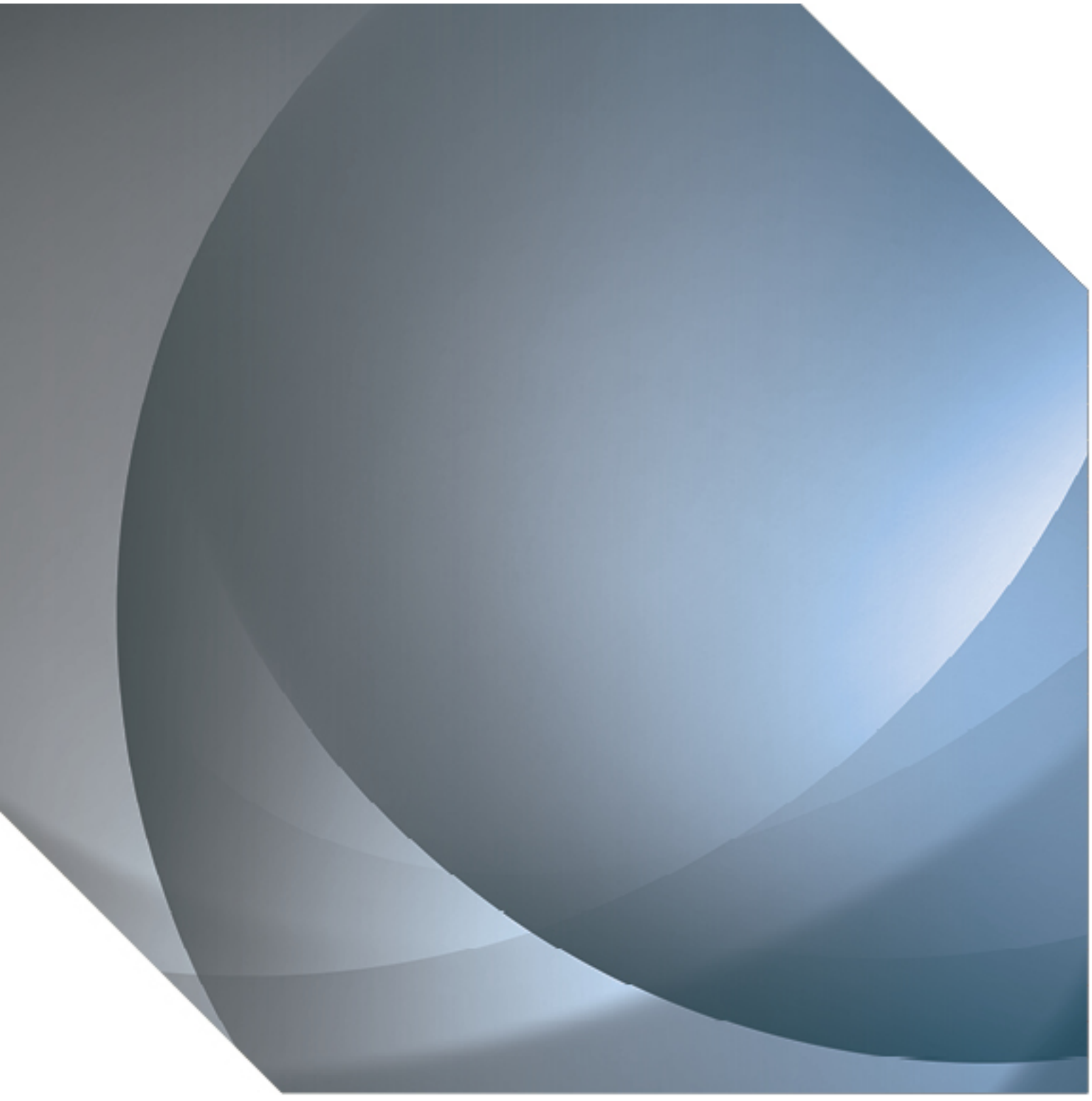
Consultation on the Future Structure of the CAA's Medical Department

CAP 1214



Contents

Foreword

Purpose of Consultation

1. The purpose of this consultation is to seek the views of all interested parties on the options available to the CAA for carrying out aeromedical regulation and oversight and enabling the provision of aeromedical services.

2. This consultation document is structured as follows:

   - Foreword
   - Background
   - Options on which views and opinions are sought
   - Consultation questions

Next steps and how to respond to the consultation

3. The consultation will begin on 16 October 2014 and run for eight weeks until 5 p.m. on 11 December 2014.

4. Stakeholders are invited to email their comments to Medical.Consultation@caa.co.uk. Comments made after the deadline may not be considered.

5. Once all comments have been received, the CAA will publish a summary of comments and consider these views as part of its decision making process about the future of the Medical Department.

Freedom of Information

6. When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear who the organisation represents and, where applicable, how the views of members were assembled.

7. Information provided in response to this consultation, including personal information, may be subject to publication or disclosure in accordance with the Freedom of Information Act 2000 (FOIA) or the Environmental Information Regulations 2004.

8. If you want information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence.

9. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the CAA.

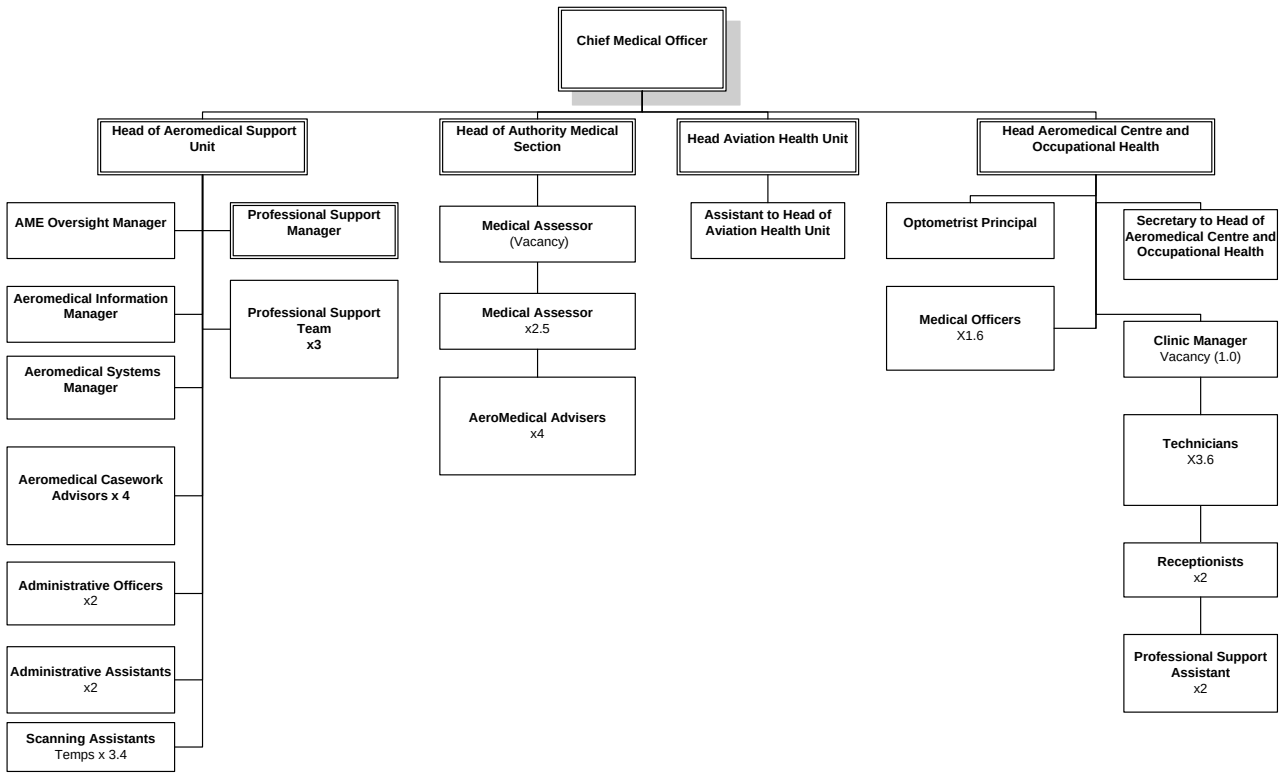
10. The CAA will process your personal data in accordance with the Data Protection Act 1998 (DPA).

Background

The CAA Medical Department's Current Structure

11. The CAA Medical Department is part of the Flight Operations Capability Team in the Safety and Airspace Regulation Group (SARG). The current organisation structure is set out below.

Medical Department Organisational Chart (October 2014)



12. The CAA Medical Department contains four discrete business units. These are the Authority Medical Section ("AMS"), the AeroMedical Centre ("AeMC"), the Aviation Health Unit ("AHU") and Occupational Health ("OH").

Why is the CAA conducting a review of the CAA Medical Department, and seeking the views of stakeholders in this consultation paper, now?

13. There are 3 primary reasons why the CAA is consulting on the future structure of the CAA Medical Department now. These relate to cost, the issue of a regulator providing regulated services, and ensuring that the CAA has a Medical Department fit for the future. These are explained in more detail below.

Cost

14. The majority of the CAA Medical Department's work is funded by UK charge payers.

15. The cost of the CAA Medical Department, which is approximately £4.3 million annually, exceeds its income.

16. The CAA Medical Department's direct income is received from two sources:

- AeMC charges of approximately £700,000 annually, which is lower than the cost of running the AeMC. This is income generated from initial assessment of Class 1 medical examinations and a variety of other medical services which AeMC provides, such as assessment of other medical examinations, and the running of specialist clinics; and
- AMS charges to AMEs of approximately £500,000 annually. These fees include AME approval charges and an indirect charge to licence holders for registering their medical certificate with the CAA.

17. Currently the excess cost of the CAA Medical Department is borne by Air Operator Certificate ("AOC") holders (essentially operators of commercial aircraft/airlines), Air Navigation Service Providers via their Aerodrome and Air Traffic variable charge and En Route Safety Regulation charges.

18. The CAA needs to ensure that the cost burden of the CAA Medical Department on charge payers is minimised. Additionally the CAA wishes to reduce the need to pass on any of the cost of the CAA Medical Department to charge payers other than those that are using that department. This consultation sets out options that the CAA has identified to achieve these aims and seeks stakeholders' views on them.

Regulator providing regulated services

19. The AeMC carries out a range of clinical services, all of which are regulated by the AMS. For example, one of the functions currently carried out by CAA is the issue of initial (i.e. first grant) medical certificates to pilots or ATCOs that require Class 1 Medical Certificates. A decision was made in 1972, when the CAA was established, that all initial Class 1 medical examinations and assessments would be undertaken centrally. Another of the CAA's functions, which is carried out by

AMS, is to issue and oversee the AeMC's approval to act as an AeMC and to remove that approval if necessary.

20. The CAA as competent authority is therefore responsible for regulating itself as an AeMC, which the CAA believes could theoretically give rise to potential conflicts. The CAA is aware that it is currently best practice to have a separation between the service provider and regulator.

21. The CAA wishes to seek views on any potential issue of the CAA acting as a service provider (i.e. its in-house AeMC) and regulator (i.e. its role in issuing and overseeing AeMC approvals).

Having a CAA Medical Department fit for the future

22. The CAA seeks views on the role that the CAA, via its Medical Department, should perform in the coming years to ensure that it is fit for the future. In this context, the CAA wishes to be in a strong position to influence and develop European and global aeromedical policy and practice.

The CAA Medical Department's overriding objectives

Safety Objective

23. The CAA Medical Department's safety objective is to minimise poor flight crew or ATCO performance caused by, or arising from, medical conditions and the risk of in-flight incapacitation arising from medical events.

24. The last large commercial fatal accident in the UK in which the medical condition of the pilot was a causal or contributory factor was the loss of a Trident at Heathrow in 1972. Deaths and incapacitations of commercial pilots continue to occur in-flight, with the primary mitigation being the presence of a co-pilot. 10% of general aviation accidents have a medical causal factor.

25. Approximately 4% of all commercial pilots have at least one episode of unfitness requiring time off flying during any one year period. A commercial pilot has on average a 0.5% risk of having an incapacitating event at some point during each year, which is defined as "experiencing symptoms that, if they had occurred in-flight, would have resulted in an inability to act as flight crew for at least 10 minutes"[1].

26. The CAA Medical Department's remit is to minimise the incapacitation risk. This contribution to aviation safety is achieved in two main ways: by ensuring aeromedical decisions are sound and within the acceptable limits of

[1] Evans S, Radcliffe S-A, The annual incapacitation rate of commercial pilots. Aviat Space Environ Med 2012; 83:42-9

incapacitation risk for the type of flying intended, and by training, approving and overseeing the practice of aeromedical examiners certificated by the UK.

Safety Management Practice

27. The CAA Medical Department's safety management practice involves data analysis and research to provide evidence for best aeromedical practice which is key to ensuring UK aviation personnel are subject to safe, reasonable and fair decisions.

What mandatory functions do the CAA Medical Department's business units carry out, and what non-mandatory functions are carried out?

Functions performed by AMS

28. The majority of current AMS activity is based on fulfilling mandatory functions.

Mandatory

29. As the competent and licensing authority of the UK, the CAA has certain mandatory functions, which are performed by the AMS.

30. Regarding Medical Certificates these are:

- appointing one or more medical assessors to undertake the task of determining the fitness of an applicant for the issue of a medical certificate when the case has been referred by an AME or AeMC[2]
- issuing or re-issuing a medical certificate if a case is referred to it by an AME or AeMC, or it has been identified that corrections to the information on a certificate are necessary[3]
- ensuring there is a process in place to assist AMEs and AeMCs in relation to any requests regarding their decisions on aero-medical fitness in contentious cases[4]
- ensuring there is a process for the review of borderline and contentious cases with independent medical advisers, experienced in the practice of aviation medicine[5].

2 ARA.MED.120 and 125

3 MED.A.040(f)

4 ARA.MED.315(b)

5 ARA.MED.325

31. Regarding Aero Medical Examiner Oversight these are:

- considering the limitation, suspension or revocation of an AME approval certificate[6]
- ensuring there is a process in place to review medical certificates issued by an AeMC, AME or General Medical Practitioner (GMP)[7]
- ensuring there is a process in place to review reports received from all AeMCs, AMEs or GMPs and inform them of any inconsistencies, mistakes or errors in the assessment process[8].

32. Regarding research and advice on aviation health matters these are:

- The AHU is responsible for researching and advising on matters that may impact on the health of passengers and flight and cabin crew in aircraft and considers current and future risks. The CAA is obliged to provide advice and support to the Secretary of State for Transport, although it has a range of options as to how to provide it.

Non-mandatory

33. In addition to the mandatory functions set out above, AMS engages in a range of other non-mandatory business activities, such as providing an advisory service to certificate holders and applicants, contributing to European and ICAO rulemaking and standardisation and providing and managing the AME online capability.

34. The CAA, through the AMS, also engages with and positively influences European Aviation Safety Agency (EASA) and other international organisations.

Functions performed by AeMC

Mandatory

35. No mandatory functions are performed by the CAA's AeMC.

Non-mandatory

36. The AeMC performs all initial medical examinations on professional aircrew and carries out some revalidations where these are not done by appropriately trained AMEs spread across the UK. 2,000 – 2,500 medical examinations are completed each year and this has remained relatively constant for the last 7 years.

37. In addition, medical practitioners in AeMC provide the services of specialists in cardiology, psychiatry, ophthalmology, neurology and other medical areas to

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6 ARA.MED.250

7 ARA.MED.255

8 ARA.MED.315(a)

undertake advanced tests and give consultant opinions on aircrew fitness to fly to the AMS. Approximately 950 – 1,100 investigations are undertaken annually.

Functions performed by the CAA's OH unit

Mandatory

38. The CAA is required to comply with relevant health and safety legislation and, as such, provides a minimum occupational health service to its employees. As with the AHU, the CAA has a range of options as to how to provide an appropriate service to its employees.

Non-mandatory

39. No non-mandatory functions are performed by the CAA's OH.

The CAA's current thinking

40. Since the middle of 2013, the CAA has undertaken detailed reviews to determine how it can meet its regulatory duties and how this can be achieved in a more efficient and sustainable way. The scope of these reviews has been to:

- Consider the function and responsibilities performed by the four different units within the CAA Medical Department
- Consider the future options for delivering the different functions, including ceasing to perform any of these functions, potential outsourcing or delegation of these functions, and provide associated recommendations
- Consider what the CAA believes are the activities that it needs to continue to perform to be a source of influence in the field of aviation medical policy
- Examine the requirements imposed by the legal framework and the opportunities available under that framework
- Consider the CAA Medical Department's costs and income, and the fact that it does not currently cover its costs of providing services through fee income.

41. Additionally, as part of this process, the CAA investigated the Medical Departments of other European NAAs and the roles private sector service providers could play in the future.

Core criteria for assessing options

42. The purpose of this document is to seek stakeholders' views on a range of issues. However, the CAA has identified core criteria which, subject to the CAA's consideration of the responses to this consultation, it considers should continue to shape the functions of the CAA Medical Department in the future. These are as follows:

1. The CAA Medical Department should retain the ability to perform to the highest possible standard, thereby continuing to contribute to high or increasing aviation safety standards. The CAA is conscious particularly of the need to retain expertise in order to:

   - **Influence policy**

     The CAA regards the ability of the CAA to influence international and European policymaking as essential because of the impact of aeromedical policy on the safety of the public and the activity of pilots, cabin crew and ATCOs. There is a strong desire to ensure the CAA Medical Department is fit for purpose to help the CAA take an effective role in Europe in the years ahead. It would be valuable for the UK to take an effective role and to be an influential National Aviation Authority ("NAA"). To this end, the CAA would want and should have an outward-looking Medical Department capable of engaging international colleagues so as to leverage our knowledge and effective position. The CAA is minded, as part of this process, to seek an international healthcare company with experience of operating in a variety of markets which can seek opportunities to share the CAA's expertise more widely.

     Perform regulatory duties: regarding medical certificates and AME oversight

     There are a vast array of medical conditions that can occur, and which may be affected by the interactions between different medical conditions affecting the same individual, and the different characteristics of an individual. It is very common for there to be no rule which fits exactly and a decision has to be made on acceptability, which is based on likely risk of incapacitation and functional fitness or ability to perform a task and the intended type of flying (or other) task. Potential mitigating factors also have to be taken into account. So these decisions have to be made in the knowledge of these factors and previous similar decisions and experience of similar conditions, often also using the most up to date literature, to ensure the risk assessment is not affected by any recent changes in knowledge. The CAA needs appropriately skilled and sufficient medical assessors to complete these tasks.

     Additionally, a core duty of the regulator is to provide a certification and oversight system for AMEs. This includes audits of performance of medical assessments and casework by AMEs and audit visits to AMEs in their facilities. On this, the AMS is subject to EASA oversight for its compliance.

- **Achieve Financial sustainability**

  The CAA wishes to ensure that its running costs are kept as low as reasonably possible. In this context, the CAA believes that it is appropriate for users of services to pay directly where possible rather than for costs to be built into other charges. To ensure that such cost-effectiveness is sustainable in the long term, the CAA wants to build a structure which has a lower cost base, is highly capable and focused on the CAA's core criteria.

Summary of the issues on which stakeholders' views are sought

43. In order to ensure that the core criteria are met, the CAA is minded to consider either ceasing to perform non-mandatory functions or outsourcing performance of some or all of these functions. The non-mandatory functions are those carried out by AeMC and AMS (support functions only). The CAA will continue to provide a minimum occupational health service to its employees.

44. At this stage, and pending any decisions being made on these matters, the CAA has not made any decisions as to any employment issues generally, and it does not have any information on the potential effects of any future structure, or the outcome of the review, on the number of posts. Equally the CAA has no information at this time of the effect that the potential outcomes may have on charges paid by charge payers.

Options on which views and opinions are sought

Option 1

Maintain the current structure, activities and funding model of the CAA Medical Department

45. The advantage of this option is that it would deliver consistency of service, as the functions of the CAA Medical Department will continue as before without any transformation activity.

46. However, this option will continue the current situation whereby the CAA Medical Department does not cover its costs through income generated by the fees that it charges. In the CAA's view, under this option, it is likely that costs will continue to grow unconstrained, but that despite this, the CAA would not have the skills to avail future opportunities for growth and to leverage sources of revenue by sharing our expertise with other NAAs.

47. Further, this option will perpetuate the situation in which the CAA as competent authority is responsible for regulating its own service provider (the in-house AeMC) and would not contribute to the CAA's ambition to increase its ability to influence European and worldwide aeromedical policy.

Option 2

Cease all non-mandatory functions (i.e. those carried on by AeMC and AMS support functions).

48. With regard to AeMC:

It is the CAA's current view that this will have the advantage of removing the situation by which the CAA as competent authority is responsible for regulating its own service provider. The CAA notes, however, that there are no AeMCs in the private sector that have a similar size and scope. Without a lead in time to the implementation of this option, therefore, there would be a gap in provision of this service in the UK.

49. With regard to AMS support functions:

It is the CAA's current view that it is likely this will have the advantage of reducing costs. It would be possible for the CAA to continue to perform certain AMS support functions in-house, but only to the extent necessary in order to perform mandatory AMS functions.

Option 3

Outsource all non-mandatory functions (i.e. those carried out by AeMC and AMS Support services)

50. With regard to AeMC:

There are different outsourcing models that could be considered which have different impacts on income and net costs. However it is the CAA's current view that this option would reduce overall costs. This option would remove the conflict by which the CAA as competent authority is responsible for regulating its own service provider. Furthermore, it is the CAA's current view that outsourcing AeMC's functions would create market conditions in which alternative suppliers of these services could compete, which may contribute to a more cost efficient provision of this service for UK licence holders.

51. With regard to AMS support services:

It is the CAA's current view that outsourced, these services could be performed more efficiently, thereby reducing overall costs to the CAA. In addition it is the CAA's view that an external service provider could contribute skills that may generate future business opportunities that may enable CAA expertise to provide income to the CAA. It would also contribute to the CAA's ambition to increase its ability to influence European and worldwide aeromedical policy. The CAA may be able to contract with an outsource partner which has the skills and ability to invest in long-term opportunities for growth and to leverage sources of revenue by sharing our expertise with other NAAs.

52. The CAA is aware that where any function is outsourced the provisions of the Transfer of Undertakings (Protection of Employment) Regulations 1981 need to be considered, and the process is likely to be disruptive to staff. If any proposals are developed as a consequence of this consultation, the CAA would ensure that the appropriate discussions take place.

Consultation questions

53. The CAA is seeking the views of stakeholders and welcomes comments on any of the information and options contained in this consultation.

54. It would be helpful if stakeholders could identify and comment on the effects on users of services and providers of services. When providing a response the CAA would be particularly interested to receive stakeholders' views on the following points.

1. What are your views on the proposition that the CAA ceases to be a service provider, via its AeMC, that is regulated by the CAA as a competent authority under the EASA rules?
2. What are your views on the current situation by which the costs of the functions performed by the CAA Medical Department exceed its income?
3. What are your views on the manner in which the costs referred to in Question 2 are currently distributed? How they should be distributed in the future?
4. Do you agree that the CAA, which is funded by industry, should continue to retain and develop the expertise necessary to take an effective role in developing aeromedical policy and practice in the years ahead?
5. What are your views on each of the options considered in this consultation?
6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?
   - What are your reasons for this view?
   - Why have you rejected the other options?
7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?
8. In your view, what risks should the CAA seek to manage and pay special attention to as part of the implementation of any option for its services?