exceptionality' is an option and the need to publicise this and ensure that doctors (and therefore their patients) are better informed, is required. Panel felt that a clearer definition of what is meant by 'full functional adaptation' is required and proposed that the hazard perception test, as is used as part of the driving test, may be a useful arbitrary measure of functional adaptation.

8. Sleep Apnoea

In order to ensure that the current medical standards are compatible with the requirements of the EU directive, Panel was advised of the proposed changes to the At A Glance guidance. It was agreed that the word 'daytime' would be removed from the proposed phrase 'excessive daytime sleepiness' due to concerns that use of this word would exclude people who drive at night yet are affected by sleepiness due to OSAS. It had been proposed that the wording in the introductory sentence in the At A Glance guide also be amended to add the word 'significant': 'sleepiness having, or likely to have, any significant effect on the ability to drive safety" as this would be in-keeping with the idea that a clinical judgement is required. However panel was advised that this would lead to difficulties in defining the word 'significant', that this addition would also not be compatible with the EU directive

which makes no reference to the severity of the sleepiness and panel was reminded that the currently proposed wording had been approved by a lawyer.

For clarity, Panel suggested that in the At A Glance, the standards for the bottom row (below), be explained more fully, rather than stating as currently proposed 'as for excessive sleepiness'. The following was therefore agreed:

OSAS/sleepiness
Current AAG standards (changes in red):
For the purposes of this document, excessive sleepiness is defined as sleepiness having, or likely to have, any effect on the ability to drive safely.

MISCELLANEOUS CONDITIONS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**
EXCESSIVE SLEEPINESS To include: 1) Obstructive Sleep Apnoea syndrome. See also below 2) Any other condition or medication that may cause excessive sleepiness severe enough to likely impair safe driving. Further information can be found on leaflet **"INF159"** www.gov.uk/government/uploads/system/uploads/attachment_data/file/193586/INF159_1_.pdf	Driving must cease **until** satisfactory control of symptoms has been attained.	**Driving must cease until** satisfactory control of symptoms has been attained, with ongoing compliance with treatment, confirmed by consultant / specialist opinion. Regular (normally annual) licensing review required.

New section:

Obstructive sleep apnoea syndrome (OSAS)	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**
Mild (AHI < 15 **or related sleep study measurement)**	As for excessive sleepiness	As for excessive sleepiness
Moderate (AHI 15-29 **or related sleep study measurement)** **AND** sleepiness or Severe (AHI > 30 **or related sleep study measurement)** **AND** sleepiness	If suspected, may not drive until diagnosis is confirmed and the condition is controlled, sleepiness is improved and treatment is complied with. This will require medical confirmation. Licence holders will have to confirm that they will have medical reviews no less frequently than every 3 years.	If suspected, may not drive until diagnosis is confirmed and the condition is controlled, sleepiness is improved and treatment is complied with. This will require medical confirmation. Licence holders will have to confirm that they will have medical reviews no less frequently than every year.
Moderate (AHI 15-29 **or related sleep study measurement** **WITHOUT** sleepiness or Severe (AHI > 30) **or related sleep study measurement WITHOUT** sleepiness	Driving must cease **until** satisfactory control of other symptoms (eg poor concentration) has been attained.	Driving must cease **until** satisfactory control of other symptoms (eg poor concentration) has been attained.

It was noted that car/motor bike drivers with OSAS will be required to sign a declaration promising to undergo 3-yearly medical review by a doctor. For bus/lorry drivers, the frequency is yearly. The medical review must be sufficiently rigorous to confirm the ongoing ability to meet the driving standards. The difficulties encountered in making arrangements to provide information to customers were discussed, and it is hoped that DVLA may be able to direct customers to another website for further information about the condition.

9. New Introductory Paragraph in the At A Glance Guide.

Panel was advised that the following has been proposed to ensure that the EU directive is transposed into practice:

'Changes to Annex III to the EC Directive 2006/126/EC require that driving licences **may** not be issued to, or renewed for, applicants or drivers who have a serious neurological disorder unless there is medical support from their doctors.
A serious neurological disorder is considered as:
-any condition of the central or peripheral nervous system with a risk of progression and with functional (sensory (including special senses), motor and/ or cognitive) effects likely to impact on safe driving.
Further information relating to specific functional criteria is provided on
-specific neurological conditions in this chapter (Neurology)
-Cognitive and Related Conditions in Chapter 4
-Visual Conditions and Disorders in Chapter 6
-Excessive Sleepiness in Chapter 8
When considering licensing **for these customers**, the functional status and risk of progression will be considered. A short term medical review licence is generally issued when there is a risk of progression.'

Panel suggested the following amendment to the second paragraph:

A serious neurological disorder is considered as:
-any condition of the central or peripheral nervous system presently with, or at risk of progression to a condition with, functional (sensory (including special senses), motor and/ or cognitive) effects likely to impact on safe driving.

10. Recurrent Gliomas

In March 2011 Panel agreed that 'where there is imaging evidence of tumour recurrence or progression and the licence holder is currently driving, licensing may be allowed subject to the following conditions:

- There has been an appropriate seizure-free period (one year for WHO Grade I and II tumours, two years for WHO Grade III and IV tumours).

• They are free of clinical disease progression.
Licensing will be allowed in these circumstances whether or not chemotherapy is given. An annual review licence will be appropriate. This change of standard will apply now and will be reviewed at the next Panel meeting.'

In the subsequent meeting it was agreed that 'the standards for grade I and II can be implemented in- house. More data is required for grade III tumours.
Grade IV tumours should not be allowed to drive if evidence of progression due to the speed of progression.
These guidelines are not to be included in At a Glance until further review'.

Subsequent meetings have concentrated on grade III Gliomas, and for the time-being it was decided that there is currently insufficient evidence to change the current standards as per AAG. However the AAG standards for grade I and II Gliomas have also remained unchanged (in accordance with original advice above). Panel was asked whether the proposed changes from 2011 can now be adopted into At A Glance and licensing permitted despite imaging evidence of recurrence/progression provided the driver is free of clinical disease progression and seizure free for one year. It was agreed that for grade I and II Gliomas, having established one year seizure free following completion of primary treatment it would be appropriate to permit relicensing despite imaging evidence of recurrence or progression as long as there is no clinical disease progression (and whether or not chemotherapy is given – as proposed in 2011). The At A Glance may therefore be changed accordingly.

Panel was also asked whether the person must 'be a licence holder and currently driving' as suggested in 2011, or could someone whose licence has previously been surrendered/revoked/refused also be considered? It was confirmed that this change of standards should apply to all (whether licence was previously revoked/refused/surrendered or remains valid).

With regard to grade III tumours further clarification will be sought and any proposed changes would need to be endorsed by a Neuro-oncologist. It was agreed that in principle, the key issue should be presence or absence of clinical disease progression as opposed to radiological progression or recurrence.

11. Legal Advice in Relation to Isolated Seizure; Previous Epilepsy with 5-year Gap in Seizures

Panel was reminded that the current interpretation of legislation means that, for the purposes of driver licensing, a driver is considered to have 'epilepsy' if there have been two or more seizures in the previous five years and if there have not been two or more seizures in the previous five years, a seizure is considered to be an 'isolated seizure'. Therefore a recent seizure affecting a person with a history of epilepsy, whose previous seizures occurred more than 5 years ago, is considered to be an isolated seizure - because there have not been two or more seizures in the previous five years. As a result, because the seizure is regarded as an 'isolated seizure' as opposed to 'an epileptic seizure', a person who might otherwise be considered to meet the criteria under one of the epilepsy concessions, cannot be permitted to drive because these concessions do not apply to 'isolated seizures'. The concessions apply only to epilepsy. In this instance the licence would therefore be revoked (usually for twelve months because the person would be regarded as having had an isolated seizure with an underlying causative factor that may increase future risk). If however such a person were to have a further subsequent seizure then driving may resume because the diagnosis of 'epilepsy' would again be established (due to the presence of two or more seizures in the previous five years) and therefore if the criteria for one of the concessions (such as the sleep concession) can be met, then driving could resume. This might therefore encourage poor control of epilepsy in order to regain (or indeed retain) a licence. Legal advice has therefore been obtained to determine whether there is scope within the legislation to consider seizures as 'epileptic seizures' despite there not having been two or more seizures in the previous five years.

Legal advice proposed that once a diagnosis of epilepsy has been established, by the presence of two or more seizures in the previous five years, then any subsequent seizure should be considered to be an epileptic seizure and the epilepsy regulations applied, regardless of the duration between seizures – even if there may be decades between seizures.

Panel agreed this to be a sound approach and that if a patient with epilepsy had been in remission for more than five years but had a subsequent relapse, it would make clinical sense for the seizure to be considered part of the epilepsy and for the licence therefore to be revoked for twelve months, or, if concession criteria can be met, for driving to be allowed to continue. It was noted that in previous Panel discussions Panel had suggested that following a long gap (>five years) in seizures, the concessions would not apply as the latest seizure would be an isolated one with no legal allowance for the concessions, however it was agreed during this meeting that concessions should in fact still apply, as the seizure following a long gap would still be part of the same condition (*e.g.* asleep seizures).

Panel was asked whether seizures in childhood due to a different mechanism may be disregarded, but it was agreed that other than febrile convulsions below age 5 – which are disregarded as provoked- the diagnosis of epilepsy, once established, should lead to any subsequent seizures being considered as part of the epilepsy.

In contrast to the suggestion from the legal adviser that two or more seizures in five years would first be required before a diagnosis of epilepsy can be made, panel felt that even if there had only been a single unprovoked seizure in the past, followed by a gap of five years or more, a subsequent unprovoked seizure should still be considered to be an epileptic seizure, despite there not having been two or more seizures within five years, because clinically this would still be regarded as epilepsy. It therefore follows that the regulations for isolated seizures will hence forth only apply to first-ever unprovoked seizures.

12. Legal Advice in Relation to 20% Risk for Isolated Seizures

During the last Panel meeting it was agreed that legal advice would be obtained in relation to whether or not it would be possible to permit driving after six months (rather than

Important: These advisory notes represent the balanced judgement of the Secretary of State's Honorary Medical Advisory Panel as a whole. If they are quoted, they should be reproduced as such and not as the views of individual Panel members.

twelve) for people who had suffered an isolated seizure and who had an underlying causative factor that increases their risk of further seizures but by no more than 20%. Members of the panel felt strongly that the basic principles of a 20% (Group 1) or 2% (Group 2) risk that are generally applied when determining medical standards for driving, should not be forgotten.

It was agreed (see Item 11 above) that isolated seizures would now only apply to people who have had a first unprovoked seizure. It is known that in some instances, for example where abnormalities may be found on imaging but the EEG is normal, although at increased risk of further seizures, the annual risk of further seizures after the first six months may not necessarily be greater than 20%.

The legal advice received has confirmed that for isolated seizure, given the wording of UK legislation, if there is an underlying causative factor that may increase risk (of further seizures), a licence must be revoked/refused for twelve months (rather than six). This is regardless of the degree by which the risk may be increased (even if <20% risk).
A change in UK legislation would be required to permit licensing after six months for those whose risk of further seizures is considered to be increased but by no more than 20%.

Panel accepted that DVLA must adhere to the law and that therefore, in the case of an isolated seizure with an underlying causative factor that may increase risk, driving must cease for twelve months.

Correspondence between a neurologist and medical advisers at DVLA was included in the panel bundle to highlight to panel members the confusion that exists in relation to the medical standards. It was agreed that better informing of doctors in relation to the medical standards is required and this was discussed further under Item 18 (below).

13. Should Provoked Seizures Sometimes Incur a Driving Ban?

Panel discussed a study published earlier this year which concluded that 'data supports an across-the-board driving ban of at least five months for provoked seizures'. Panel decided

that the raw data should be reviewed by some of the Panel members and that feedback would thereafter be given both to Panel and to the journal in which the paper was published.

14. Infective Endocarditis and Seizure Risk

DVLA has been advised that the incidence of seizure following infective endocarditis is significantly higher than for aneurysmal subarachnoid haemorrhage. Panel was asked whether At A Glance should therefore alert doctors to this risk following infective endocarditis, particularly in relation to Group 2 drivers? Panel felt that the advice provided to DVLA probably referred to mycotic aneurysms only and that it was not possible to quantify the risk. Cases should therefore continue to be assessed on an individual basis.

15. Solitary Metastasis Treated by Stereotactic Radiosurgery

At A Glance currently states (Group 1):

1. For metastatic deposit(s): At least 2 years off driving from time of completion of primary treatment
2. For a solitary metastatic deposit ' If totally excised, can be considered for licensing 1 year after completion of primary treatment if free from recurrence and no evidence of secondary spread elsewhere in the body'.

Panel was asked whether it is therefore correct to assume that if not totally excised (e.g. treated by stereotactic radiosurgery) then two years off driving is required (as per the first standard)? And whether, if there is evidence secondary spread elsewhere in the body then two years off driving is required? Does this apply only to secondary spread of disease subsequent to the primary treatment?

Panel confirmed that the standard should be the same whether the tumour was treated by surgery or by stereotactic radiosurgery and that the words 'if totally excised' should therefore be removed. Panel also clarified that the wording should be changed to 'no evidence of disease progression elsewhere in the body'. If there has been evidence of disease progression elsewhere in the body (subsequent to the primary treatment for metastasis) then two years off driving would indeed be required.

For a similar query in relation to the standards for Low-Grade Ependymomas, Panel confirmed that the standard should require one year off driving following completion of primary treatment (as for other low grade infratentorial tumours), whether or not the tumour had been completely excised, and that the separate standard for Low-Grade Ependymomas quoted in At A Glance should therefore be removed to avoid confusion.

16. Non-epileptic seizure standards

Current standards state: can be considered once attacks have been satisfactory controlled and there are no relevant mental health issues. This standard is interpreted differently by different people and is understood by some to mean that driving may resume if there is sufficient control of the non-epileptic seizure attacks such that they would not affect driving (sufficient warning of an attack, symptoms that would not affect driving *etc.*), and by others to mean an event-free period of at least three or at least six months. Panel was asked to provide guidance about what should be considered 'satisfactory control' and whether it may be possible to identify those who would be a risk when driving and those who pose no risk to road safety?

Panel advised that there is no good data on how the condition will behave and felt that operationally, a fixed time period of driving cessation would provide the best workable standard. It was agreed that a period of three months without event would generally be acceptable, unless attacks had occurred or were felt likely to occur whilst driving – and in which case, a specialist's review would be required prior to re-licensing.

17. Neurofibromatosis: Medical Standards for Group 1 and Group 2

Panel was asked to consider whether general guidance/standards for this condition could be offered or whether each case should be considered individually. It was agreed that as this is such a variable condition and patients with the disease may or may not have seizures, so it would be appropriate to continue to consider each case on an individual basis.

18. Advising Clinicians about the Medical Standards in Relation to 'Permitted Seizures Without Influence on Consciousness nor the Ability to Act'

It was explained to the panel that DVLA receives many queries from clinicians and identifies very many cases in which it is clear (from documented advice given to patients by their doctors) that there is a lack of understanding amongst doctors of the criteria for seizures to be considered as 'permitted seizures without influence on consciousness nor the ability to act'. Often it has not been appreciated that there must never have been any other type of seizure, and that seizures must cause no functional impairment and must have no effect on consciousness. Consideration is being given to the most appropriate and effective means of providing clarification to clinicians in relation to the medical standards and panel was asked to provide suggestions of the best ways to communicate this information, and perhaps to suggest organizations which may be prepared to assist in this.

Panel proposed that the Association of British Neurologists may be able to assist, and it was agreed that one of the Panel members would approach the President Elect to ask whether it may be possible to be given a session at the next meeting for a talk on the relevant driving standards.
Panel also suggested that the GMC should be encouraged to allow DVLA to support/develop a module for medical schools and/or CPD modules for clinicians. Consideration should also be given to providing an extra explanation in the At A Glance guidance.

Discussion followed about whether there may be sufficient evidence to approach Europe for consideration of changing legislation, if the risk of seizure is sufficiently low in certain circumstances to propose that driving should be permitted despite a history of another type of seizure in drivers who would otherwise meet the criteria for this concession. The example discussed was a patient who has undergone surgery for epilepsy, whose previous seizures affected consciousness or ability to act, but who has established a longstanding pattern of seizures following surgery, which have been demonstrated to cause no functional impairment and have no influence on consciousness. Professor Duncan kindly offered to collect relevant data to inform panel with a view to making this proposition.

19. Cases for Discussion

Two cases were discussed. One of the cases raised a query about whether six or twelve months off driving is required following surgery for a grade 1 meningioma [with 'surgical removal of the cause of seizures'] in a patient who had experienced an isolated seizure prior to the surgery. Panel considered that the epilepsy regulations should be applied (necessitating 12 months off driving) and that the seizure should be considered as 'lesional epilepsy' as opposed to an 'isolated seizure' per se. It was pointed out that the risk of further seizures is also increased if the seizure occurred prior to surgery.

The second case referred to a driver with Transient Epileptic Amnesia and the panel was asked to consider whether someone with this condition may be considered to meet the criteria for 'permitted seizures without influence on consciousness nor the ability to act'. Panel advised that the condition does cause a functional impairment and affect ability to act, in that seizures cause amnesia and drivers would not know where they are going. Seizures in this condition cannot therefore be considered as permitted seizures.

Any Other Business

20. Joint Neuro/Cardio Meeting to Review Standards for Blackouts

Dr Parry was not present as anticipated to discuss proposals for this meeting, however Panel was advised by DVLA Policy that both the A to Z and the At A Glance Guide are currently being reviewed and rewritten with the aim of making both more accurate and more user-friendly. In particular the section relating to blackouts is being scrutinised and is likely to be changed. Members felt that Panel should be consulted and closely involved with this process and stressed that whilst the layout may be altered without consultation, any changes to the wording of standards or to content would need to be agreed by Panel, and that Panel members would be happy to cooperate.

Panel was also advised by DVLA Policy that the process in relation to D4 medical examinations for Group 2 drivers is also likely to change to ensure that doctors completing the D4 questionnaire are either the patient's own General Practitioner, or that they have access to the patient's medical records or that the D4 is counter-signed by the patient's General Practitioner.

21. Query by Panel Member

A query was raised about whether nurses can complete and sign DVLA questionnaires. It was confirmed that this is permitted but only if the form is also a counter-signed by a senior doctor.

19. Date and Time of Next meeting

The proposed date for the next meeting is Thursday 7th April 2015.

DR N LEWIS
Panel Secretary

26 October 2015