

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

**THURSDAY, 3 MARCH 2016**

**Present:**

Dr M Griffith                      Chairman  
Dr A Kelion  
Dr L J Freeman  
Mr A Goodwin  
Dr R Henderson  
Dr D Fraser  
Dr S Lim

Mr D Simpson

**Ex-officio:**

Dr S Bell                              Chief Medical Officer, Maritime and Coastguard Agency  
Dr W Parry                            Senior Medical Adviser, DVLA  
Dr A Kumar                            Panel Secretary, Medical Adviser, DVLA  
Mrs C Green                         Joint Head of Medical Licensing Policy, DVLA  
Mr J Donovan                         Medical Licensing Policy, DVLA

**1. Apologies for absence**

Apologies have been received from Mr M Gannon, Dr D Northridge, Professor C Garratt, Dr E Keelan, Northern Ireland representative, Mr B Jones, Mr B Nimick.

The Chairman welcomed all attendees and introductions were made by all present.

**2. Panel membership changes**

Dr A Kelion has completed his term as a Panel member. On behalf of the Panel, the Chairman thanked Dr Kelion for his valuable and active contribution to the Panel. The Panel Secretary also thanked Dr Kelion on behalf of the Medical Advisers and the DVLA.

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The nominations for Dr Kelion's successor on Panel have been submitted by the Panel Secretary to DVLA, however, the nomination process is currently on hold due to the internal audit of the Secretary of State's Honorary Medical Advisory Panels.

Dr Kelion queried whether there is an interim plan to facilitate DVLA referrals to the Panel, of complex cardiovascular cases requiring input/advice from a cardiologist with imaging expertise. The Panel Chairman requested if Dr Kelion would be happy to continue to provide such advice in the interim. The SMA (Senior medical adviser) confirmed that it would be welcomed by DVLA if Dr Kelion, (if agreeable to him), would be able to provide such advice in the interim as an independent consultant/expert. All such cases which are already in the referral process to Dr Kelion in his capacity as Panel member may continue. Dr Kelion kindly agreed to provide such ongoing support to the DVLA in the interim until his successor is nominated/appointed.

### **3. Chairman's remarks**

The Panel Chairman commented that the links to several international driving guidelines were sent to him a few months ago by the SMA. Chairman had reviewed these guidelines and his view was that they are much more complicated and lengthy than the existing UK 'At a Glance Guide to the Current Medical Standards of Fitness to Drive', and not necessarily superior to the existing UK guidelines, in fact some of them have not been reviewed since 2008. He did mention that the Canadian guidelines seem to be of a good standard. He added that some of the guidelines are actually derived very much from the existing UK At a Glance guide.

The Chairman wished to discuss the new version of the 'Assessing fitness to drive' guide which the SMA had e-mailed to the Chairman recently and a further version had been e-mailed to all the Panel members the day before the Panel meeting.

A lengthy discussion on this issue ensued.

The Chairman appreciated that although the presentation style of the new version of the 'Assessing fitness to drive' guide seemed good, Panel expressed reservations about the

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drafting in the revised version of At a Glance but helpfully reviewed the contents in detail at the meeting and recommended changes that DVLA were able to take on board. The SMA suggested that it would be useful for Panel to go through the latest version in detail and this took place later in the meeting.

The Chairman emphasised that he has mentioned in previous meetings that the main issue in a recent fatal accident inquiry was not the At a Glance guide syncope standards but the failure of notification of the medical condition by the individual to the DVLA. Chairman further advised that had the driver notified the DVLA of his medical condition, DVLA standards would have been applied and hopefully would have avoided this accident. Concerns were expressed that there is a lack of prosecution in these cases of non notification. The SMA advised that the relevant authorities were aware of the issues.

#### **4. Minutes of the meeting of 24 September 2015**

The minutes of the meeting were accepted as accurate and agreed after making minor changes as discussed in the 'Matters arising'.

#### **5. Matters arising**

DVLA's ETT protocol for Group 2 licence: discontinuation of anti-anginal medication prior to exercise testing.

Dr Kelion welcomed the change in the protocol for Group 2 licensing purposes and that the exercise tolerance test could now be carried out whilst individuals remain on their usual/regular anti-anginal medication. He mentioned that, however, it needs to be clearly stated that the current DVLA protocol for stopping anti-anginal medication before MPS/stress echo needs to remain unchanged. Although the minutes mention that there is 'weak evidence to suggest that beta blocker reduces the sensitivity of MPS or Dobutamine stress echo for demonstration of myocardial ischaemia', it needs to be clearly stated that anti-anginal medication must be stopped before these tests as per current protocol.

The word 'weak' needs to be removed. Panel advised that it was conventional practice to stop beta blockers before MPS/stress echo.

There was discussion around the issue of ongoing compliance with anti-anginal medication, in light of relaxation of the ETT criteria to be met. Previously, exercise tolerance testing was done off anti-anginal medication and a licence was issued if the individual passed this test whilst being off the anti-anginal medication. Hence, compliance was not a big concern from a licensing point of view as they would have demonstrated that they met the standards while being off the medication for 48 hours. As the exercise tests are now being done whilst on the regular anti-anginal medication, the question arose whether there should be a requirement for having a question to the individual (via the clinician undertaking the exercise test) about their compliance. There was a discussion whether it would be reasonable to ask the individual to certify that they are taking their regular anti-anginal medication as prescribed. The wording of the new protocol was reviewed as in the minutes. Dr Kelion pointed out that on the DVLA questionnaires to the licence holders/applicants, the individuals are required to put a list of their regular medications taken and they do sign the form, so this would be a certification to say that they are on those regular medications. The SMA agreed with the above and that there should not be any need for any additional certification. The new wording 'whilst on their usual/regular anti-anginal medication' implies that they are taking them regularly.

## **6. Progress on amendment of the Annex III of EC Directive**

The Panel Secretary updated the Panel regarding the voting by EU member states on the Draft for the amendment of the **Annex III** at the Driving Licence Committee. She explained the categories 9.1, 9.2 in the cardiovascular section and the implications of these sections in the Annex III. The details of the progress on the amendment were included in the agenda bundle and are as follows:

The European Union Member States attended the Driving Licence Committee meeting in Brussels on 27.1.16 for the purpose of voting on the proposed Draft Commission Directive amending the Annex III of the EC Directive. This amendment is to update the provisions on medical fitness concerning the

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cardiovascular diseases for all drivers. The draft was circulated to Member States prior to the meeting.

*(This was the version very similar to the one which was sent to Member States in 2014 and the Panel Secretary circulated it at the Panel meeting in March 2014. Panel's view was that as this format simply lists the conditions which need to be taken into account before licensing and mentions that they should be adequately controlled as judged by competent medical authority, it would allow UK to apply its existing licensing standards as in At a Glance).*

The Exceptional Clause was a new addition.

The UK sent its comments to the Commission prior to the meeting, expressing 2 main concerns which were also raised at the meeting.

1. The Exceptional clause after section 9.2 should not be applicable to both Group 1 and Group 2 licence categories but only to Group 1 licence category. This was to ensure that for Group 2 licence purposes, the acceptable risk for a sudden incapacitating event does not exceed the agreed 2% per annum.
2. The UK also considered that the text structure could appear in some parts ambiguous and misleading the way the phrase 'applies to Group 1 only or to Group 2 only or both Group 1 and Group 2' have been put in brackets against each condition. The UK's suggestion was that it would be preferable if the provisions could be divided between Group 1 and Group 2 for each of the conditions.

Whilst there was support for the above from some Member States, a consensus wasn't reached on the Exceptionality clause and the Commission agreed that due consideration will be given to the Exceptional clause in light of the discussion.

The Commission concluded that the vote is postponed, it will make the minor clerical adjustments mentioned to the current draft text and will proceed with the vote in a written procedure.

The Commission has now issued the papers for voting via a written procedure to amend the medical annex for cardiology.

1. The Commission do not propose to change the Exceptional case clause, it will continue to apply to Group 1 and Group 2 drivers. It will be for Member States to decide if and how they make use of this option.
2. The structure of the Annex is to remain the same. The Commission view is that the Directive (recital 3) refers to the cardiovascular report and the report states how the provisions should be applied. In addition, Member States can transpose the provisions nationally into their preferred format.

The agreed position was to vote in favour of the proposal even if we were unable to change the exceptional cases clause, and apply a higher standard for the cardiology provisions. If the proposal was referred back to the Driving Licence Committee it would be September at the earliest before the next meeting is held. This would also delay the diabetes provisions.

The 2 main issues UK was concerned about should be addressed with the following wording in the Written Procedure section of the directive:

*Furthermore, as the proposed draft amendment has the legal form of a directive, Member States would have the competence to decide on the form of the implementing measures which would transpose the proposed amendment into the national legal system. These measures could take the form of a table or the provisions could be separated by the group of drivers that are affected, if Member States decide that this would be beneficial to the efficient implementation of the proposed cardiovascular provisions.*

Re Exceptional criteria for 9.2:

*The Commission would underline that this additional flexibility would not be mandatory and that Member States would have the competence to decide if and how they want to make use of this option.*

The Panel Secretary explained in detail the UK's concerns regarding the exceptional clause after Section 9.2 in the Annex III. Panel members expressed concern that having an exceptional clause makes it open to legal challenge such as in a case where a licence is revoked due to certain cardiovascular condition(s) and exceptionality not applied for those conditions. The Chairman explained that as per the wording in the written procedure, it is not mandatory to include exceptional clause, as these are minimum standard guidelines and the UK can apply higher standards as required. However, if certain countries choose to apply the Exceptional clause for certain conditions where the UK has higher standards, then there could be concerns about road safety issues for those conditions, especially if drivers from those countries would be eligible for licensing in their own country and would be driving on UK roads.

The other issue discussed at length was the standards for 'Brugada syndrome with syncope'. This has been put under Section 9.2 in the Annex III, that is, the category which includes conditions where driving licences shall not be issued or renewed for applicants or drivers in the indicated groups. The Panel Secretary advised that she had sent her amendments to the

EU draft before the voting procedure and had placed ‘Brugada syndrome with syncope or aborted sudden cardiac death’ within Section 9.1 for Group 1 licence purposes in her proposed text (her draft had been included in this Panel bundle). By having ‘Brugada syndrome with syncope or aborted sudden cardiac death’ removed from 9.2 for Group 1 purposes, it would mean that for Group 1 a driving licence may be issued or renewed for applicants or drivers after the condition had been effectively treated and subject to competent medical authorisation with regular medical assessment. However, the Driving Licence Committee has transposed this in Section 9.2 for both Group 1 and Group 2 as its original version. The Panel Chairman advised that there had been extensive correspondence between the Panel Chairman and the EU cardiovascular Working Group prior to the draft being drawn advising that the current standards for Brugada syndrome as in the Working Group report were too restrictive for a Group 1 licence. The Chairman advised that it is not uncommon for patients with Brugada syndrome to have an episode of syncope at some point in their lives but as long as they are on the appropriate medication to prevent any future sudden and disabling events and the condition is well controlled they should be allowed to drive Group 1 vehicles. The Panel Secretary queried if interpretation by Panel of ‘Brugada syndrome with syncope or aborted sudden cardiac death’ could be interpreted as a recent syncope directly relevant to Brugada syndrome rather than any history of syncope, and whether then once the condition is appropriately treated it would be possible to allow Group 1 licensing. The Chairman asked Chris Green if there could be a possibility for the UK to use the Exceptional clause just for Brugada syndrome in Section 9.2. Chris Green advised that this would need legal advice as standards are usually quite prescriptive.

There were discussions on the issue that although, on one hand, the current EU standard for Brugada syndrome was too restrictive, on the other hand, there were concerns also raised that if the UK did apply exceptionality and allowed individuals with Brugada syndrome with a history of syncope or near aborted sudden cardiac death to drive, and if there would be an accident in the particular case, then, that would not be acceptable from the public road safety risk aspect, especially if the standards are higher in the EU Annex. Chris Green asked the Panel to give their advice in which direction it wishes to go towards this issue as if Panel advises that medically it is not acceptable and hence standards need to be relaxed for Group 1 in case of Brugada syndrome with syncope, she would need to look into this further to explore whether this issue could be contested with the EU Driving

Licence Committee just like in the case of hypoglycaemia in diabetes. The Panel Chairman advised that most patients with Brugada syndrome in the UK are currently able to drive as long as they are asymptomatic and the condition is well controlled with appropriate treatment. Currently, the UK does not have standards for Brugada syndrome for either Group 1 or Group 2 licence standards.

**Conclusion:** The Chairman suggested that Brugada syndrome for Group 1 licensing purposes is much better placed in Section 9.1 of the Annex rather than 9.2. Chris Green will seek further legal advice on this whether exceptionality could be just applied to ‘Brugada syndrome with syncope or aborted sudden cardiac death’ and/or whether it would be worth contesting this clause.

## **7. Update on DVLA internal audit of Secretary of State’s Honorary Medical Advisory Panels**

There has been an internal audit review of Panel’s role and function by the independent audit group at DVLA over the past 6 months. The Chairmen of some of the Panels have been approached by the audit group. The Chairman confirmed that he had sent an e-mail response to some questions from the audit group about a year ago. The SMA advised that a representative from PHSO had also attended one of the other DVLA medical Advisory Panel meetings to get an understanding of Panels’ role and function. He further advised that the internal audit has looked at issues such as Panel’s role and function, interaction with DVLA and compliance with Government guidelines. Panels were supposed to be compliant with the COPSAC agreement but now this has been superseded by guidelines from the Cabinet Office and all Government Scientific Advisory Groups have to comply with the Cabinet Office guidelines. The final draft of the audit is not yet ready but recommendations are likely to be around the ‘Terms of Reference’ for Panel members, Panel membership recruitment process, relationship of Panel and the DVLA with the Royal College of Physicians and other relevant Colleges, the format of the Panel meeting minutes etcetera. There was a discussion around how medical standards are arrived at. The Panel Chairman advised that there is evidence-based literature available relevant to the topics discussed at Panel meetings, however, they are not always directly related to traffic medicine.

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Cardiovascular Panel do review evidence-based literature regularly when looking at issues brought to Panel meetings, and the guidance is based as much as possible on evidence-based medicine and rarely based on clinical practice which are not evidence-based. He cited examples of a recent change in guidelines for severe aortic stenosis, exercise tolerance test, guidelines of myocarditis, heart failure, LVAD and transplant standards, which were discussed at panel meetings with reference to evidence-based literature, and relevant papers being included in previous Panel agenda bundles. He emphasised that the guidelines were not ‘just made up’ when there was a lack of data available. The SMA advised that he has made clear to interested parties that the Cardiovascular Panel do discuss evidence-based literature before recommending changes to the standards.

Regarding the recruitment process, the SMA mentioned there is a view that this needs to be open to a wider group of relevant specialists rather than focusing on a selected group of experts. The Chairman advised that a few years ago at a Government Scientific Advisory Groups’ meeting there was a discussion around the COPSAC requirements and it was agreed by all that if there was paucity of a very specialised expert needed for advisory role in a specialist area, then having a formal application and interview process for such a position would create a recruitment problem. The Chairman commented that Panel guidelines and advice has to be more and more evidence-based, appointing Panel members in a random fashion would not meet this requirement. A Panel member also mentioned that expert opinion is also evidence-based and considering that most Panel discussions are based on a lot of background evidence-based knowledge and are well argued in the meeting, there may be a valuable opportunity to get these discussions and guidelines being developed as a position statement for it to be published in order to give credibility to Panel guidelines for a wider audience. This would be important in certifying Panel work. Panel agreed that although it seems a good idea as it may show transparency and have credibility, however, the work involved in developing this work into a document or a paper which could be published with international credibility, would require a lot of time and resource. The Chairman agreed that a high quality publication paper needs a lot of resource (time and work involved) so using Panel discussions and guidelines to publish a paper would not be very beneficial for the Panel for DVLA purposes as Panel would know the answer to the issues already from their discussions. Chris Green advised that the DfT research

budget/funds have been available in the past for assessing road traffic accidents in relation to underlying medical conditions, however, there has been limitation in linking data from insurance companies. If there is a justifiable research topic there may be funds available.

The Chairman advised that the Cardiovascular Panel have in the past submitted topics to DfT for research but the topics were not considered to be suitable for funding by the DfT research body.

The SMA concluded the discussion indicating that he just wanted to give Panel a flavour of current considerations. He agreed the Cardiovascular Panel mostly do have evidence-based background to their discussions and guidelines development.

#### **8. Resting LVEF (Left Ventricular Ejection Fraction) greater than 40% but drop in post stress LVEF (MPS/stress echo):**

##### **Interpretation for Group 2 licence standards**

Dr Kelion gave a comprehensive presentation on this topic.

##### **Conclusion:**

Sufficient evidence is not available to change the current guidelines for an isolated drop in left ventricular ejection fraction at stress with no significant regional myocardial ischaemia. For Group 2 licence purposes, the resting LVEF is the value that needs to be taken into consideration for licensing purposes. If there is a drop in LVEF at stress, regardless of whether the post stress LVEF is greater than or less than 40%, the case needs to be referred to a Panel member (ideally a member with imaging expertise) to get an opinion. This is important as a drop in LVEF could be the only clue to a balanced multi-vessel disease. If there are other abnormalities/concerns reported on the scan, for example, TID (transient ischaemic dilatation), such cases may also need to be referred to a Panel member.

##### **Discussion points:**

Most of the prognostic data in cases of myocardial perfusion scan is around the ejection fraction (mostly greater or less than 40%), there are analogous recommendations for stress echocardiogram or cardio-magnetic resonance imaging. However, there are a number of non specific markers of severe ischaemia which is seen every so often on scintigraphy. One of such markers is transient ischaemic dilatation (TID): TID is said to be present when the left ventricular cavity is larger on the stress scan than on the resting scan and on gated scans sometimes a lower ejection fraction on stress is noted as compared to the rest scan. All these findings may raise concern that there is an abnormal response of the left ventricle during stress as compared to during rest but in a non specific way. Most of the data surrounds the TID. TID predicts adverse outcomes independent of perfusion abnormalities and so amplifies the prognostic information. The concept of TID is not very well understood, but the favoured explanation is that TID represents ‘a global myocardial stunning’ – severe ischaemia during stress which made the left ventricle dilate and hence larger LV dimension is seen during stress as compared to a smaller LV dimension during rest. This indicates a severe ischaemia independent of the perfusion abnormalities seen on the scan as the same time. Another school of thought is that TID represents diffuse sub-endocardial under perfusion that might make the endocardial cavity look bigger during stress as compared to rest. Although TID is not very well understood, it is recognised that it predicts adverse outcomes independent of perfusion abnormality and that it tends to occur only in individuals with associated left ventricular hypertrophy and diabetes with ischaemic heart disease. In the context of a perfusion abnormality, the presence of TID increases the risk of an adverse event, however, TID seen on a scan which is otherwise normal, with no perfusion abnormality does only slightly increase the prognostic risk.

### **Drop in LVEF at stress:**

There have been several cases referred by the Panel Secretary to Dr Kelion asking advice if resting LVEF has met the Group2 ejection fraction criteria of 40% or more and the reversible ischaemia criteria has been met but there has been a drop in LVEF at stress. Dr Kelion advised that 2 important things that need to be borne in mind : firstly to exclude any technical or artefactual issues; secondly, how much drop is there in the LVEF at stress compared with that at rest. Keeping the reproducibility of technique in mind, the published

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literature evidence shows a drop of 6-7% is significant. This drop could be due to a lot of myocardial ischaemia which may just have been missed in terms of perfusion abnormality or could be a non specific response of left ventricle. There is not much literature available on this topic and the limited literature available is conflicting. It could be that this represents balanced multi-vessel ischaemia and because the whole of the left ventricle is ischaemic, it may be difficult to be seen as a perfusion defect and this ischaemia may be represented by a drop in the LVEF. If this was the case there would be greater prevalence of a drop in LVEF in the population with multi-vessel disease, but such prevalence is not seen hence the evidence base is conflicting. One study showed slightly higher risk of sudden events in patients with drop in LVEF at stress, in an otherwise normal scan, however, it is important to look at those scans which are not entirely normal and also has a drop in LVEF. One small study of 57 patients showed an increase in event rates in patients with a drop in LVEF at stress, one cardiac death and one heart attack in these cases compared to no cardiac death and one heart attack in the group with no drop in LVEF at stress. All this has been driven by revascularisation. The Panel Secretary queried whether all such cases should be referred to Panel even if following the drop the LVEF is greater than 40%, that is, there is a drop in LVEF at stress but both resting and stress LVEF are greater than 40%. Panel's advice was that all these cases do need to be referred to Panel especially if there are any concerning comments by the reporting specialist.

The issue of variability/reproducibility during the measurement of LVEF was mentioned, as it is not uncommon for LVEF to be reported as a range so an absolute value may at times not be 100% reliable. Dr Kelion advised that if there was a significant drop (for example 7%) in the LVEF, in an ideal situation it would be repeated and the average of the drop with standard deviation may need to be taken into account. It is well recognised that LVEF in one individual can vary slightly when measured at different times, however, this is acceptable in clinical practice, and if for licensing purposes there is a doubt cases would need to be referred to a Panel member.

## **9. Notification of pacemaker and ICD implants: Group 1 licence**

A lengthy discussion ensued on this topic.

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## **Conclusion:**

Panel's advice was that patients with ICD are a higher risk group of individuals as compared to patients with pacemakers in terms of a sudden and incapacitating event; they usually also have various co-morbidities. All patients with ICDs implanted should notify DVLA.

## **Discussion points:**

There was a lengthy discussion on the notification process for pacemakers, ICD, on issues of clinical follow-up, compliance and signing of declaration forms. The Chairman advised that pacemakers have historically always been notifiable, the standards for ICD were historically very restrictive and any individual with an ICD could not drive in the past, however, over the years the guidelines have been reviewed and relaxed and currently those with prophylactic ICD and an ICD with no associated history of incapacity do not need to notify the DVLA. He mentioned that when reviewing the process it is important that for any of the listed medical conditions in the At a Glance where there are driving standards that need to be met, or restrictions to be observed, individuals do need medical follow-up to ensure that they continue to meet the standards. The individual has responsibility to ensure he continues to meet the standards and hence they need to comply with all the medical therapy (whether drug therapy or device therapy) and hence the need to sign a declaration form. Even with the prophylactic ICDs there is potential risk of inappropriate shocks, so technically that could impact on road safety and if the prophylactic ICD group are exempt from the notification process, they would not be signing up to a declaration form either. The Chairman advised that notification of all ICDs would obviously have operational implications in terms of caseload at DVLA, however, road safety needs to be borne in mind. Chris Green advised that if the requirements for individuals with an ICD is to comply with the points mentioned in the DEFIB declaration form, then all individuals with an ICD should need to notify the DVLA. The H1 and DEFIB1 forms linked to the A-Z website for pacemaker and ICD sections were discussed and reviewed at the Panel and were considered appropriate. Chris Green added that if pacemaker notification has been there for

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medical reasons then it would be appropriate for them to continue being notified and signing a declaration form, and they should not be removed from the process to satisfy operational needs. By having a notification and hence signing a declaration form the responsibility is on the driver to ensure that he or she meets the medical standards for fitness to drive. The Panel Secretary advised that from an operational point of view individuals with pacemakers get an unrestricted licence if the H1 form is completed favourably, and a declaration form signed (and there is no other medical condition requiring a review licence). By introducing notification of an ICD in the currently exempt group, a similar process would be undertaken and if a DEFIB1 form has been completed favourably and the declaration form signed with the CONSDEC form (where appropriate) they would be given an unrestricted licence, provided they have met all other standards. The Panel Chairman further mentioned that if an individual with an ICD in the current group exempt from notification, had been driving without attending regular follow-up (as they would not have signed a declaration form for driving purposes), and they cause an accident it would be a difficult scenario regarding the responsibility of the licence holder as they could claim they were not bound to attend regular follow-up from the driving point of view. The SMA agreed that pacemakers should continue to be notified and all individuals with ICDs should notify DVLA regardless of increased operational load.

**10. Review of the new ‘Assessing fitness to drive’ cardiovascular section (as agreed earlier in the meeting)**

**Conclusion:**

The Chairman advised that the final version of the new guide with the changes discussed at the meeting needs to be incorporated and then circulated to all Panel members and all changes agreed before Panel would endorse the new guide.

**Discussion points:**

The Panel reviewed both versions (AAG and Assessing fitness to drive) suggesting changes as appropriate. The SMA advised that certain styles of wording ‘must not drive’ at the start

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of each box with a traffic light system has to be maintained in all sections of the new guide for the sake of consistency. For the ICD section Panel's advice was that the existing guidelines as in the original At a Glance version are quite complex already and have been developed over the years with intense scrutiny of words/phrases used, so ideally would be better to have them in the existing style. The new version is rather confusing and difficult to interpret. The Panel Chairman stressed that due to the limited time available at the meeting, the aim of the review today was just to ensure that the meaning of the standards from the existing guidelines are not changed or lost in the wording of the new version. Any revision of the actual standards would have to be addressed at a future Panel meeting.

## **11. Cases for discussion**

There were no cases for discussion today.

## **12. Any other business**

The Business Analyst Group from DVLA gave a short slide show presentation on the 'Fitness to Drive' project. There was a brief outline about the current process of notification and the 'first notification' in the digital forms. Two forms for cardiovascular section, H1 and DEFIB1 have been digitised, to get core information from the customer about their medical condition. Other forms that are currently being worked upon are the diabetes and glaucoma forms, which are hopefully going to be available for first use in May 2016, and is expected that the live service would be operational between May-August 2016. It is hoped that other conditions would be added to the digital process from August to December 2016. A digital version of DEFIB 1 was displayed as an example and the various steps in the flow chart were explained to Panel. Panel were advised that the phase 2 of this digitalisation process would involve vocational licence forms. Panel were reassured that there would be a verification process for individual's identity just as like in any other Government process. Panel were also reassured that at present the paper version of these forms would still be available for those would not have internet access.

**13. Date of next meeting**

The proposed date for the next meeting is 15 or 22 September 2016 - to be finalised.



**Dr A Kumar MBBS MRCGP**  
Panel Secretary

10 March 2016