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

HELD ON MONDAY 5 OCTOBER 2015

Present:

Professor D Cunningham-Owens Chairman
Dr G Jones
Professor S Banerjee

Lay Members:

Dr T Beanland

Ex-officio:

Dr T Jagathesan	Civil Aviation Authority
Dr W Parry	Senior Medical Adviser, DVLA
Dr A White	Panel Secretary, DVLA
Dr P Prasad	Medical Adviser, DVLA
Dr K Harrison	Medical Adviser, DVLA
Mrs S Charles-Phillips	Business Change & Support, DVLA
Mrs J Leach	Medical Licensing Policy, DVLA

1. Apologies for absence

Apologies were received from Dr P J Connelly, Mr B Alexander, Professor K Addley and Dr P Fearon.

2. Matters arising from the minutes of the chairman's meeting held 18 June 2015

Dr Parry informed the Panel of the progress of two reviews into Panel function and areas of responsibility. The first was an internal review commissioned by the Executive Board of DVLA. Secondly, there was a systemic review by the Parliamentary Health Services Ombudsman. This had been prompted by a report from the Independent Complaints

Assessors. The Panel expressed concerns that the report and enquiry process had been conducted with no discussion or contact with serving Panel Members.

2.1 Driving and dementia

The ongoing problem of dealing with cases of dementia and Mild Cognitive Impairment (MCI) was discussed at the chairman's meeting. It was felt that a joint meeting between the Psychiatry Panel and Neurology Panel would be of benefit to both Panels. It was Panel's opinion that the Neurology Panel would benefit from the experience of the Psychiatrists who have discussed this conundrum for a number of years. Panel hoped that a joint meeting would help avoid previous pitfalls and problems that had been experienced. It was felt that joint working would be extremely beneficial to such a contentious and expanding area.

The Panel was given a brief update on progress following the implementation of the new Drug Driving Legislation; it was informed out that the first arrest took place on the day of the implementation. It was reported that the use of the new legislation is somewhat varied across the country, some areas being more enthusiastic than others. The Panel was informed of the probability of a High Risk Offenders scheme being implemented in the future for drug related offences.

3. Minutes of the last meeting held on 22 September 2014

The minutes were accepted as a true record of the proceedings and duly signed by the Chairman.

4. Matters arising from the minutes

Panel discussed the early presentation of cognitive impairment, the older driver and the role of practical on–road driving assessments. At the previous meeting the issue of a lack of formal recorded diagnosis equating to a lack of a medical problem was discussed: this had caused problems when referring drivers for assessments when cognitive problems are suspected following a traffic incident but the driver has not presented clinically with any issues. At that time the difficulty of getting a formal label of dementia or cognitive impairment was explored and the issue of the various thresholds that had to be met and

overcome was raised. This subject had been raised in the media in the intervening months particularly by the British Medical Association at their Annual Representative Meeting (ARM).

There was discussion around the various neuropsychiatric tests that can be employed in the diagnosis of dementia or cognitive impairment and it was emphasised that the commonly used Mini Mental State Examination (MMSE) and Montreal Scales (MoCA) are screening tools for dementia and are not detailed or diagnostic tools. These are not adequate to fully assess cognitive impairment in someone where there are concerns about a degree of impairment; they were intended for use as part of a clinical assessment where concerns do not initially exist.

Panel commented that the commonly used and quoted screening tests the MMSE and MoCA scores do not examine executive functioning and this is of prime importance in driving. It was reiterated that people can score quite highly on the screening tests and still have significant functional cognitive impairment particularly if executive functioning is affected – these domains not being examined by the screening tools: likewise people can score quite low on screening tests and still function very well. Scoring being affected by the underlying pathology and educational level; scoring may also be affected by such co-morbidities as depression and physical illnesses.

Panel was informed that there exist a number of neuropsychiatric assessment tools that do explore the various areas relevant to driving including the visio-spatial skills and executive functioning and that in some cases formal assessment of these could be indicated. It was noted that the simple General Practitioner examination may not be able to supply the information required, a more specialised examination being required to determine this. These services should be available via secondary care services. It was stated that in the majority of cases during the early stages of the illness particularly the first three years, there may not be a formal diagnosis. Indeed there may be a degree of avoidance of diagnosis to avoid problems with areas such as driving and accommodation.

Panel stated however that the gold standard for assessing a driver's ability to drive was the practical, on-road driving assessment rather than formal office based testing. This would be by definition the only test that would measure the actual driving ability in traffic.

There was extensive discussion around the early presentation of cognitive impairment of whatever origin in driving. Panel stated that driving is a complex multi sensory process and in fact acts as a high level cognitive test in itself. Road traffic incidents although rare may well act as the "uncovering event" and unmask an existing impairment. It was noted that in psychiatric practice changes in behaviour over a passage of time are recognised as the presenting complaint for pathology in contrast to the model often used in other medical specialities, which is the binary yes/no test result or absence/presence of a symptom criterion. It was emphasised that age is a marker for cognitive impairment in that impairment becomes more common as age increases.

Panel informed that changes and deterioration in driving may well predate the formal diagnosis of a dementia despite there being no recorded diagnosis and the analogy was given to a persistent cough being the harbinger of possibly serious lung pathology.

The Panel was reminded that what was being discussed was cognitive decline rather than long standing cognitive impairment compatible with learning disability.

5. Medical standards for Group 2 licensing

The panel was provided with a brief update on the progress of the revised Group 2 mental health standards. In particular the lowering of the previous requirement to attain 3 years good, stable mental health to a period of 12 months. The impact was limited to date although a small number of licences had been issued successfully. A more extensive publicity campaign was planned in the near future.

6. At a Glance update

The panel was provided with information regarding the updated mental health sections in the At a Glance Guide (AAG). These were reviewed and further amendments suggested by the panel members.

Further changes were made to the advice regarding medication; this was to reflect the increased problem of drug misuse and overdose involving the combination of licit and/or illicit benzodiazepines and opioid analgesia, often lorazepam and dihydrocodeine in the UK.

The learning disability section was further clarified.

Panel was informed that the AAG was in the process of being extensively revised and re-written and would likely appear in a different form in the near future.

7. Cognitive impairment and dementia guidelines

The Panel was updated on meetings at Newcastle to discuss work on guidelines for dementia and Mild Cognitive Impairment (MCI) in driving. This resulted in a detailed discussion and it was provisionally agreed that DVLA would lend its endorsement to the guidelines when completed. A full update was planned when the work was completed.

8. Recruitment update

The Panel was updated on the recruitment process; three applicants have been identified and will be invited to join the Panel.

9. Fitness to drive presentation

Dr Parry advised the Panel of the developments within DVLA to digitalise and improve services in processing selected medical conditions and pathways. This would have limited impact on the processing of mental health cases at present.

Some reservation was expressed at the drive to digitalise services, concerns were expressed about the potential to disenfranchise and disadvantage those who chose not to access the service via an electronic or digital pathway or are for various reasons unable to do so. It was felt that those drivers with mental health problems were at particular risk of this. Reassurances were given by DVLA that this would not happen and that traditional pathways of communication would remain available.

10. Research update

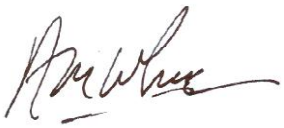
There was no research to update.

11. Any other business

The Panel was informed of the imminent retirement of Mrs Jan Leach who has represented DVLA for many years at the Secretary of State's Panels. Panel expressed their gratitude for her long standing service and support and extended their best wishes for her retirement.

12. Date and time of the next meeting

The next meeting will be in the spring on 7th March 2016, a decision was made not allocate a date for an autumn meeting pending the recommendations of the various reports.



Dr A M White MB BCh
Panel Secretary