Civil Aviation Authority

The future structure of the CAA's Medical Department – Response to views raised in consultation

CAP 1276

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Background

The purpose of this document is to respond to the key themes that were raised by stakeholders in the public consultation undertaken between 16 October and 15 December 2014.

The CAA had asked stakeholders for their views on a range of issues concerning the future of the CAA's Medical Department. There were three primary reasons why the CAA consulted on the future structure of the CAA Medical Department. These relate to ensuring the Medical Department is fit for purpose in the future, cost and the issue of a regulator providing regulated services (full details were supplied in the consultation document).

The CAA explained in the consultation document that its core criteria for assessing options for the future were the following issues:

- To influence policy
- To perform regulatory duties: regarding medical certificates and Aviation Medical Examiner (AME) oversight
- To achieve financial sustainability

The CAA further explained that in order to ensure that the core criteria are met in any future option, it is minded to consider, as alternatives to the present approach, either ceasing to perform non-mandatory functions or outsourcing performance of some of these functions. Details of the three options that the CAA has identified were then explained, and in summary they are:

- Maintain the current structure, activities and funding model of the CAA Medical Department
- Cease all non-mandatory functions (i.e. those carried on by AeMC and AMS support functions).
- Outsource all non-mandatory functions (i.e. those carried out by AeMC and AMS Support services)

The questions asked of stakeholders were:

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?

Responses to consultation

In total the CAA received 40 responses to consultation. These are all published with this paper. The CAA was pleased that this included a range of opinions from different stakeholders including airlines, individual pilots, unions, professional associations, doctors who perform regulated services, specialists who perform services to the CAA under contract and members of the public.

These responses have been fully reviewed within the CAA. The CAA's key concern in reviewing the responses is to ensure that it considered risks to public safety and whether there were concerns raised which had not been properly considered before.

In responding to the many points raised, the CAA has decided to group the main issues it considers have been raised by the responses and to respond to the themes that it identified as being highlighted by the responses. The CAA has published the responses in full so that interested parties can review the full details of the responses received.

In considering our response, the CAA's primary concern is its duty as a regulator and the statutory responsibilities to regulate and to provide oversight of medical services. At present the CAA also engages in other activities, for example providing an AeMC, engaging in research and providing resource to influence policy decisions. The CAA believes that any services beyond core regulatory duties need to be justifiable economically and need to relate to the core duties and be supportive of them.

It would be helpful also to point out, as there appears from some consultation responses to be confusion, that the CAA is independent of Government. The CAA cannot therefore consider any suggestions of raising taxes as a means of funding functions within the CAA.

CAA response to identified themes raised by stakeholders

Cost and benefits related to possible usage of options 2 or 3 set out in the consultation document

Many of the respondents raised the issue of cost with suggestions of how to make the Medical Department more efficient, questions about the detail of our costs and suggestions of how to raise more revenue. As a result of these questions the CAA decided to issue, during the consultation, additional information about the breakdown of our costs which showed that most costs sit within the AMS though the AeMC is also far from breaking even (see 'Medical Department Costs and Revenue' slide, published as part of the Consultation). The CAA welcomes the suggestions about how to raise more revenue and is including some of these in assessing its options going forward. The CAA agrees with the principle which has been expressed that higher charges could be applied in some

cases. However, these would need to be proportionate and applied in a reasonable way. The CAA does agree though that ensuring fair charges may help to some degree to close the financial gap that it faces.

The CAA realises that cost and value are sensitive issues. It does not believe in putting a price on public safety, however the CAA is obliged to operate in a proportionate way and to use its resources on its key goal: public safety. We do not accept that savings cannot be found from a £4.3M budget or that things could not be done in a more efficient way, as was set out in Options 2 and 3 of the consultation document.

With respect to the detail of the finances that were provided in the consultation document, the CAA believes what has been published is more than adequate for the purpose of stakeholders' understanding the challenges it faces.

The CAA believes that the Medical Department could become more efficient. It believes that there is a good case either to slim it down to its core function or, while keeping a core capability in place, to outsource some activity to an organisation which can demonstrate efficiency whilst delivering high standards (see Consultation Document, p14). We note that other European countries succeed in meeting their duties with smaller teams and have not found there to be any evidence of lower standards.

Separation of oversight and service delivery functions

The CAA recognises that there is some concern among respondents about whether it is indeed necessary to separate a service delivery function from the body that oversees and regulates it. Firstly it would like to say that there is no suggestion being made that there has been any conflict of interest in respect of the AeMC. The CAA's concern is about the principle of having a separation of functions.

In this context, whatever processes are put in place to avoid conflicts of interest, the fact remains that where there is no such separation of functions, organisational integration will always occur at some level and that this is not consistent with the complete independence of a regulator. The CAA believes that the principle of separation outweighs any benefits that have been suggested from co-location and integration.

Whilst the integrity and professionalism of the CAA's own Medical Department staff is without question, the CAA needs to ensure that there is a structure in place that avoids even the potential for a conflict of interest to exist.

Being an influencer on the global stage – is this compatible with a smaller function?

Concerns were raised in the responses about the ability of the Medical Department to influence global aviation issues if it is reduced in size, and that it will lose the expertise to do so. The CAA thinks it is valuable that this concern has been raised as it is legitimate and it is something that, whatever our future approach, we intend to maintain as a key priority.

The CAA's view, however, is that size is in no way the only determinant of expertise and the ability to influence. It is about having the right people, with the right knowledge, doing the right things. Far from diminishing our ability to do this, the CAA's future objective is to enhance it. In being more efficient the CAA aims to ensure that its highly capable senior leaders have more focus on core responsibilities such as global influence and policy. In the event that the CAA makes a decision to outsource, the thinking in part is to remove the more mundane functions, reduce the management burden and free up capability whilst bringing in new external support skills. What the CAA will not entertain is the loss of its ability to influence globally in implementing any of the three options but the CAA believes that this can be achieved even with a smaller function.

Private sector capability and options for competition

Concerns have been expressed by respondents around contracting with private bodies, whether a market exists for these services and indeed if there is a competitive market. These are valid concerns and the CAA certainly recognises that it is by no means always the right answer to choose to outsource. Indeed, it is very clear from all three options suggested by CAA in the consultation that the CAA is committed to ensuring that the primary duties it exercises and the core capability will remain in-house. In the event that the CAA were to use the market, it would only be to support this.

With respect to private sector capability the CAA needs to be clear that although Aviation Medicine is its core function, many of the activities to support this are undertaken by a wide range of companies, whether it is in back office support, testing and screening, administration or indeed commercial advice. During the review process the CAA undertook market engagement activity to see if there was either interest and/or capability in providing some of these services. In the course of this review process, the CAA's Medical Department presented a very detailed level of information of what is done. The response in terms of interest in providing such services was very positive, especially in the context of the AeMC but also with regard to supporting the AMS. This was of course only an initial engagement and should the CAA decide to pursue this further it would involve more detailed dialogue about what the market can deliver. Even in the event that this were to lead to a procurement process, the CAA is committed to the principle that it would only sign a contract where it improved its capability and lowered costs.

Finally, it should be noted that some of what the Medical Department does is already delivered by outsourced contracts, whether it is in terms of office support or indeed expert medical advice. Therefore the CAA does not accept that it is impossible to find expertise in the market or to integrate it with other sources of service provision.

Option to set up non-profit function or shift to CAA International (CAAi)

Among the many suggestions were other ways to handle the AeMC without either shutting it down or outsourcing it.

An idea was proposed about shifting the AeMC within the CAA to CAAi and allowing it to be run as a commercial entity. This has been given serious thought as it is an interesting concept. However, in removing the AeMC from its position in the Medical Department and, in effect, shifting it across the building, the CAA is not convinced that this would really look like much of a change from an external perspective as CAAi is a wholly owned subsidiary of CAA. This would also mean that it fails to achieve the goal of separating the regulated activity from the CAA as a regulator.

An idea was also expressed about the CAA turning the AeMC into a non-profit function. Again, this is an interesting concept. However, at present the AeMC is far from profitable (see 'Medical Department Costs and Revenue' slide, published as part of the Consultation) and would need significant reform in order to become so. The CAA is also not clear where funding would come from to fund a non-profit entity. The CAA also would not wish to be responsible for this non-profit within it (for similar reasons to not having it within CAAi) so it is hard to see it being a viable solution.

Meeting statutory oversight functions under changed systems

Questions were raised about the ability of the Medical Department to meet its statutory functions under each of the options presented in the consultation document. For clarity, there is no suggestion that this is currently not being done. Indeed, much of the CAA's interest in change comes from its concern to build a structure which is sustainable and cost effective so it can continue to do this well into the future.

The Medical Department has a set of statutory duties (set out in the consultation document) which it is required to perform. Under the European regulations it has a considerable degree of freedom in how it delivers these duties. It is not a requirement that these will all be delivered in-house and many of the European states have widely differing systems which use resource in different ways.

The CAA will continue to perform all mandatory functions at all times. If we initiate a change to the current system it will be with a view to doing this better. If activities are to be ceased then they will be non-mandatory functions.

Defining mandatory from non-mandatory activity and ensuring relevant expertise is retained

Questions were raised about the definition of mandatory and non-mandatory functions. These were explained in the original consultation document but we do understand and accept that the CAA has in place processes to support good decision making which are not strictly mandatory under the various regulations.

In all of the options open to the CAA, it will keep the expertise that it needs in order to deliver its statutory duties. As part of this review process the CAA has exhaustively examined what its staff do, how they do it and why they do it. This has been a big imposition on the CAA's staff but it has been undertaken because the CAA needs to know which actions are mandatory for each task. The CAA is therefore in a position to determine which elements are mandatory and which are not (see Consultation Document, Pages 8-10).

In the longer term the CAA will always have a challenge in ensuring it has the right set of skills to perform the duties required. The CAA believes that it can achieve this by focusing on its core duties.

Maintaining safety and quality

Public safety is the CAA's primary duty. There are many ways it delivers on this and much of this will continue to be done in the future, whatever the organisational structure.

In terms of quality, the CAA believes this can still be maintained with any initiated change in how the Medical Department is set up. For instance, the CAA currently provides valuable training to AMEs, and this will not change in the future. How this is delivered though is a matter for the CAA to consider and seek to improve year on year. Likewise, within the CAA's in-house AeMC there is access to expert specialist advice (delivered through contractors) that is drawn on to deal with complex medical cases. It is important that the CAA has access to such advice but that does not mean that the CAA requires an in-house AeMC to access it. Indeed, at present, the specialists are contracted in. In the event that the CAA changes how the AeMC service is delivered, or alternatively closes it, it needs to continue to have access to such capability. The CAA is aware that expert advice may be accessed in this way by smaller EU states, but not in the larger states, yet all are subject to the same European regulations.

One of the ways the CAA believes it can assure safety and quality in the long term is by making the Medical Department financially sustainable and by ensuring that it is focussed on core regulatory duties and influencing policy in Europe and internationally.

Who should pay for the medical department?

The CAA has benefited from the thinking that has come in during the consultation about who should pay for the Medical Department and what it does.

Clearly there have been a wide range of views from respondents and obviously this tends to be influenced by the stakeholder's personal position, which is no bad thing as it helps us to consider a range of perspectives.

Having considered all the views, the CAA takes from this that overall, the Medical Department, like the rest of the CAA, needs to be proportionate in what it spends, how it charges and in who it charges. At present the CAA needs to consider whether this is the case. By reducing the total cost and by ceasing activities that are not essential, the CAA believes it will be possible to lower the total burden to industry. However, the Medical Department is and will remain vital to what the CAA does and in that context it will seek to implement some of the ideas that have been received during this consultation so as to share the cost more fairly.

Upgrading medical department IT

The CAA received some valuable thoughts about the Medical Department's IT system. The CAA is aware that this is an issue and it is under review. Obviously much will depend on how the CAA structures the Medical Department in future, but the CAA wanted to acknowledge this issue and to give assurance that this is the key to ensuring an efficient future Medical Department.

Whether the CAA can benefit from selling their skills to other NAAs

Some responses raised the issue of whether the CAA can actually sell services to other NAAs, as is envisaged as a possibility in Option 3.

This is a very valid question. The CAA has given this thought and investigated it during the review process. The CAA believes there is evidence of other countries doing this successfully, and equally there is evidence that the Medical Department has abilities that could be shared in a manner that could legitimately involve charging.

The CAA wants its Medical Department to be as well-funded as possible in the future and thinks this is an opportunity to take this forward. The CAA specifically notes that all European states have to comply with the same European regulations. Yet some of these European Authorities are very small and as a consequence it is more difficult to develop the skills needed to do this. Our expertise puts the CAA in a strong position from which we may be able to derive profit from our knowledge.

This concept is not the most important to the CAA. However, if the CAA are considering change then it is worth developing this as a concept as it can contribute to long term sustainability.

Conclusion

The CAA has reflected carefully on the issues raised and the implications for the future of our Medical Department. It recognises that in implementing any changes the CAA needs to be mindful of retaining expertise and access to specialist support.

The CAA will focus on any risks to the public of any change it decides to make. The CAA acknowledges that where it ceases to undertake activity which is valuable to stakeholders this may result in industry or individuals having to bear costs. However, this is necessarily different to a risk to public safety.

Having reflected in detail on the responses received to the consultation, the CAA does not believe that there are additional risks to public safety from undertaking either Option 2 or Option 3 (or continuing under Option 1). Should the CAA undertake either, it would be mindful of the need to resource the internal capability adequately and, if outsourcing, to ensure a robust process of transferring capability and ensuring good governance within an outsourced provider. The CAA must stress that in all three options it will retain internal resource to take the necessary regulatory decisions within CAA.

The CAA also has a duty to be efficient and to spend proportionately so long as it does not compromise safety. Having now reviewed over the last 18 months and undertaken the consultation, the CAA is of the opinion that it will be possible to resource the Medical Department in a more efficient manner, focussed on its core duties, and good for services users and sustainable in the longer term. The CAA continues to believe that it is appropriate and best practice to separate regulated services from those who regulate them and to this end it intends to proceed with investigating options to outsource the AeMC. With respect to the AMS and AHU, it will continue to ensure that some resource is retained within the CAA. However, the CAA is minded to think that greater efficiency may be achieved by outsourcing some of its activities. The CAA will only do this if it is convinced that such an outsourcing provides value for money, and represents an improvement on current capability. The CAA is not, therefore, in a position to offer a view at this time as to what the final option will be, but it felt that it would appropriate to advise of its current thinking at this stage.

Responses to consultation on the future structure of the CAA's Medical Department

In total the CAA received 39 responses to consultation. These responses are reproduced here. The CAA was pleased that this included a range of opinions from different stakeholders including airlines, individual pilots, unions, professional associations, doctors who perform regulated services, specialists who perform services to the CAA under contract and members of the public.

Comments were received from:

- 5 Pilots
- 23 Doctors and/or Medical Groups
- BALPA
- British Airways
- The British Balloon and Airship Club (BBAC)
- The British Helicopter Association (BHA)
- British Gliding Association
- British Microlight Aircraft Association
- Flybe
- The Honourable Company of Air Pilots
- The PPU
- Prospect
- PCS (Public and Commercial Services Union) and Prospect Trade Unions
- Virgin Atlantic Airways Ltd

The CAA thanks contributors for their comments and for the care and attention that they afforded this consultation.

Unions and associations

No.	Comments
1	XXXX was established as a Guild in 1929 to ensure that pilots and navigators of the (then) fledgling aviation industry were accepted and regarded as professionals. From the beginning, the Guild was modelled on the lines of the City of London Livery Companies, which were originally established to protect the interests and standards of those involved in their respective trades or professions. In 1956 the Guild was formally recognised as a Livery Company and in 2014 it was granted a Royal Charter in the name of XXXX. Today, XXXX's principal activities are centred on sponsoring and encouraging action and activities designed to ensure that aircraft are piloted and navigated safely by individuals who are highly competent, self-reliant, dependable and respected. XXXX fosters the sound education and training of air pilots from the initial training of the young pilot to the specialist training of the more mature. Through charitable activities, education and training, technical committee work, aircrew aptitude testing, scholarships and sponsorship, advice and recognition of the achievements of fellow aviators world-wide, XXXX keeps itself at the forefront of the aviation world. XXXX is honoured to have this opportunity to respond to the Consultation on the Future Structure of the CAA's Medical Department CAP 1214. This response has been prepared following debate in our Education and Training Committee and our Technical and Air Safety Committee and consultation with our members who are practicing Aeromedical Examiners. Our response takes the form of general comments, followed by answers to the specific questions posed at paragraph 53 of CAP1214. For completeness, those questions are also repeated below with our comments. **General comments** The XXXX believe that proposals to cease or to outsource the non-mandatory parts of the current CAA aeromedical capabilities: ▪ Would diminish unacceptably the UK's aviation medicine competency, research capability and global reputation for excellence and leadership. ▪ Would over time diminish the robust and cohesive implementation and maintenance of pilot medical status oversight, leading to an inevitable reduction in AME standards and knowledge. That would impact adversely aviation safety and the safety of air passengers and the over-flown population. ▪ Will have an adverse impact on flight safety. Over the last 10-20 years, there has been a significant change in the pilot/AME relationship. Historically, pilots would avoid an AME at all costs because any medical variance seemed to result in automatic suspension of flight duties; indeed, pilots preferred not to report medical problems rather than seek qualified assistance. Under CAA Medical Department leadership, that relationship has changed to a supportive one and UK AME's are now seen as part of a pilot's support network rather than a threat to

No.	Comments
	continued employment. That transition has been driven in part by CAA Medical Department initiatives and research enabling insulin-dependent pilots to continue flying and the rationalization of colour vision standards. ▪ Threatens the current approach of AMEs in facilitating pilots to return to flying duties will be threatened whenever an outsourced organisation reviews its risks and potential liabilities. ▪ Will have an adverse impact on the UK economy not addressed within CAP1214; the cost of training a commercial pilot who becomes unable to fly burdens the UK economy through increased operator costs feed through to the cost of travel and loss of tax income as well as disadvantaging the individual and his/her family. **Specific questions from CAP 1214** 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?** As long as human pilots are part of the aviation safety chain, it is essential that their fitness to operate is monitored and supported by an expert community without fear of or bias from commercial pressures. A central research capability remains essential to sustain and improve aeromedical knowledge and that needs to be linked to those who implement medical standards in the pilot population. There is no evidence that these aspects would be sustained through dismantling parts of its medical organisation; history shows that where such areas have been dismantled in other sectors (e.g. defence research establishments) the UK's ability to remain at the forefront atrophies. The XXXX see no conflict in the CAA's regulation of its own AeMC that, notwithstanding EASA viewpoint, reflects established and effective practice in other aviation areas. 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?** This question assumes that the CAA Medical Department has to be financially self-sufficient. This ignores the CAA global activity as a leader in aeromedical matters and expertise. This ignores the beneficial impact that services provided by and through that department have in the continued employment of medically challenged individuals. Alternative options do not offer the same support and would exist in a different commercial environment where XXXX believes pilots would receive less support and be less likely to retain the appropriate medical certificates necessary for continued employment. Losing those individuals from the pilot profession would then have two adverse effects:

No.	Comments
	▪ First, airlines would face an increased recruitment and training cost in replacing pilots lost through failure of a medical. ▪ Second, the experience levels within airlines would become diluted as fresh trainees replace those more experienced pilots. ▪ Loss of experienced individuals from the professional piloting community through natural demographics already poses a safety risk. Increased wastage of experienced pilots exacerbates that risk, especially when airline expansion suggests there will be a global shortage of pilots. Furthermore, the financial evidence in CAP 1214 is not compelling because it lacks supporting detail. Even if the headline numbers are correct, it is impossible to construct a view of the possible corrective actions or likely benefits or disbenefits of the alternatives proposed. One of our members has asked for a detailed financial breakdown to assist with this analysis but the information provided was little more than already contained in CAP1214. The Company finds it difficult to support embarking on a major change programme on the grounds of income/cost imbalance (or to make properly informed decisions on the Options proposed) without a full understanding of the current financial status. The Company is also aware that where medical functions have been outsourced elsewhere, actual costs have increased as much as eight-fold while the level of service, including the time that qualified medical expertise is available to staff, has decreased. **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?** The service provided by the CAA Medical Department benefits the (professional and leisure) aviation communities, the aviation industries and the general public whether as fare paying passengers or as part of the over-flown population. All beneficiaries should play a part in funding the Department. More broadly, the UK's knowledge, research and global credibility in the aeromedical sector benefits UK industry and UK government's standing with aviation. The fiscal benefits arising from this would be difficult to quantify but should be reflected in any funding arrangement. **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?** For the reasons already mentioned in answer to questions 1 and 2, XXXX sees no viable alternative to CAA retaining and developing its aeromedical expertise. It does not believe the alternative proposals safeguard either the sustainment of necessary pilot aeromedical standards or satisfy individual, company or UK economic needs. **5. What are your views on each of the options considered in this consultation?** For reasons already stated, based on the information provided within CAP1214 XXXX believe only Option 1 is viable and safe. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?**

No.	Comments
	Option 1. **What are your reasons for this view?** The financial case for Options 2 and 3 has not been made, nor have the risks identified in answer to questions 1 and 2 been addressed. **Why have you rejected the other options?** As stated in answers to questions 1-4. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** CAA should review how it makes aeromedical information available outside the UK and whether the costs of that service could be recovered from the recipients. CAA should review whether Medical Department costs should be borne solely by the aviation communities/industries or whether a general taxation income would also be appropriate. **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?** CAA must address flight safety and the safety of air passengers and the overflown public through ensuring that only pilots of appropriate medical fitness are permitted to fly; this applies similarly to Un-manned Air System operators and to Air Traffic Controllers. CAA must ensure that unnecessary safety, personal and economic (personal, industry, UK) damage does not occur through the unnecessary loss of pilots from professional or leisure flying due to medical conditions that a more robust, informed and up to date aeromedical community might otherwise have kept flying and in employment. This concept applies equally to Un-manned Air System operators and to Air Traffic Controllers and is further expanded in bullet points within the answer to question 2.
2	XXXX has made enquiry of its members in preparation for our response to this consultation. The enquiry was made through an article in our XXXX magazine which invited comment on the consultation. At this time the indications are that we should conduct a wider more detailed survey of our members in order to provide a representative response. We understand that this survey, which may take some 2 months to complete, may not be ready in time to meet the CAA's time scales but we hope that nonetheless our comments when provided will be of value.
3	**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?** Aviation Medicine is an integral part of flight safety, with the human forming an essential component of the overall flight system. Regulation of the AeMC by the competent authority has ensured continuation on the UK of the internationally recognised highest standards of

No.	Comments
	human aspects of flight safety. This option would have a devastating effect upon the support that is provided to Aeromedical Examiners in the UK, and the leadership and influence of the UK CAA in aeromedical matters both in Europe and the rest of the world. It would send a very dangerous message that the CAA is more interested in saving money than it is in flight safety. It is difficult to understand how the CAA would meet its statutory oversight functions. The CAA benefits from a 'critical mass' of medical expertise as a result of its service provider role and statutory regulation role. There is mutual benefit from the dual provision and co-location, and if there is any evidence of the theoretical or perceived risks of inappropriate collusion, examples should be provided. **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?** The dearth of information provided in the consultation document makes it difficult to understand or support this statement. A full financial analysis would need to be provided to ensure that only costs that are exclusively incurred by the Medical Department have been counted. Specifically, the lack of any estimate in the document of the cost of the UK CAA meeting its statutory obligation, make the whole process a flawed one. We believe that, on this point at least, any outcome, other than the status quo, is open to legal challenge. **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?** In principle those who receive or benefit from a service should incur costs. Whilst it may be simple to identify those who receive a service, the concept of those who benefit is more difficult. The CAA Medical Department makes a valuable contribution to global flight safety through its European and worldwide reputation. It contributes to the knowledge base of aerospace medicine in ways that are difficult to quantify in financial terms. The importance of influence is acknowledged in the document but no attempt is made to ascribe a financial value to it. On these grounds it is reasonable that there is an element of general financial support from the aviation industry as they, and the travelling public are beneficiaries. Significant taxes are levied upon air passengers, and in view of the large passenger numbers it would require only an insignificant increase to resolve the perceived financial shortfall for medical services. **4. Do you agree that the CAA, which is funded by industry, should continue to retain and develop the expertise necessary to take an**

No.	Comments
	effective role in developing aeromedical policy and practice in the years ahead? This is essential. The CAA medical department has historically been recognised as leading pragmatic aeromedical opinion, particularly in Europe. It supports evidence based decisions, and actively contributes to the evidence base. Flight safety has benefited from evolution of standards that have ensured the continuing certification of many experience licence holders. This stance does not always make friends in some member states, some of whom are more comfortable with a less flexible, entirely rules-based approach, often to the disadvantage of the individual pilot or controller. Without this influence the balance would tip in this direction very rapidly. **5. What are your views on each of the options considered in this consultation?** It appears that the document is biased towards option three, as this is the only option that it is considered will balance the budget. It is very hard to understand how an outsourced private provider, with a need to make profits, could reduce costs. An outsourced private provider would have no interest or incentive in leading the continuing evolution of licence medical standards, for the benefit of industry. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** The CAA should prefer option one. **What are your reasons for this view?** This would maintain the CAA position as a leader in aeromedical matters in Europe and the world. The CAA needs to explain the statement in 47 that this would not contribute to influence. The reality is that option 3, outsourcing, would reduce its influence, as reputations built up over years if not decades, would be difficult to replicate by a private provider. At best, such a reputation and influence would take many years to be re-established. **Why have you rejected the other options?** Option 2: Ceasing all non-mandatory functions would destroy the UK CAA reputation, bringing the UK to the level of other member states who do not have the rich heritage of aerospace medical expertise that we, as a country, have invested in, and built up, over decades for the benefit of flight safety. AMEs have vast experience and the highest ethical standards; they care passionately about the quality of their work in maintaining aircrew health and flight safety. It is likely that many AMEs would feel obliged to withdraw from the participating in a service that they might perceive to have lost its moral compass and sacrificed its ethical standards.

No.	Comments
	Option 3: This option is likely to cause disruption in the short and medium term, and loss of reputation and influence in the medium to long term. It can be assumed that this would be the desired option of EASA; it meets their flawed perception of the desirability of the separation of functions, which fail to acknowledge that ethical professionals who are well aware of the boundaries of their different roles provide the services. Certain other member states will applaud the change, as there will be a loss of influence and leadership from which the UK CAA may never recover. Aeromedical expertise in the UK is in short supply, particularly at a senior level. It is unclear where the CAA believes it will find sufficient expertise, of appropriate quality, in an outsourced provider. Change should not be driven by the envy of others. We believe that the CAA is exhibiting the classic trait of knowing the cost of everything but the value of nothing. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** The CAA should maintain its current pattern of provision. It should celebrate the high quality and global reputation of its medical services, and not apologise for them. It should seek to maintain its level of investment in the service on the grounds that it is of benefit to overall flight safety. The CAA should consider the revenue raising opportunities that could arise from appropriate marketing of various policies and procedure pioneered by the medical department. For example the comprehensive guidance material produced in response to EASA Part Med is freely available to other member states via the website. This is inappropriate, and should be charged for. **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?** The CAA should pay attention to the rights and welfare in individual staff members if Options 2 or 3 are pursued. Morale is already at rock bottom, and this could have adverse effects of efficiency and consistency, particularly if there is a long period of uncertainty. The CAA must be mindful of the reputational risk that could arise from the loss of the current medical expertise. The XXX is particularly concerned about the real loss of support to AMEs in complex medical cases. This could result in pilots being declared unfit because of lack of adequate decision-making support from the CAA medical services, which in addition to being difficult for an individual pilot, is likely to adverse consequences for the industry.
4	**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?** Aviation Medicine is an integral part of flight safety, with the human forming an essential component of the overall flight system. Regulation of the

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	AeMC by the competent authority has ensured continuation in the UK of the internationally recognised highest standards of human aspects of flight safety. This option would have a devastating effect upon the support that is provided to Aeromedical Examiners in the UK, and the leadership and influence of the UK CAA in aeromedical matters both in Europe and the rest of the world. It would send a very dangerous message that the CAA is more interested in saving money, than it is in flight safety. It is difficult to understand how the CAA would meet its statutory oversight functions. The CAA benefits from a 'critical mass' of medical expertise as a result of its service provider role and statutory regulatory role. There is mutual benefit from the dual provision and co-location, and if there is any evidence of the theoretical or perceived risks of inappropriate collusion, examples should be provided. **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?** The paucity of information provided in the consultation document makes it difficult to understand or support this statement. A full financial analysis would need to be provided to ensure that only costs which are exclusively incurred by the Medical Department have been counted. Specifically, the lack of any estimate in the document of the cost of the UK CAA meeting its statutory obligations, make the whole process a flawed one. We believe that, on this point at least, any outcome, other than the status quo, is open to legal challenge. **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?** In principle costs should be incurred by those who receive or benefit from a service. Whilst it may be simple to identify those who receive a service, the concept of those who benefit is more difficult. The CAA medical department makes a valuable contribution to global flight safety through its European and worldwide reputation. It contributes to the knowledge base of aerospace medicine in ways that are difficult to quantify in financial terms. The importance of influence is acknowledged in the document but no attempt is made to ascribe a financial value to it. On these grounds it is reasonable that there is an element of general financial support from the aviation industry as they, and the travelling public are beneficiaries. Significant taxes are levied upon air passengers, and in view of the large passenger numbers it would require only an insignificant increase to resolve the perceived financial shortfall for medical services. **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?** This is essential. The CAA medical department has historically been recognised as leading pragmatic aeromedical opinion, particularly in Europe. It supports evidence based decisions, and actively contributes to the evidence base. Flight safety has benefited from evolution of

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	standards which have ensured the continuing certification of many experienced licence holders. This stance does not always make friends in some member states, some of whom are more comfortable with a less flexible, entirely rules-based approach, often to the disadvantage of the individual pilot or controller. Without this influence the balance would tip in this direction very rapidly. **5. What are your views on each of the options considered in this consultation?** It appears that the document is biased towards option three, as this is the only option that it is considered will balance the budget. It is very hard to understand how an outsourced private provider, with a need to make profits, could reduce costs. An outsourced private provider would have no interest or incentive in leading the continuing evolution of licence medical standards, for the benefit of the industry. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** The CAA should prefer option one. **What are your reasons for this view?** This would maintain the CAA position as a leader in aeromedical matters in Europe and the world. The CAA needs to explain the statement in 47 that this would not contribute to influence. The reality is that option 3, outsourcing, would reduce its influence, as reputations built up over years if not decades, would be difficult to replicate by a private provider. At best, such a reputation and influence would take many years to be re-established. **Why have you rejected the other options?** Option 2, ceasing all non-mandatory functions would destroy the UK CAA reputation, bringing the UK to the level of other member states who do not have the rich heritage of aerospace medical expertise that we, as a country, have invested in, and built up, over decades for the benefit of flight safety. AMEs have vast experience and the highest ethical standards; they care passionately about the quality of their work in maintaining aircrew health and flight safety. It is likely that many AMEs would feel obliged to withdraw from participating in a service that they might perceive to have lost its moral compass and sacrificed its ethical standards. Option 3. This option is likely to cause disruption in the short and medium term, and loss of reputation and influence in the medium to long term. It can be assumed that this would be the desired option of EASA; it meets their flawed perception of the desirability of the separation of functions, which fail to acknowledge that the services are provided by ethical professionals who are well aware of the boundaries of their different roles. Certain other member states will applaud the change, as there will be a loss of influence and leadership from which the UK CAA may never recover. Aeromedical expertise in the UK is in short supply, particularly at senior level. It is unclear where the CAA believe it will find sufficient expertise,

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	of appropriate quality, in an outsourced provider. Change should not be driven by the envy of others. We believe that the CAA is exhibiting the classic trait of knowing the cost of everything but the value of nothing. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** The CAA should maintain its current pattern of provision. It should celebrate the high quality and global reputation of its medical services, and not apologise for them. It should seek to maintain its level of investment in the service on the grounds that it is of benefit to overall flight safety. The CAA should consider the revenue raising opportunities that could arise from appropriate marketing of various policies and procedure pioneered by the medical department. For example the comprehensive guidance material produced in response to EASA Part Med is freely available to other member states via the website. This is inappropriate, and should be charged for. **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?** The CAA should pay attention to the rights and welfare of individual staff members if Options 2 or 3 are pursued. Morale is already at rock bottom, and this could have adverse effects on efficiency and consistency, particularly if there is a long period of uncertainty. The CAA must be mindful of the reputational risk that could arise from the loss of the current medical expertise. The Association is particularly concerned about the real risk of loss of support to its AMEs in complex medical cases. This could result in pilots being declared unfit because of lack of adequate decision making support from the CAA medical services, which in addition to being difficult for an individual pilot, is likely to have adverse consequences for the industry.
5	The present functions of the CAA medical department are several: a) It acts as component of the Department of Transport recommending or deciding policy nationally and representing the UK internationally b) It runs an 'in house' medical examination business some of which is a monopoly activity c) It authorises AMEs on a franchise basis enabling them to conduct a business but paying for the privilege d) It has an aviation health unit which supports commercial air transport The CAP1214 consultation recognises the essential conflict of interest whereby the policy element makes the rules enabling the other parts to establish a monopoly. XXXX believes that the conflict that emerges from a regulator undertaking business on their own account is acceptable provided there are defined safeguards to ensure the business is treated and managed as though it was separate.

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	We understand that the figure cited in CAP1214 that 10% of fatalities in GA have a medical cause is unsupported by published papers which have been in the range 3-5%. We understand that the CAA has included cases which expose medical malfeasance without causation. However, the key issue here is that the present earnings of the medical department do not cover costs which are which are made up from other CAA charges, that is essentially from commercial aviation. In other countries the cost of the NAA medical department is usually borne by general taxation. XXXX believes that the principle should be that the beneficiary pays. Thus the cost of the aviation health unit should fall upon the airlines as at present. If the purpose of the regulator is to stop aircraft from falling upon the heads of the population, then the cost should fall on the taxpayer. If in commercial aviation it is for the safety of passengers, then they should pay, albeit indirectly through airline charges. Because non-commercial aviation derives no benefit from medical regulation, then as experience has shown management of that risk can be safely delegated to Associations with no cost incurred, except that justified by international representation on their behalf.
6	We welcome the CAA medical department issuing a consultation document on its options for carrying out aeromedical regulation and oversight and enabling the provision of aeromedical services. The prime function of the CAA medical department is, as stated, to minimise incapacitation risk for flight crew and ATCOs. This is done by setting standards of aeromedical examination and overseeing their proper implementation. These standards should be evidenced base and proportionate to keep costs to the minimum without compromising safety. The standards should be regularly reviewed to take into account any new evidence on aeromedical risk such as improved life expectancy and use of medication with fewer side effects. Recently the CAA medical department has had to take on a new role in the consultation of Europe wide legislation for medical standards under the European Aviation Safety Agency (EASA). We realise that this type of consultation is costly but benefits the aviation community widely if we continue to believe in evidence based legislation unhindered by conflicts of interest that currently appears lacking in the EASA standards proposed. XXXX has likewise invested substantial time and effort in persuading legislators to implement proportionate rules such as deferring Approved Training Organisation (ATO) requirement for training balloon pilots to 2018 to enable much simpler procedures to be developed and increasing CPL 'retirement' for public transport to the age of 70, not age 65. We applaud the CAA in trying to represent the views of common sense unfettered by commercial interest but realise that this type of activity is costly and may well increase the department's overheads without easily recouping the costs incurred. This may be the main reason that the present earnings of the medical department do not cover costs. However we all benefit from ensuring that regulations are proportionate and cost effective, whether that is pilots, passengers or the general public and therefore should be mostly born by

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	general taxation. However to address the options on which views and opinions are sought: Option 1 has the advantage that it would deliver consistency of service. However charges would have to rise. We do not believe these would grow unconstrained as it has been the implementation of much of EASA legislation that has caused these increased costs and hopefully these will abate. As we all benefit from ensuring proportionate legislation is enacted then we may all have to bear these increased charges, which we believe should include some from general taxation. As regards the conflict that emerges from a regulator undertaking business on their own account we believe that this is acceptable provided there are defined safeguards to ensure the business is treated and managed as though it was separate. We are unsure why this option will decrease the CAA's ambition to influence European and worldwide aeromedical policy. This we feel is a vital role for the CAA medical department and if this is the case then we would not favour this option. Option 2 concerns ceasing all non-mandatory functions. As some AMEs appear to make a living from aeromedical examinations we presume the cost of issuing initial Class 1 medicals covers the cost. We presume it is the running of specialist clinics that is not cost effective and these could cease if an alternate provider is sought. As regards the non-mandatory functions of the AMS then most appear to deal with contributing to European and ICAO rulemaking and standardisation and we believe that this is a vital role of the CAA and must be supported. You already state in Option 1 that it is the CAA's ambition to influence European and worldwide aeromedical policy. Non-mandatory AMS support functions could cease. Option 3 concerns outsourcing all non-mandatory functions. Our comments are identical to those for Option 2. Non-mandatory functions of the AMS dealing with contributing to European and ICAO rulemaking and standardisation is a vital role of the CAA and must be supported and not out-sourced. The running of specialist clinics could be outsourced but it is important to make sure that this does not add prohibitive costs to those that it affects. Non-mandatory AMS support functions could be outsourced. We agree with XXXX that because non-commercial aviation derives no benefit from medical regulation, then as experience has shown management of that risk can be safely delegated to Associations with no cost incurred, except that justified by international representation on their behalf.
7	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?** Why does the CAA need to be a service provider? It reports that the service is provided at a loss to CAA; a cost that will filter into the overall costs which among others GA will be expected to pick up although most of GA will not use the service. I suggest it is better to let commercial AeMCs develop without CAA competition. I don't think this is a question about the ethics of a regulator regulating itself. 2. **What are your views on the current situation by which the costs of the functions performed by the CAA Medical Department exceed its**

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	income? We all need the CAA Medical Department, even if only to propose and create proportionate regulation. We are all the consumers to some extent, so we will all have to share the cost. However, as above, if the service provision is a significant part of the overall cost a simple way of reducing costs would be to close the service provision and let it be serviced by commercial interests. This is in line with other CAA changes. For example they don't have a flight test department now. They regulate flight testing but leave the actual hands on work to commercially available approved individuals. **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?** The user should pay for costs, however overhead costs should not be inflated by losses due to service provision. **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?** Yes, but this does not require the provision of medical services. **5. What are your views on each of the options considered in this consultation?** Option 1: Costly, should be looking for an improvement in efficiency. Option 2: Will reduce costs and any potential for criticism of regulating itself. Will still be able to effectively set standards, without having to provide a service, and continue to influence EASA regulation. Option 3: Potentially unsatisfactory as would still have responsibility for providing non-mandatory functions and may be required to take back if unable to outsource. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** Option 2 is the most preferable. It maintains regulatory responsibility, oversight and representation without service provider costs and complications. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** No **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?** There will be a transition period for any change and that transition period needs to be adequate for emerging service providers to develop capacity

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8	**Introduction** XXXX is an independent trade union representing 120,000 professional, managerial, technical and scientific staff across the private and public sectors. Our members work in a range of jobs in a variety of different areas including in agriculture, civil aviation, communications and IT, defence, energy supply, environment, heritage and scientific research. We have thousands of members employed in regulatory bodies, including the CAA and HSE. XXXX has approximately 4,500 members working in the civil aviation sector: including airports, airlines (specifically Licensed Engineers); Air Traffic Controllers and Air Traffic Systems Specialists in NATS and elsewhere; and, of course, the CAA itself. We have an Aviation Group to coordinate our policy and lobbying work within the sector. This submission is on behalf of XXXX's Aviation Group and is therefore from the service users' perspective. Our members in the CAA (including staff in the Medical Department) have been engaged separately in the internal consultation and have contributed their perspective as service providers. **General comments** XXXX is acutely aware of the need for an expert and fit for purpose CAA Medical Department. This must regulate the issuing of medical certificates appropriately and as required in order for the exercising of the privileges of air traffic controller and pilot licences. Furthermore we expect the regulator to be active in the drafting of regulations and policy at domestic and international level, particularly in EASA. The CAA Medical Department enjoys a strong reputation and it is important that this is retained. Regarding the Authority Medical Section (AMS) of the department, we feel strongly that both the mandatory and the non-mandatory functions (including the advice service to certificate holders) should be maintained. We explain our rationale for this below. We are not convinced with the view expressed a number of times in the consultation document that the CAA Aeromedical Centre (AeMC) is the sole AeMC capable of operating at a level of high demand. NATS AeMC conducts several hundred medicals a year for both internal and external clients, and is capable of expanding. **Specific response to the consultation questions** 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?** We agree with the principle of adequate separation between the regulator and the function being regulated. However, we do not believe that this must necessarily mean cessation or contracting-out this function in its entirety. The construct of the separation should be thought through

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	carefully, and it may be that functional separation with the CAA - AeMC incorporated in to a separate company, but wholly owned by the CAA would be sufficient. We would not wish to see a function that is critical to the safe operation of UK aviation become a business opportunity to be used to make excess profit, when its purpose should solely be to provide a professional and cost effective (ideally on a cost recovery basis) service for the provision of medical certificates. That said, it is also important to ensure that all Aero Medical Centres are treated fairly and operate on an equal basis. We also feel that the expertise in the AeMC- any AeMC – given that it is dealing with 'real world' cases, should have a mechanism for feeding back to the AMS so that the regulator is able to evolve its decision making as more advanced thinking progresses. Following the separation of the CAA AeMC from its Medical Department, we would have concerns over a knowledge gap arising due to the separation and probable current state of cross operation by CAA personnel over the different functions. The preservation and sustainability of the AMS's capability has to be the primary objective. **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?** The consultation document provides little detail of the cost breakdown and it is difficult to determine which areas of the CAA Medical Department costs are allocated to. The costs of the AMS, Aviation Health Unit (AHU) and the CAA internal Occupational Health (OH) service are all functions of, or the result of, being a regulator. The excess costs (those not provided for by charges levelled on AMEs) should continue to be recovered through AOC holders, and fees to ANSPs. The separated (functionally or otherwise) CAA AeMC costs should be recovered on a pure cost recovery basis. **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?** As per the answer to Q2, costs for regulatory and internal CAA functions should be recovered by a blend of charges to AMEs (for approval charges and the indirect charge to licence holders) and charges to AOC holders and ANSPs. Part of the regulatory function deals with policy and contributing to the drafting and maintenance of regulations, domestically and at EU level, and it is essential that the CAA maintain this level of expertise for the greater benefit of UK aviation. Therefore it is reasonable that AOC holders and ANSPs contribute. **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?** It is essential that the CAA continue to both retain and develop expertise. An effective UK regulator is a must for promoting UK interests on the world stage, and particularly at EASA level. Progressive and modern thinking with respect to aviation medicine is required to improve regulation. **5. What are your views on each of the options considered in this consultation?**

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	Option 1 – status quo If it is accepted that EASA is unlikely to continue to allow a regulator to provide a service that is not at the very least functionally separated, we suggest that Option 1 is not really an option! But we would prefer to establish whether functional separation within the CAA would meet EASA's requirements with minimum disruption. Option 2 – cease all non-mandatory functions Although we do not accept that there are no other AeMCs of similar size and scope (we mentioned the NATS AeMC earlier) we agree that a transition period would be needed to minimise disruption in the event that the CAA ceases to operate its own AeMC. This option resolves the separation issue but is not acceptable. To cease all non-mandatory functions, particularly in the AMS area, could lead to a lack of expertise and influence at European and ICAO level. This would be to the detriment of the UK aviation industry. In addition, the cessation of an advice service to certificate holders and, to a lesser extent, applicants, could have a detrimental impact on safety. We wish to see a formal method for licence holders to contact an AME, AeMC or the AMS as appropriate in order to seek day-to-day advice on medical issues that may affect the status of their medical certificate. This advice should be free or be included in the annual medical certificate registration fee. A risk of outsourcing or removing the AMS advice service is that AMEs or AeMCs are likely to charge for aviation medical advice (e.g. seeking advice about a particular type of medication). Should this situation arise there is a significant safety risk that individuals will not seek the appropriate advice (due to unreasonable cost) and may work whilst unfit to do so. Conversely individuals may report to their employer they are unable to work as a fail-safe option, when they actually may be fit for work, therefore incurring the employer additional cost. Option 3 – contract out all non-mandatory functions This option is not acceptable. While these functions should cover their costs, there is little to be achieved by introducing profit motive and a market. And there is a lot to lose, as this would introduce new risks. The consultation document neglects to identify and assess these risks; focussing on finance rather than safety. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** We do not believe that any of the options are desirable or to be preferred. We suggest a fourth option below. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** It is our opinion that both the mandatory and non-mandatory functions of the AMS, AHU and OH should remain within the CAA, but with functional separation of the AeMC. We suggest that the AeMC could be located within CAA International or in a separate "for profit" body of the CAA with its own accountability and governance structure. This would also allow CAAi to grow the business internationally. To meet the CAA's criteria and objectives, we suggest in addition that there is a review of the charging regime. Currently the cost of initial pilot medicals is

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	considered below the norm as the CAA can only recoup its costs plus 5%. 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?** Our concern is that the safety risks are not being identified and evaluated as part of the review process. It seems that, whatever happens, there is a very real risk that AMEs or AeMCs will introduce a charge for general advice. This must be avoided, as it will drive the wrong safety behaviours. Ongoing advice should be provided as part of license and certificate charges because it supports the maintenance of those licenses and reduces costs and risks for industry. The CAA must also ensure that the AMS and AHU retain its high level of detailed and expert knowledge in the field of aviation medicine. It must also continue to be effective at influencing and shaping future policy and regulations at European and ICAO level.
9	**Submission on behalf of XXX and XXX to CAA Ex-Co on the future of the Medical Department** XXX and XXX are the recognised trade unions within the CAA. We have a significant number of members across all grades within the Medical Department carrying out a variety of functions. Earlier this year, the CAA carried out a review of the Medical Department and presented its findings to the unions. This is the second review of the department in the last few years and despite several requests to see copies of the previous review, these have not been forthcoming. We met with the CAA in July where we were presented with a slide pack. In essence the review identified three main areas of concerns: • Cost of the department • EASA concerns over the regulator providing medical services • Need to grow the business into Europe This submission queries some of the assumptions made, but also makes suggestions on how the department could be improved and made more efficient. We had requested information from the CAA to inform this submission, but this had not been forthcoming by the time this submission was made. In essence the unions accept that efficiencies can be made but not at the expense of outsourcing, safety, business continuity and damaging the reputation of the medical department as an industry leader. **EASA regulator vs. service provider** The unions understand the concerns expressed by EASA over the regulator and service provider being one and the same. However we believe there is no evidence to suggest that the service provision in the CAA has ever compromised the regulatory role of the CAA. However, we would support as

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	an alternative to outsourcing, making the service provision role more stand alone from the regulatory role. This could be achieved by moving the service provision to CAA International or creating a separate "for profit" body of the CAA with its own accountability and governance structure . We do not believe that within the UK presently there is service provider which could fill the gap that would be left by the CAA not providing its current medical services. Circa 2000 medical examinations were conducted in AeMC last year . The department is integral in ensuring that airlines have sufficient deployable pilots within civil aviation and we believe that there is a case for growing the CAA medical business by bringing in renewals and revalidations. There is currently no outside provider that could step in and provide the services the CAA does and any change to the current Medical Department could result in a hole in the market could see pilots not being able to fly with significant delays and costs to airlines and the travelling public. According to XXXXX (XXX AME) in evidence he gave to ICAO in May 2014, *"the cost of short term sickness absence is relatively easy to quantify - E.g. a pilot having one day sickness absence costs a company $1000 (£590) to $1500 (£885) depending on seniority'- Up to date figures estimated at closer to £700-£1200 per day (depending on seniority) based on sick pay and extra staff to cover the flights. A lack of safe pilots would result in flights being cancelled"* **Growing the Business abroad** The trade unions support the concept of growing the business abroad and believe this can be done by looking to partner up with existing medical services abroad. We do however have a concern, based on experience elsewhere, that some aviation industry providers who look to move beyond traditional boundaries, often do so by risking their business interests closer to home. **Making the medical department more efficient** **Charging and appeals** Currently the cost of initial pilot medicals is considered below the norm as the CAA can only recoup its costs plus 5%. The CAA should review the charging mechanism and also consider charging for appeals. If the AeMC was taken out of the CAA and put into a CAA owned body (possibly CAAi) then the charges could be increased to as much as the 'operator' feels. **Phone calls and miscellaneous** Currently the CAA charges pilots for medicals. However charges are not made for advice and general enquires from pilots/initial applicants and overseas applicants. As an industry leader in aviation medicine this results in a considerable burden on the UK CAA as it is the first point of contact for many applicants. In fact, call backs, often to overseas numbers does cost the CAA. We recommend that the CAA: • discontinues the use of a voicemail facility and utilises a queuing system as an alternative. This would result in a considerable reduction of call backs required – particularly to overseas numbers. • applies a cost neutral charge to all phone calls received advising the caller of the charges before connecting them and that calls are charged at 10p/min using an 08 number generating an income stream. Based on data we have been able to collate – calls in excess of 2200 per

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	month with an average duration of 2.5 minutes each would result in a yearly income of £22,650 a year. This is in addition to the savings made due to a reduction in the number of calls made. Reduce number of medical journal subscriptions & transfer to ejournals where cost saving is available. **Correspondence & repeat requests – information not received letters** We recommend that the CAA: • Change method of correspondence to electronic means for **all applicants** with a postage saving?. • Charge cost neutral administrative fee for all guidance material posted out to applicants which is available free for download from the website or via a link in the letter telling the applicant where to find the document • Apply a cost neutral administrative fee for all INR letters issued to include recouping the cost of registered delivery for formal notifications. Applicants to be notified at the time follow up reports are requested that administrative charges will apply if further requests for the information are required • Applicant is reminded at the time of the first INR letter that charges apply • Increased generic charges to be applied to all applications to cover follow up correspondence **Cross Charging** The Medical Department should be charging other AeMCs and AMEs for referrals to cover administrative costs, i.e typing reports, letters etc As this is a statutory function this should be charged to the airlines. **Training** The Medical department does not currently charge for AME training courses. We recommend that the CAA should charge for training and also for meetings such as the diabetes meetings, talks, lectures. **Summary** The trade unions believe that there is scope for efficiencies to be made in the Medical Department but also the ability to create greater income streams if the CAA is able to adopt its over governance arrangements as a subsidiary of the CAA. Union members with the Medical Department give excellent service to Pilots and the wider UK and European aviation industry and believe strongly that the services they provide should continue to be provided by the CAA (albeit the relationship between the core CAA and the Medical department may need to be reviewed to meet EASA's concerns). We oppose any move to outsource work which is currently being done by staff working in the CAA to third parties. We are conscious that the CAA is commencing consultation in early September. At this stage we are concerned that this is the start of a consultation to outsource services which will be met with a robust response. We are requesting that this consultation be halted and consultation commences with the recognised trade unions on options within this paper to retain all existing services in-house.

Airlines

No.	Comments
1	**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?** The aviation industry is a highly regulated industry and the medical conditions and restrictions attached to the award and maintenance of a professional licence are also highly regulated. It would be incompatible for such a regulated industry to abdicate direct oversight of the medical requirements to general practice. The CAA is the competent authority within EASA regulation, that also sets the medical requirements and so from a commercial aspect should maintain direct oversight of the requirements as the service provider. This is where the expertise and regulatory relationships lie. **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?** A close analysis of cost spend within the area is required to ensure that costs incurred through professional licence (ATPL/CPL) holders is net through the costs distributed across the AOC holders. AOC Holders employ professional pilots and generally support the maintenance of medical certification; therefore, costs associated with this aspect should be distributed across the AOC holders and regulated by the CAA. Medical requirements pertaining to the non-commercial pilot requirements should not be supported through AOC holder contributions. **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?** As indicated above, costs associated with professional medical certification probably lie with the AOC holders and charges recouped through AOC charges. The initial issue of a professional licence and medical certificate is not part of the requirement of an AOC holder and, therefore, should fall outside the charges associated with AOC holders. AOC holders are concerned with the maintenance of medical standards once they have employed the holder of a medical certificate. **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?**

No.	Comments
	This is important as only the CAA has the direct link through to EASA and also the airlines under its remit. The CAA maintains the resident experts in aviation operations and support and working through this entity ensures consistency of approach and a centralised, industry-focused organisation to ensure the medical standards are appropriate. **5. What are your views on each of the options considered in this consultation?** The current system provides the support and information that is required by professional pilots and AOC holders. The out sourcing of functions always has the potential for cost saving; however, the ability to ensure consistency and regulation is degraded. An large amount of audit and monitoring is traditionally required to ensure the same level of service and also to ensure that the performance of any outsource agency does not affect the service delivery to the industry. Whilst there is an issue with the current system in that the CAA is effectively auditing its own service, it is better to outsource the audit function, perhaps to another EASA agency, and maintain direct control of the service for the professional industry **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** Option 1. ▪ What are your reasons for this view? This is an established process maintaining the close contact between EASA and local competent authority, which is a major benefit for the commercial AOC holder. This may not be so relevant for a non-commercial or leisure certificate holder. ▪ Why have you rejected the other options? The concept of outsourcing from the competent authority is totally cost based when medical certification has a safety aspect within the professional organisation. Although usually successful in saving costs through outsourcing, oversight, consistency and maintenance of standards does become an issue requiring a substantial amount of audit activity. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** Restructuring of the medical support provision to have separation between leisure and professional pilots where the maintenance of a professional licence and medical certificate comes under the CAA may lead to consistency and necessary support in this area funded through

<table>
<tr><th>No.</th><th>Comments</th></tr>
<tr><td></td><td>AOC charges whilst the leisure side and initial acquisition of a medical certificate is self-funded away from the AOC holders.

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?

Continue to maintain a common contact area that industry can use to gain a consistent interpretation of EASA regulation and current thinking on medical conditions and developments in the medical area. For an AOC holder, if a pilot is unavailable due to a medical condition, this has a direct cost impact. The AOC holder requires access to advice and technical help quickly and through a known source.</td></tr>
<tr><td>2</td><td>XXXX welcomes the opportunity to respond to the consultation paper for the Future Structure of the CAA's Medical Department that was published by the CAA on 16th October 2014. In responding to this consultation XXXX has sought opinion from various internal departments, which are reflected in our feedback. This response does not include the views of our parent company, XXXX.

XXXX notes that the CAA in maintaining the medical department's overriding safety objective, has identified 'core criteria' that it wishes to protect in the future, following any restructuring following the consultation; namely:

▪ Perform regulatory duties
▪ Achieve financial stability
▪ Influence Policy

XXXX accepts that these are sensible core criteria on which to consider the options but has also considered the options in terms of our ongoing access to quality, cost effective, fit for purpose services, and the degree to which it believes that the alternative models could deliver improvements to current service levels. XXXX is most keen that any change in the structure of the Medical Department results in faster and more efficient decision making and processing of paperwork, and further development of the current progression towards closer liaison with industry.

XXXX is fully supportive of the CAA's rationale for reviewing the structure of charges relating to the provision of services the Medical Department supply; namely to reduce the subsidy that currently exists which is being funded from other charge payers.

Removing cross-subsidies is a fundamental part of the CAA 'Charging Principles'.</td></tr>
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No.	Comments
	XXXX fully supports the need for the CAA to perform the regulatory duties identified in the paper. In regards to the CAA being an influential National Aviation Authority capable of engaging international colleagues so as to leverage your knowledge and effective position, XXXX can see that, if the CAA maintains close ties and regular liaison and communication with industry that there is benefit to UK aviation, as well as safety improvements. Further to the issues raised in this letter, there is a response to each of your consultation paper questions attached as Annexe A, which together form the XXXX response. **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?** ▪ XXXX main priority in looking at the future of the provision of these services is for speed and efficiency; with the service being fit for purpose. Unnecessary delays in decision making, or the communication of decisions and outcomes cause operational issues and cost pilots and the airline money. ▪ Whilst XXXX can see the potential conflict of interests of the CAA regulating the AeMC as a service provider, we believe that with appropriate separation of duties that it would be possible to alleviate these conflicts sufficiently; and do not see this a major reason to cease the CAA's provision of its AeMC facility. This issue is not of major concern to XXXX. ▪ If the CAA were to seek to cease provision of services that their AeMC currently provides, they would need to ensure that their exit was structured in such a way as to allow enough time for the external market to adjust and adapt. ▪ As the CAA itself notes, in the paper, various models of outsourcing exist. It is difficult to form developed views on this option without more detail. **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?** ▪ XXXX supports all efforts by the CAA to remove cross subsidy.

No.	Comments
	▪ XXXX supports the principle that the charges levied by the CAA should be cost related, fair and reasonable. ▪ The fact that overall, the charges raise only £1.2m p.a., but that the costs are £4.3m p.a. is a significant discrepancy, and it is good that the CAA wishes to address this. ▪ The current situation, whereby the under recovery of costs incurred by the Medical Department are borne by Air Operator Certificate holders, Air Navigation Service Providers (via their Aerodrome and Air Traffic variable charge and En Route Safety Regulation charges) effectively means that operators of commercial aircraft pick up all of the under recovery, as they pay the ANSPs costs as well. ▪ XXXX notes the requirement for the CAA to provide mandatory Occupational Health services to its employees. The slide that the CAA published on the consultation website to further detail to the previously published Financial Information details that the cost of provision of this service contributes to the gap between the current costs of the provision of medical services and the income received detailed in the paper. XXXX believes that this is erroneous and that those costs should be charged back to the CAA and then (financially) treated in an appropriate manner (probably as a staff cost) to ensure recovery of the costs in proportion to the way in which they have been incurred. ▪ In regards to the AMS (the largest contributor to the deficit) – it is not clear, without further information, the degree to which the services provided here (that do not currently recover the costs of provision) could be provided more cheaply, if done by an outsourced provider, or by a private sector supplier. It is also unclear what the rate of charges would need to be to prevent under-recovery in the future, nor the degree to which users would actually value the provision of those services and be prepared to pay for them. ▪ XXXX sees that there is benefit in the services provided by the AHU, but cannot determine a charging methodology that appropriately recovers these charges – and so would accept a situation whereby the costs of provision are funded from revenues received from AOC charges. If this were to be accepted as a position, as ever XXXX would wish to ensure that the AHU was operating efficiently and in a cost effective manner. **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?** ▪ Future charges should be based on the CAA's Charging Principles. Specifically in regards to the provision of medical services the charges should:

No.	Comments
	▪ Be fair and reasonable. ▪ Minimised through efficient provision of the services ▪ Aim to recover the costs of the provision of the services being provided. (The 'costs' of the services should include direct costs, support costs, allocated and apportioned overheads and the cost of the capital rate of return, stipulated by HM Treasury, for the statutory duties. [For any retained non-statutory duties the CAA should be seeking an appropriate rate of return, commensurate with commercial provision of the service.]) ▪ In the case of the provision of medical services, where there is current demand for AeMC services (beyond the mandatory functions the CAA must provide) that are currently being satisfied by the CAA's AeMC, XXXX is not adverse to that situation continuing despite a part of the principle regarding 'minimising costs' referring to "focussing only on the provision of services that are necessary and proportionate to meet statutory duties". The non-mandatory services provided by the AeMC already face a degree of competition from other providers. That external market could become more competitive if the CAA ceased provision of these services, or even outsourced them (dependant on outsourcing model selected), but there is no guarantee currently that extra competition would be generated. If the CAA could provide the non-mandatory AeMC services on a commercial basis, with no requirement for cross subsidy, and be efficient and effective enough to still compete in an open market for those services then XXXX would support that model. ▪ It is not fully clear to XXXX what specific services that the CAA Medical Department does that actually cause the shortfalls in revenue required to cover their costs. Without a greater breakdown of the costs of provision of the various services provided, and the associated income it is difficult to comment. ▪ XXXX is supportive of any plans that the CAA has to ensure that users of services pay the actual costs. XXXX is also supportive of moves the CAA would make to ensure cost efficient provision of service and the reduction of overall costs by either stopping doing things altogether, or doing some things differently. **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?**

No.	Comments
	▪ XXXX is supportive of CAA's role in developing aeromedical policy and practice in the years ahead. ▪ XXXX would always prioritise the CAA's role within the UK ahead of any aspirations that the CAA has to influence internationally, however, as a long as the primary focus of the CAA's Medical Department is on providing fit for purpose service, XXXX agree that there is also role for the CAA to play internationally. ▪ XXXX believes that there is a role for the CAA Medical Department in contributing to European and ICAO rulemaking and standardisation and would support models relating to the future structure of the Medical Department that enable this. However we would stress that for that contribution to aeromedical policy and practice to be effective the CAA Medical Department must continue to develop close ties to industry, both with the airline medical departments/advisors and Flight Ops. Although it is acknowledged that few UK airlines have medical departments., most have a medical advisor and further strengthening the line of communication here is imperative. Liaison between the CAA Medical Department and the CAA co-chaired Flight Ops Liaison Group could be further strengthened, including the formation of a specialist working groups where appropriate, reporting to the Flight Ops Liaison Group, to ensure regular communication of issues and an agreed set of objectives and focus. (N.B. XXXX acknowledges recent positive developments to strengthen the relationship between the Medical Department and the Flight Ops Liaison Group – and welcome these, and wishes to see these continue and for them to be developed further.) ▪ XXXX supports the continued role of the CAA in seeking to influence international rule making and standardisation, as much as to promote positive changes that aim to improve safety, as to prevent the creation of erroneous and unnecessary standards that could occur if the CAA were less capable of having a voice at the requisite forums and with the appropriate regulatory bodies. **5. What are your views on each of the options considered in this consultation?** Option 1 – XXXX does not support the continuation of the current situation in regards to charges. The current structure of charges is not in accordance with agreed charging principles. XXXX does not support the status quo as delays and inefficiencies are disruptive and costly to industry. XXXX is not overly concerned about the regulatory issue the CAA identifies in regard to self-regulation. The current concerns that CAA has about this issue could be addressed through organisational design. Option 2 – XXXX believes that the potential risk of the conflict of interests caused by a regulator regulating its own service provision, whilst not

No.	Comments
	best practice, could be overcome with the right separation of duties within the CAA. Ceasing non-mandatory AeMC functions seems intuitively attractive, as a way to reduce CAA costs, however to do so without ensuring that alternative service providers are able to take on the demand that would be created would be irresponsible. The CAA notes in the paper that there is no private sector AeMC with a similar size and scope to the current CAA AeMC. XXXX considers that a private sector response, to take up the provision of the AeMC services (in terms of the 2,000-2,500 medical examinations and the 950-1,100 specialist investigations per year) could naturally provide a cost effective and efficient service; but only in as much as the market created was attractive enough to cause competition. In the absence of strong evidence that a competitive market would be created as a result of the CAA AeMC withdrawing from the provision of these services this would not be XXXX's preferred solution. XXXX would be happy to engage in further discussion to consider this point, and if evidence exists to indicate a strong private sector competitive market would be created, then XXXX would support this position. Although effective provision of high-quality aeromedical services is paramount in our considerations of this question we have commercial concerns regarding the future costs of provision of these services. As we work in such an internationally competitive market place we have a duty to our customers and shareholders to seek to protect ourselves from further exposure to the effects of monopolistic supply markets. In regards to the cessation of non-mandatory AMS support services, XXXX is not clear on exactly what the non-mandatory support service are. XXXX understands that a non-mandatory AMS function currently provided relates to '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' and your ability to positively influence European Aviation Safety Agency (EASA) and other international organisations. As previously noted, XXXX does see there could be the benefits to UK aviation of the CAA performing any such role, and as such XXXX generally would want to see this function continued by the CAA. If the AMS "support" services that you would propose to cease are performed by the team headed by the Head of Aeromedical Support Unit more information about exactly what non-mandatory services are currently provided, and which would cease, is required. Option 3 – As the CAA observes 'There are different outsourcing models that could be considered which have different impacts on income and net costs.' It is difficult for XXXX to form a developed opinion on this option without a better understanding of which form the CAA favours.

No.	Comments
	'Outsourcing' would normally mean that you would propose to pay another organisation to conduct work that you currently do in-house. Whilst XXXX can see that such an option may improve efficiency and reduce costs, it does not see that the case, made in the paper, that this option would also remove the conflict of the CAA regulating its own service provider naturally follows. We note that, whichever version of outsourcing that you are considering, you have the view that this would reduce costs and create market conditions in which alternative suppliers of these services could compete. As previously noted, if XXXX could see evidence to support the view that an effective free market would be created then it would support this option. XXXX notes that, in our experience, outsourcing does not always equate to access to an effective competitive market. If the model of outsourcing you are considering, does indeed support a situation, as you suggest in the paper that it does, whereby an effective competitive market for some of the medical services would be created, the CAA's costs of provision would be reduced and the opportunity for the CAA to generate future business income exists then XXXX supports that model. However, XXXX does not sufficiently understand the outsourcing model being considered that would deliver all of these benefits, and as such considers it difficult to comment. In an ideal world the CAA would not outsource a problem, rather it would seek to correct any issues and inefficiencies itself, prior to any outsourcing. However if internal change is considered too difficult to achieve, or that the quality of potential external providers is such that the benefits of improved service delivery could be delivered much faster through the outsourcing model then XXXX would be very keen that the CAA spent time defining appropriate service levels and ensuring that all processes were sufficiently defined to ensure minimal disruption to service provision and more assured delivery of envisaged benefits of the outsourcing model. **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? On balance, without further understanding of why the CAA believes that the outsourcing model would provide the benefits of:- ▪ reduced CAA costs ▪ removal of cross subsidy

No.	Comments
	▪ access for users to an effective competitive market ▪ opportunities for the CAA to generate commercial revenue ▪ effective influence of regulators and policy makers to the benefit of UK aviation it is difficult to make an informed decision. However, on balance, XXXX would support Option 3. XXXX stresses that our primary concern is continued focus on delivery of fit for purpose provision of medical services within the UK, without interruption or disruption, and without jeopardising safety. XXXX does desire improvements to the current level of service provision and as such would support models that enable this to be delivered early within the programme. XXXX suggests that close liaison with industry is required to support effective influence of international regulators and policy makers. XXXX supports all models that support the CAA's delivery of the charging principles. Option 1, as stated, does not support delivery of the charging principles. Option 2, as stated, has the disadvantage of curtailing the generally beneficial role the CAA can play with international regulators and policy makers and could lead to disruption in the continued supply of sufficient capacity and capability within the market if not handled well. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** ▪ It would be possible to maintain the current structure and activities of the CAA Medical Department without having to maintain the same funding model. With the correct organisation structure the CAA could ensure 'separation of duties' in order to minimise the possibility of a conflict of interests through regulation of your own AeMC. The funding model to support this variation on your current Option 1 would need to change to make it compliant with the Charging Principles. ▪ It would also be possible to consider outsourcing the provision of the non mandatory AeMC functions without also having to cease or outsource the AMS support functions. These two areas of service provision could be considered separately. Further, the current non-mandatory functions of the AMS could be considered separately, it does not seem logical that an ability to effectively influence regulators and

No.	Comments
	policy makers is linked to the provision of the AME online capability. An ability to outsource administrative process would seem separate to an ability to influence beyond mandated minimum levels. ▪ There appear to be a great deal of support costs contained within the Support Unit. These appear to be greater than necessary to influence policy makers and regulators. However the costs as given for all areas within the medical department are difficult to interpret ▪ This is the unit where it may be possible to, through greater efficiencies, generate improvements in the processing and communication of decisions and outcomes that XXXX would value highly. These efficiencies, and costs savings could potentially be accessed via the appointment of a Business Process Outsourcer (BPO). ▪ Maintaining the 'AME on-line capability, a non-mandatory function of the AMS, is important and it is unclear from the paper how this would continue and be improved on. Outsourcing of the service may work, dependant on the model of outsourcing chosen and could bring much needed and desired benefits in terms of the provision of a more fit for purpose service. **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?** Risks associated with Option 1 The CAA has stated the risks associated with this model effectively within the paper. XXXX considers the associated risks with this model to be minimal. Risks associated with Option 2 Disruption to the provision of service. 'Throwing the baby out with the bath water' by ceasing to provide service that could easily be retained by the CAA beyond the minimum mandated levels of service and which would have otherwise benefited UK aviation. Failure of the free-market to thrive and to become effective. Lost opportunities to effectively influence on behalf of UK aviation

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<tr><td></td><td>Risks associated with Option 3

Disruption to the provision of service.

Outsourcing of inefficient/broken processes.

Failure to secure long-term access to any initially envisaged savings and efficiency gains.

Failure by the CAA to 'retain the brain' when outsourcing and losing the ability to properly manage the outsourced provider.

Failure by the CAA to ensure that outsourced provision is able to be moved between suppliers easily and readily and thus maintaining access to competitive services levels and prices.

Failure of the free-market to thrive and to become effective.

Lost opportunities to effectively influence on behalf of UK aviation through poor liaison with industry.

Inability for the CAA to win business and gain commercial revenue.

In addition we would ask that there is appropriate communication with all affected staff throughout this time of uncertainty, as they continue with their safety critical work.</td></tr>
<tr><td>3</td><td>We note that the CAA Medical Department contains four discrete business units. i.e.

1. the Authority Medical Section ('AMS'), (responsible for the oversight of all aviation medical examiners in UK

2. the Aeromedical Centre ('AeMC'), (responsible for the pilots medicals for someone starting out on a flying career and also some repeat medicals)

3. the Aviation Health Unit ('AHU') (deals with passenger health as opposed to regulation of pilots health issues)

4. and Occupational Health ('OH'). (Occ Health for the CAAs own staff)</td></tr>
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No.	Comments
	The OH and AHU are small units with mandatory functions that it would appear are not in the review. **The CAA Management have put forward three scenarios on which they are seeking comment** **Option 1** Maintain the current structure, activities and funding model of the CAA Medical Department **Option 2** Cease all non-mandatory functions (i.e. those carried on by AeMC and AMS support functions). **Option 3** Outsource all non-mandatory functions (i.e. those carried out by AeMC and AMS Support services) **It is our impression** that the reviewers have already decided what they think is the best way forward and it would appear that their three potential options exclude:- **Option four** which is Option 1 with changes i.e. current structure and activities of the CAA Medical Department, but with a different funding model with more attention to income generation and cost reduction within the Aeromedical centre. (The Aeromedical centre only seems to account for £500k out of the £3 million negative variance in the CAA Medical Department generally and could potentially be seen as the most profitable element) We would like to observe that If it is going to be cost effective for an external provider to provide the service i.e. that they will make a profit, then why can the CAA not effect that change internally? **Risks in wholescale change** With our experience in UK aviation medicine it is clear this is a small speciality with a finite number of true practical experts in the field and that there is a priceless 'nerve centre' of expertise in the CAA that would be diluted and lost. ▪ For an effective AMS, we feel that its personnel need to have a sound background of being at the forefront of aeromedical decision making, having been immersed in the day to day business of the medical certification of pilots.

No.	Comments
	This is especially important for us so that we can have timely decisions on 'returns to work' in the commercial environment. ▪ We would also have great concerns that getting rid of the Aemc will be detrimental to the future of the British influence in the development and implementation of future policy. It has been clear to us over the last few years that it is the efforts of **the combined team** at the CAA medical department that has shaped policy and rebuffed some of the more non evidence based demands of EASA. ▪ The only element of change that we would want to see (and in fact we are already starting to get it) is that people like VAA and BA with their own aviation medical departments should be able to have rapid access to the aeromedical advisers and docs so that when a straightforward case is worked up and presented appropriately that a rapid return to flying can be facilitated. ▪ We estimate that every extra day's absence costs us as an airline £1000 so it's not appropriate to wait for paperwork to be opened and scanned in (for example), so we are confident that there are other efficiencies that could be made. ▪ In summary the basis of our response is that Options 2 and 3 would be a problem, but that Option 4 could be a 'win win' for XXXX, the CAA and UK aviation generally. Please note that we have not responded in the format requested as we feel that this feedback format and questionnaire appeared to be biased towards particular scenarios and hence our open declaration of our comments for consideration.

Pilots

No.	Comments
1	Last month, I had my medical at your Gatwick Medical Department. I had my initial in 1994 - that is already twenty years ago. As a regular customer, I was a bit disappointed by the information I had about the future of your medical center. During all this period of time, I had no complaint regarding the service I had. As a French Airline Pilot, I passed all my licences in the UK. I worked for XXXX as a First Officer and Captain then for XXXX as an F/O and captain. I am working now with XXXX and I will continue to have my Medical at the

No.	Comments
	Gatwick Medical Centre if I am given this opportunity. Even driving every year from XXXX (France) to Gatwick, I strongly prefer to have my medical with you than with any other organization. Having with age some limitations on my medical, I would like to have my medical issued by an AME employed by the regulatory authority. I would like the CAA Medical in Gatwick being able to provide me the same level of service I had during the last twenty years.
2	In my considered opinion, I favour Option 1. As a regular user of your AeMC at LGW under the guidance of visiting Consultant Dr XXXX during his clinic, I feel that one central facility that a stakeholder can visit from anywhere in the UK is very important; I travel directly from Glasgow every 6 months. It provides a pivotal focal point for all who visit AeMC and importantly provides a shared "knowledge" base for all visiting Consultants who may only visit 2-3 times per month. In December 2012, my fitness status was immediately returned to 'Fit' after a consultation in situ without having to wait for typed reports, opinions and the associated time-lag that this can cause. I had a chat with Chief Medical Officer at the time and he immediately changed my flight status and issued me a 'fit' letter. My own Consultant has many years experience in his field of Aviation/General Psychiatry and I would still have to travel as he is based in SE England. To my knowledge, no one with his specialist knowledge exist in my area. Whilst I acknowledge the requirement for financial prudence and to ensure separation as a regulator, I would find it a great shame if AeMC were to close access to specialist clinics and years of Consultant knowledge and experience. This cannot be measured in monetary value.
3	Background to the respondent; A CPL holder who has benefited from the constructive way the CAA has adopted the evidenced based approach to medical fitness. In 1987 when I applied for my initial class 3 medical I was informed that because of my short sighted ness I could never be anything other than a private pilot. Since then things moved on. With my eyesight meeting the JAR renewal requirements although outside the initial issue requirement, I was issued a deviation on my class 1 medical which was lifted upon issue of my CPL. So in the course of 25 years I have gone from not being able to operate in a professional capacity in aviation to now being a flight instructor and examiner. My only disappointment is that the current approach was not the norm in 1970 when I would have liked a career in aviation. But there are now lots of people flying today who would not be doing so without the changes that have taken place. Since the 70s where there was a surfeit of military aircrew there was not really the incentive to do anything other than replicate what had already

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	been done in the military. But with the demise of the military and the growth of commercial aviation way beyond the capacity of the military to supply aircrew, a more pragmatic approach became necessary. The CAA has been at the forefront along with the FAA in driving the change. My non-aviation interest in this consultation centres on my main occupation. I am the chief executive of a chartered professional body responsible for regulating and setting the standards for the profession. General observations on what is 'best practice' I have done extensive research into the issues of what is considered best practice in how regulatory bodies manage the potential for conflicts of interest. In my experience the term best practice is a misnomer and is often used to prejudice any alternative views. In other words if it's not best practice it must be inferior. It also suggests that there is only one solution which is best. This assessment is made more complex when different countries have different approaches to regulation and taxation and therefore colour what might be considered as 'best'. Countries which can hypothecate taxation to specific activities such as the USA must be able to approach matters in a different manner to say the UK where all taxation goes into a general fund for allocating as the treasury sees fit. Often there is no relationship at all to taxes raised in a particular area and the amount of public spending in that area. Good examples are the Vehicle Excise Duty and the Airline Passenger Taxes. The better term is good practice and allows for variations in what is considered good practice much in the way we consider alternative means of compliances. The danger in following a unitary model of 'best practice' depends on where one starts from. For some countries the "best practice" model might just reflect what they do as a minimum. For others the so called 'best practice' model means dropping lots of other activities which when added to the regulatory work created synergy. It cannot be considered best practice when the whole is worth less than the sum of the parts. What that happens its vandalism. **Response to the Consultation questions** **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?** I don't see how the proposition to diminish the CAA medical services can been seen as desirable or in line with the stated objective of the CAA of being able bring sufficient influence across global aviation. There is a certain critical mass available to the CAA both in its paid for team, the team that pays to be part of the process (AMEs) and a network of aeromedical professionals working in other spheres but inputting to the CAA voluntarily which contributes to the position the CAA has. For all its perceptions, the CAA does act as a sort of glue which holds all this together. Dissolving the glue risks irreparable damage to one of the

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	best regimes of medical flight safety in the world. How is that in the best interests of anyone? **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?** There is no information available to make an informed view on the issue of costs and any alleged deficit. The alleged deficit of £4.3M is small when you consider the total turnover of the UK aviation industry. A more detailed analysis of the income and expenditure would be required along with economic cost/ benefit analysis. **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?** The simplest way to recover the costs would be to recover them from those who receive the service. Unfortunately these are not the sole beneficiaries of the service. Besides which, there could be inequity in the way charges are recovered. For example a weekend flying instructor with a class 1 pays the same for the medical as an airline pilot working for a major carrier. The service they have received is the same, a Class 1 medical exam. If he/she is fortunate, the airline pilot has the cost of the medical paid for by the airline. The public benefit accruing though is different. The part time flying instructor might work with a dozen students, whilst the airline pilot carries hundreds of passengers a day. It would seem sensible and equitable that the costs should be recovered on the basis of who benefits from the activity. The travelling public certainly benefits. It should not be difficult to share out £4.3 m. If the CAA and the DfT cannot resolve this without destroying the CAA medical service then we might as well pack it all in. It might work out at something like 70p per ticket bought. **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?** Without doubt the CAA should retain its expertise. To not do so puts at risk all the CAA has gained over the years through its pragmatic approach. It would be a criminal waste to see that all thrown away. The industry needs to realise that its gets the aeromedical service on the cheap and should be prepared to explore how it gets properly funded. In addition the CAA stated aim of being influential in the aviation world would be diminished if its expertise was lost or the resource diminished for simple cost reasons. There is a desperate need for an influential body within the EASA structure to promote the common sense approach. European countries have a tradition of being rules based probably because they have the Napoleonic code as the basis of their legal system as opposed to our more flexible and evolutionary common law.

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	5. What are your views on each of the options considered in this consultation? It is pretty clear that the preferred option is option three and the driver is cost. The only way a service provider would be able to provide the service and make a profit as well as cover their additional admin charges (Oversight by the regulator) would be a major increase in charges to their customers for no additional benefits. The industry would see this as a dismal attempt to pass on responsibility for and increase the costs of the medical services under the guise of a separation of powers - the 'best practice' myth. The public sector is littered with failed examples of private contractors failing to pick up adequately previously publicly provided services. There is currently no organization in the private sector capable of doing what he CAA can do without being led by and supported by the CAA. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** **Option 1** What are your reasons for this view? Only option 1 maintains the position of the CAA to provide any influence in world aviation. Options 2 and 3 undermine any credibility the CAA might have to be a leading player in aviation medicine and in aviation in general. Be under no illusion the resources that are currently available to the CAA under the current regime either on the payroll or not would dissipate very quickly and once they have gone they would gone for good. No private for profit provider would be able to hold it together. Why have you rejected the other options? **Option 2** throws away decades of investment and knowledge and reduces the CAA to the level of member states with no heritage of aeromedical leadership. Besides which the benchmark should not be set with the inferior member states but with the best outside the EU. **Option 3** is probably the worst option done under a number of seemingly reasonable disguises but aimed at undermining a great institution. EASA would prefer to have a general consensus of mediocrity than be faced with an outstanding institution posing difficult questions for the rest. Hence the spurious quest for best practice, no doubt something defined by EASA. As stated previously the solution is only best practice if all parts are enhanced by the changes. In this case not all parts are enhanced in fact it is quite the reverse so option three fails the test of best practice, it even fails the test of good practice, in simple terms it fails every test other than the alleged saving of £4.3m. Although with extra scrutiny I suspect that whilst the CAA might save £4,3m the industry would have to pay considerably more as a consequence. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** Yes.

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	The CAA might consider setting up a not for profit organization or charitable trust to run the CAA medical services as the service provider with the CAA as the regulator. This would have the benefit of separation of regulation from provision but still retain the provider with the CAA family. It would probably enhance the relationship of all those working towards the aims of the CAA and the leadership in Aeromedical matters. The trust would comprise the main stakeholders including the industry, the aeromedical professionals, the government and others committed to advancement of the aims of the trust. The advantage of this would be the likely retention of all the current players in aeromedicine, the retention of knowledge and skills, and the probability of being able to leverage more money into the organization through strategic partnerships whether they are through providing similar services elsewhere or through funding for research. Crucial to the success of this idea would be taking time to get the governance right. **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?** Firstly, to be successful the CAA needs to protect its staff whatever it chooses to do. Its reputation will be on the line in any transition. In addition to the payroll, it also needs to consider the many hundreds of non-payroll associates who have invested their time and energy and resources into aeromedical science and practice. Any simple dismissal of those associates will do more to undermine the success of whatever option is chosen because they have the ability to just walk away and not come back. Finally the CAA needs to be aware that there could be a lot of pilots like me who could find themselves unable to fly not because of an aeromedical risk but because the rules say so, even if I could continue because of grandfather rights. What the CAA has achieved in many respects is remarkable they need to ensure they don't lose it. Additional comment: I am sorry but the financial information supplied is pathetic. Of interest would be to know precisely how much of the costs attributed to the medical section are direct costs and those which are an allocated share of CAA group overheads. Furthermore, of the share of allocated overheads how much would be saved if the medical role was not a part of the CAA and how much would be retained and reallocated elsewhere for example the costs of the CAA board and executive? Finally what s the CAA's projected cost in providing an oversight function in the proposed new arrangement put forward from the CAA. Without this information it is impossible to make any further informed comment other than that the CAA is not really committed to a real consultation. The paucity of the financial information supplied is just roof of this.
4	For a number of years I have been a UK PPL holder and during the first ten years went along to my AME or Gatwick to have my medical for my PPL

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	and my FISO licence. After I reached 50, it become quite a burden for relatively few flying hours to have to pay around £200 every other year, so I opted for the Medical Declaration, countersigned by a GP. This lasts me 5 years and was an excellent choice. Sadly this has now ended, since I cannot re-validate my SEP with a medical declaration. Nonetheless, I and many of my flying friends found this to be an affordable way to keep flying in what is becoming an outrageously expensive hobby particularly for those of us with fixed incomes. May I ask if the Medical self declaration may be re-opened for us with SEP ratings and Old Style UK PPL(A) (brown licence). The alternatives of a LAPL still require an AME as none of the doctors in my practice are prepared to do LAPL medicals, with its high associated cost. A DVLA type driving medical also costs in excess of a hundred pounds at a doctors. Please re-instate the Self Declaration route for those of us flying in UK airspace, it was an excellent idea, and I heard of no aircraft dropping out of the skies because the pilot was on a self declaration.
5	With regard to the Consultation document as per Subject. I am not only a PPL involved in General Aviation (GA) but also a Health Professional. My comments are primarily relevant to GA. You state that GA fatalities are 10% attributable to Medical Conditions. You have trained and qualified AME's that are particularly looking for medical conditions relevant to aviation. Their failure rate is therefore 10%. Most AME's are GP's who are involved with day to day medicine and are also responsible for assessing whether an individual is capable of driving a car or truck or train. They are in most cases not the individuals GP! I believe that the fatal accidents attributable to other forms of transport is no greater than that for aviation. In France the opinion is that a GP, more specifically an individuals GP is far better placed to assess the medical risk of an individual to operate what is no more than complex machinery. The Organisational Chart you present has evolved over many years to such an extent that your headcount and responsibility of individuals has become unfocused from the real purpose of having a 'Medical' that says an individual is fit to command an aircraft. Yes you need a system of authority and standard setting which of course has now also been a role of EASA. From an outside perspective, commercial aviation obviously carries a considerably higher risk than GA and there is an involvement with the insurance industry in the event of an accident involving an aircraft or human life. It is therefore logical that the insurance industry should step up to the mark on taking some responsibility for the burden on medical fitness in a commercial environment. They already have the infrastructure to assess medical fitness whether it is a simple matter of an individual going on holiday or someone who insures his life in a hazardous occupation. Essentially:

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	1. Remove the medical risk assessment from a bloated organisation to organisations that have responsibility and culpability. 2. Remove AME's generally to enable GP's to assess their own patients as to their fitness to 'fly' as they have a far better knowledge of a patient history. 3. Retain a core base of AME functionality to monitor and if thought valid randomly assess individuals for fitness. 4. Reduce your headcount of ancillary staff that have created an overburdened and high cost organisation that cannot prove it has actually enhanced safety. 5. The liability for fitness to fly assessment has no purpose in an organisation that is not culpable. 6. Think laterally and do not try to evolve the current system. Re-design it from scratch with a blank sheet of paper!

Doctors/Medical Groups

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1	Thank you for the opportunity to comment on CAP 1214 "Consultation on the Future Structure of the CAA's Medical Department." This response from XXXX has been drawn up in consultation with XXXX Financial, Legal, HR and Occupational Health Departments. In response to specific questions: **Q1: "What are your views on the proposition that the CAA ceases to be a service provider, via its AeroMedical Centre (AeMC), that is regulated by the CAA as a competent authority under the EASA rules?"** R: It is felt that the role of regulator and service provider in the one organisation creates an inherent conflict of interest. XXXX therefore supports the proposition that the CAA should cease to be a service provider because this is in keeping with Better Regulation principles. **Q2: "What are your views on the current situation by which the costs of the functions performed by the CAA Medical Department exceed its income?"** R: The mandatory and non-mandatory (as per para. 33 & 34) functions of the CAA Medical Department delivered by the AeroMedical Section (AMS) together with that of the Aviation Health Unit (AHU) and the CAA Occupational Health (OH) unit must be borne by the Industry. The service provided is essential and must be funded. However there are opportunities to seek efficiencies in headcount, procedures and systems and to divest un-necessary tasks to ensure that the Industry gets value for its outlay. Greater transparency of costs will be an important enabler for this (see response to question 3 below). **Q3: "What are you views on the manner in which the costs referred to in Question 2 are currently distributed? How should they be distributed in the future?"** R: The consultation document gives some detail on the funding of the CAA Medical Department and states that the actual cost of the department is £4.3 million. However virtually no detail is given to a breakdown of the actual costs of the department. From the organisational chart it is clear that the vast majority of the cost must related to headcount, but without more information it is difficult to give detailed comment. The future distribution of costs should be incurred by the users of the services as well as those bodies that benefit from the services that will be provided. AeMCs, individual AeroMedical Examiners (AMEs), pilots and ATCOs should pay for their direct costs. However the AOCs, Aerodromes, ANSPs and UK plc all benefit from the safety regulatory advice generated by the AMS and AHU and should continue to contribute to the funding. Currently the General Aviation and sports aviation communities do not contribute to the indirect funding and consideration should be given to them making contributions in future.

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	Q4. "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?" R: Yes absolutely. The CAA medical department has a core of expertise that is in the forefront of developing evidence based regulation. It is very highly regarded worldwide (the CMO at ICAO and interim CMO at EASA are both ex-CAA Medical Department doctors). It is essential that this expertise is maintained and developed to ensure high quality pragmatic regulation is applied for the future. **Q5: "What are your views on each of the options considered in this consultation?"** R: Option 1 is not viable. EASA are not likely to tolerate the national competent and licensing authority also remaining a service provider and hence regulating itself in the longer term. In addition the current Department appears headcount heavy and has a reputation of inefficiencies and of being overly bureaucratic. It appears to be constrained in introducing new IT systems and new procedures of working. Option 2 resolves the issue of the CAA regulating its own AeMC. The comments in this option as stated however are inaccurate. XXXX AeMCs have the option of relatively easy expansion with a relatively short lead in time and already has the advantage of offering its services at 2 separate well established locations. It is unclear why ceasing AMS support function is included in this option as this is a separate issue to the CAA Medical department regulating itself. Option 3 again combines the AeMC and AMS support outsourcing together. This is not necessary. With regard to the AeMC being outsourced it raises several concerns. Would an outsourced AeMC be subject to the same financial rigor as the other UK AeMC (the current CAA AeMC does not charge VAT for its services)? Would an outsourced AeMC be truly independent as it is likely current staff could be TUPE transfers? Would it occupy the same facilities as the current AeMC and therefore still be within the infrastructure of the CAA at Aviation House? **Q6: "Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?"** R: As they stand it is considered that none of the options are wholly acceptable. Option 2 would appear to be the best of the 3. What are the reasons for this view? Option 2 will satisfy the EASA requirement to separate regulation from service provision. It is believed that with sufficient lead in time that current AeMCs could accommodate the demand for initial medicals, and this option would allow new entities to enter a level market place, if they can create a sustainable business case, without an outsourced AeMC having significant unfair commercial advantages. However it is felt that including the ceasing of the AMS support in this option makes it unsuitable as it stands. **"Why have you rejected the other options?"** As previously mentioned Option 1 is likely to be unacceptable to EASA and will maintain the status quo of inefficiency and high cost. Option 3 is likely to lead to an unfair and possibly unlawful competitive advantage being bestowed on the outsourced AeMC by virtue of its

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	provenance. It is assumed that strict financial ring fencing will be applied to the organisation so that it is not cross subsidised or otherwise gaining competitive advantage from synergies associated with sharing overheads with the CAA. However, commercial advantage will still arise from, among other things, its ex-CAA assets such as patient marketing lists, depreciated (and therefore low cost) but still useful medical equipment, IPR, inertia and reputation, such that steps would need to be taken to divest these assets or share them with competitors in order to ensure a level playing field. **Q7: "Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?"** R: It is believed that the mandatory and non-mandatory role of the AMS is vital and should be protected. It is suggested that the core medical team of the AMS should be supplemented by a cadre of specialist advisors to be consulted where specialist advice and opinion is necessary. This service should be based on case notes and not involve seeing and investigating patients (as is the case of the current AeMC consultant advisors). The responsibility of arranging investigations should be through external consultants as arranged by the AMEs and guided by AMS doctors as required. Decision making and medical management on all but the mandated cases should be the responsibility of the AME and they should be allowed to update casework on the AME on Line system for Class 1 pilots and Class 3 ATCOs as they currently do for Class 2 medicals. This will lessen the workload on the AMS staff. The AMS support function should remain in house but be subject to review by business improvement process experts to ensure that IT systems, medical record handling etc. are optimised. XXXX own OHS department went through a similar process in the past leading to significant staff reductions and other efficiencies. This will allow the AMS to retain core knowledge and experience as required whilst reducing staff and associated costs. It is felt that significant savings should be able to be made in this area. The AHU should remain intact. The occupational health provision for CAA Staff should be outsourced to a commercial provider. Again significant savings should be realised. The CAA AeMC should cease trading, once sufficient capacity in the market place is assured. Savings on headcount will be considerable. **Q8: "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?"** R: The CAA must ensure, absolutely, that it retains a core of knowledge and experience within the AMS which will be able to advise and influence at the International, National and Individual level. It must be able to maintain its information and other on-line guidance that is hugely valuable. It must remain the focus of medical advice for AMEs whilst maintaining its oversight and governance of AMEs and AeMCs. The CAA must remember that in securing funding especially from AMEs that any charges levied must not place an excessive financial burden

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	upon them, realising that this is a competitive market both in the UK and throughout Europe (where different medical systems often lead to European medical costs being significantly lower than in UK). Finally the CAA must be aware of the impact this consultation is having on its staff and should consider most carefully how the changes are managed and communicated.
2	Four fifths of fatal aircraft accidents are caused by human error, three fifths by pilot error. Critical task performance is influenced by fatigue and by intercurrent 'illness', much of which is minor, although two thirds of aircrew will be incapacitated at some point in their career. The cost of medical certification is miniscule when set against the overall cost of airline operation. It is incumbent on the regulator to be efficient and keep costs low but this should not be on the basis of wishful thinking in terms of what the private sector could, or should, deliver. "The quality is appreciated long after the price is forgotten "(Sir Henry Royce). **1. Pre-amble – personal** 1. I was Cardiologist to the UK Civil Aviation Authority (CAA) for 38 years, travelling Professor to ICAO and Visiting Professor in Clinical Cardiology at Surrey University. I was High Sheriff of Surrey 2011 – 2012. I am a trustee of Brooklands Museum, Weybridge. 2. I served on the Medical Advisory Committee to the Civil Aviation Authority for 35 years and for 10 years on the Secretary of State's Honorary Advisory Committee on Cardiovascular Fitness to Drive. I also served on the Royal Automobile Club Motor Sports Association Medical Advisory Committee and co-drafted the European and United Kingdom flying and driving licence standards in cardiology. During the drafting of the JAR med I represented the CMO, Dr Geffrey Bennett, at meetings in Paris and Geneva. I am a fellow of the Aerospace Medical Association, an academician of the International Academy of Aviation and Space Medicine and a liveryman of the Honourable Company of Air Pilots (HCAP), having served on the Court thereof. 3. I have over 100 publications with research into the neuro-humoral control of the circulation, mechanisms of angina, heart failure and cardiological issues in aviation safety. I am the author of a number of chapters in cardiological textbooks and wrote the International (ICAO) and European Joint Aviation Authorities (JAA) guidance chapters on cardiology in aviation. I have advised national and international airlines and lectured world-wide, visited ICAO Regional offices and advised governmental agencies on policy development. I proposed, led, chaired, funded, and published two UK and two European workshops in aviation cardiology. These were ground breaking and had several imitators elsewhere including the USA, Canada and Australia. 4. During his period I was a part time cardiologist at St Peters' Hospital, Chertsey, and served on the Council of the British Cardiac Society, and the Scientific and other committees of the European Society of Cardiology. Other committees served were at the Royal College of Physicians of London (RCP) and District and Regional Health Authorities. I twice gave evidence to the RCP committee on

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	cardiological fitness to fly – published in 1978. 5. I am a pilot with 1,100 hours flying experience and twin, night and instrument ratings. Both my sons are pilots. I was appointed OBE in the 2000 New Year Honours' List for Services to the Aviation Industry and awarded the Buchanan Barbour award of the Royal Aeronautical society in 1986 for contribution to aviation safety. 6. This evidence is based on personal experience gained whilst serving the CAA between 1974 until my retirement in December 2012. It is written on the understanding that it will be in the public domain. I intend to refer to it in the concluding chapter of a book nearing completion which covers, inter alia, my time with the Authority. I will also forward it to BALPA, HCAP and the PCSU (Public and Commercial Services Union). **2. Introduction** 1. The CAA had an outstanding reputation for excellence in its early years, notably in engineering, but also in other aspects of aviation regulation. Such was its standing at the time that it insisted upon several modifications to US aircraft before acceptance on the UK register. It also had a profile in aviation medicine in part due to the leadership of the then CMO, XXXXXX. It would be good to maintain and enhance this. 2. I served for forty years as a part time consultant cardiologist to the South West Thames Regional Health Authority as it then was. During that period I weathered (and contributed to) twelve reorganisations including the mis-conceived purchaser-provider split by XXX but missed the more recent and disastrous efforts of XXXX. The turbulence and funding cost of these changes far outweighed any gain. Worse, change fatigue crept in stultifying initiative and demotivating the workforce. Such difficulties may be about to engulf the CAA. 3. Before and immediately after the Second World War responsibility for the initial issue of the Class 1 medical certificate for the Commercial Pilot's Licence (CPL) was vested with the Royal Air Force (RAF). The examinations were carried out at the RAF Central Medical Establishment (CME) at Kelvin House. When (cardiovascular) anomalies needed resolution investigation was either carried out by RAF specialists, or, by various civilian specialists. Follow up CPL examinations were carried out at any RAF station. 4. Medical Examination for the Private Pilot's Licence (PPL) was by a general practitioner. The Civil Aviation Act led to the creation of Authorised Medical Examiners (AMEs) who were separately accredited to carry out examinations for the CPL (Class 1 medical certificate) and the PPL (Class 3 medical certificate). Initially the routine electrocardiograms (ECGs), introduced in 1963/5, and performed on CPL holders, were scrutinised by local cardiologists or physicians. 5. The CAA moved from Shell Mex House to Space House in 1976 and the clinic which replaced RAF CME opened shortly afterwards.

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	Initial issue of the Class 1 medical certificate was transferred to the CAA clinic with follow up there or by CPL accredited AMEs. 6. Following the HS Trident disaster at Staines in 1972 an expert committee suggested that all the CPL ECGs should be read centrally. I was appointed to this task in 1974 and was soon joined by the late Air vice Marshal XXX XXX. The recording fees at that time were retained by the AMEs and interpretation fees forwarded to the CAA together with the recordings. The reading fee has been of the order of £30 and the annual total scrutinised of the order 18,000 recordings. 7. The gross income which used to be generated from this activity was >£500,000 whilst the in-house scrutiny overhead was of the order of £70,000. This was given (with certain exceptions) by the Department as a free good to the AMEs for reasons which have to me, at least, have remained opaque. The consequential financial loss to the CAA was made up by a further charge upon the AMEs which was passed on to the pilot / industry. This additional cost burden on the industry seemed so extraordinary and unnecessary that I made the first of two PIDA (Public Interest Disclosure Act) statements to the board without measurable effect. 8. Now the AeMC stands to be closed partly as a result of budgetary constraint; scope for conspiracy theorists, maybe. 9. The plan for the CAA London clinic included the provision of specialist presence to review aircrew with (cardiological) issues. Initially this involved AvM XXX and myself; later we were joined by others, some from the RAF. Bennett made it a free service to encourage evenness of the standard of specialist judgement and to encourage attendance at the clinic. It was also seen as a potential centre of excellence. Previously advice had been arbitrary and uneven in part because there was no adequate civilian Standard in aviation medicine. Part of my assumed responsibility over the years was to redress this. Eventually the service had to make (below market value) charges but by then the Clinic had established its bona fides in the resolution of difficult regulatory medical issues, and, in the development of Standards. Now the plan is to abandon the centre of excellence and revert to the former inadequate process. 10. The CAA Medical Department contributed significantly to the ICAO effort to raise international standards of aviation medicine (XXX XXX, briefly CMO at the CAA is still Chief of Medicine at ICAO); I represented the UK at ICAO in 1980 as well as acting as travelling Professor to their regional offices. I was also involved with drafting the new ICAO Standard in cardiology and wrote the guidance material for both ICAO and the Joint Aviation Authorities (JAA). The Department led in the development and promulgation of the JAA Standards and later the EASA Standards. Up until a year ago the Clinic had visiting specialists of great experience and many years of collegiate practice. 11. In NHS reorganisations, consultation is normally carried out once policy has been determined; the presumption is that this is the case here. The CAA evidently believes that out there somewhere there will be a better or equivalent, sharper, leaner organisation which will allow it to shed its present responsibility and gain a profitable liaison with the outsider.

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	3. Why is the CAA conducting the review…..? **Cost** 1. **Paragraph 15:** the CAA Medical Departmental budget is given as £4.3 million / year. About one tenth of its budget had been derived from ECG scrutiny until that was repatriated to the AMEs. To put it in perspective the cost of the fuel load on a Boeing 747 is of the order £100,000 – 170 tonnes at about (the cost of Avtur has since fallen) £600 / tonne. So 40 trips in one aeroplane cover the budget of the Department which certificates some 18,000 professional aircrew and ATCOs. And this is only the fuel cost. And it is the pilots who are ultimately responsible for safety. 2. **Paragraphs 16 - 18**: the AeMC charges are absurdly below market rate and the surprise is not that the Department makes a loss but that it does not make a much larger one. Only the echocardiogram fee is in line with prevailing prices - £260 because it is contracted out; the exercise electrocardiogram, Holter ECG and ambulatory monitor all cost about the same in London at £250, not £69 - £95. The current cost, net of any investigation to see a consultant physician in London is at least £200, not £115. Outsourcing will see the immediate adoption of London charges, or more. If these charges were brought into line with the market (as they would be by an external contractor) it is likely that the Clinic deficit would disappear altogether. Rumour control has it that the CAA is not allowed to raise its fees. Who says that and are they serious? The reason should be spelt out and overturned. The budget seems to have been set deliberately low to undermine the department. Or is this lack of competence? The AMS AME charges raise an income of the order £500,000 annually. Had the ECG scrutiny fees been retained there would be no deficit. Who was culpable? **Regulator providing regulated services.** 1. **Paragraphs 19 -21**: the AMS / AeMC division is an (EASA) Chinese wall the sophistry of which seems as inane as the purchaser provider split in the NHS. Initial medical scrutiny of professional pilots has been carried out since 1976 by the CAA; it is a public corporation and the doctors involved have to maintain professional standards. If there is a need for review of its performance under the EASA rules it could be carried by protocol with an external European assessor, or by the RCP. If the CAA Medical Department cannot run a state of the art medical clinic to the highest prescribed medical and regulatory requirements it is unfit for purpose. In view of the investment in training costs of the aircrew involved it is highly desirable that a *non-commercial* properly overseen clinic is involved and supported by a cadre of appropriate specialists. **Safety objective** 1. **Paragraphs 23 - 26:** It is stated that the CAA Medical Department has an over-riding objective to pursue risk reduction of poor

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	aircrew / ATCO performance through medical conditions. This cannot be taken at face value. I am told that against the advice of the British Airline Pilots Association (BALPA) and the Honourable Company of Air Pilots (HCAP), the CAA acquiesced, in the absence of supporting favourable evidence, to flight time limitations being extended by EASA in February of this year. On re-reading the material it is not clear whether this has yet been implemented. 2. At a presentation to the HCAP at CAA House in the summer we learnt from XXX XXX, Director of the Safety and Airspace Regulation Group, that safety was to be reorganised and that there would be a new feature called the "entity". He did not explain the need for this, nor did he identify the units of risk measurement. One point one billion passengers were carried in UK registered large aircraft (>5,700kgs) in the decade 1998 – 2007 (CAP 780; 2008) for the loss of 8 souls in over 25 million hours flown - a fatal accident rate of 0.2 / million hours. Outstandingly good so why the change? 3. In contrast, small (<5,700 kgs) public transport aircraft flew some 415,000 hours over the same period and experienced 13 fatalities. This represents a fatality rate 50% higher over the same time period with < 1/60 of the exposure in flying hours when compared with large aircraft. In the light of the exceptional performance of the airline industry in safety terms it is not easy to see why CAA is reorganising its approach. Maybe this is window dressing as it is seeking to improve on excellence rather than attend to the safety of passengers in smaller aircraft for which it is also responsible although possibly not fully funded. 4. It appears to be of less concern to the Authority that there were 165 lives lost over the 1998 - 2007 review period in non-public transport accidents in the UK during which more than eight million hours were flown. This represents a fatal accident rate of 11.7 / million hours flown. The policy used to be (still is?) to discriminate between big accidents and small accidents in terms of licencing philosophy with increasing deregulation of the latter as they are less newsworthy. Most passengers on an aircraft prefer not to be killed and do not know that the relative risk of being killed in a non-public transport small aircraft accident in the UK is nearly 300 times greater than in a large one at the present time, expressed in exposure / million hours flown. Such an attitude may reflect complacency or indifference and needs to be confronted. Enlightened regulation rather than regulation with a light touch is what is required; bad regulation is easy: good regulation is not. 5. It is stated that the last medical contributory accident was G-ARPI, the Staines HS Trident in 1972. It is not stated that there have been several air taxi level losses over the past 40 years, the most recent, albeit to a private flight in a PA31P registration N95RS in January 2010, was caused by the pilot flying dying of a heart attack shortly after take-off from Kidlington, Oxford. There were potential regulatory issues which may not have come to light. 6. I raised some of the above with Mark Swan at his presentation and also sent an email; there was no response.

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	AMS responsibilities 1. Paragraphs 28 -32: Statement of fact – agreed 2. Paragraphs 33- 34: Non-mandatory function of the AMS. As a regulator it would seem to me that it is part of the AMS function, mandatory or not, to provide an advice service to enhance its mandatory activities. If the CAA wants to continue to be taken seriously on the world stage it has to support these functions **Non-mandatory functions of the AeMC.** 1. The AeMC carries out initial CPL medical examinations and some follow up ones. It also runs a unique clinic where the expertise of visiting specialist advice is available to the AMS. In turn the AMS draws on this expertise to advise the national and Europeans processes. When XXXX set up the clinic in 1976 it was to address the problem of lack of civilian specialists with training in aviation medical problems. At that time the RAF provided some back up but the Service medical side has been reduced to the point where it can no longer offer a meaningful level of input. To believe that such a resource exists in the private sector is illusory. 2. There is lack of understanding of the modus operandi of medicine in its broadest sense. Numerous career choices are open to the new graduate. Some remain actively involved with patients – 'clinicians' - some as generalists (general practitioners – GPs), some as specialists – cardiologists, gastroenterologists, gynaecologists; others become "non-clinicians" with no direct patient involvement such as pathologists and others. None of the doctors directly employed by the CAA are clinicians as they have no responsibility for patients and experience in routine medical examinations is not relevant to decision making in problems at a specialist level. Furthermore, without specialist level input they are not qualified to define the changes needed in medical Standards as medicine, and regulation, move forward. 3. The specialist clinic in the AeMC filled this gap, or did until recently when the specialist input was increasingly ignored. The extraordinary line taken by the CMO with regard to the medical certification of insulin requiring diabetics in the UK creating an infraction of EASA rules was without consulting any of the then visiting consultant physicians (including myself); and we had more collective experience than any in the UK in defining medical regulatory issues. The use of oral anticoagulants has also reached the AMC Guidance Material to PART-MED -AMC1 MED.B.010 (g), possibly on the basis of a single one off recommendation that a pilot with a mechanical valve should be made fit. Again the CAA visiting medical consultants seem not to have consulted. It is not safe that the committee responsible for EASA rules consists of non-clinicians who are advised only remotely, if at all, by specialists.

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4. Thirty years ago the UK CAA was world class and stood alongside the USA, Canada, France, Australia and France. Not anymore. Now it is part of the EU and EASA. A change to remove and contract out the AeMC is not in the interest of good science or good practice, nor, I believe of the CAA itself. If dumbing down is the objective in order to save a small amount of money to cover the consequences of a deliberate or accidental misjudgement, this policy is the right one to adopt.
The CAA's current thinking and core criteria for assessing options
Paragraph 42 (1): supported unequivocally
1. Influencing policy.
The CAA was (should be) a world leader in medical regulation if for no better reason than it is a world leader and major player in aviation. It is important that its medical services remain an entity in itself rather than a broker of bought in services over which it can have little control. As an entity it should seek international partnerships which as a fragment it cannot.
2. Perform regulatory duties….:
This paragraph is difficult to understand but appears to draw attention to the diversity of medical problems and the need to deal with them fairly, safely and scientifically. This cannot be achieved by a department staffed by non-clinical doctors, even in association with an (outsourced) AeMC unless there are properly qualified consultants attending the latter.
Oversight of the AMEs was criticised during the EASA UK MEST visit (July 2013). In two PIDA statements I have expressed concern that the performance of certain AMEs was allowed to fall short of what was required of them.
Achieve financial sustainability
1. The Medical Department adopted two policies which were financially suicidal (repatriation of ECG reading fees to the AMEs and refusal to charge a market rate for its clinical services). This has added to cost for the industry. Contracting out will further increase industry costs with the introduction of the profit component, fees will rise to a market rate and above in what will be essentially a monopoly position.
2. The creation of further AeMCs to pursue the market will dilute expertise. At present AMEs are grossly overpaid for reading the 'normal' computer report on the ECGs they produce. Mechanisms for clawing this back at least in part should be sought.
Summary of issues
1. Outsourcing is the domain of those unwilling or unable to function for themselves. That surely does not include the CAA?
2. From the employee point of view the sickness performance of the CAA is characteristic of a governmental agency in that it is worse by a factor of at least two than the private sector but better than some others. If there is a medical clinic it is sensible that there is an
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	occupational health presence there as this deals more efficiently with employment related health issues. It can also be marketed. **View on options** ▪ **Option 1 - no change** Always first and often unacceptable. Change in the Medical Department is needed to increase efficiency – the response time to correspondence has been lamentable and some of the decision making poor and unsupportable. If the market rate is not charged for its services it will make a loss. It is silly to strip out the amortisation cost of medical equipment and technician time and arrive at a wholly different investigational cost to that expressed in the market place. Hospital clinics operate without hands on regulation and a state of the art clinic run as the AeMC would be a beacon showing just how well it can be done. EASA requirements could be protocol set and externally audited. The collegiate expertise of the clinic is a great asset. Growth and leverage will come from a robust base, not an atrophied one. The CAA has the potential to lead Europe. Carpe diem. ▪ **Option 2 – cease all non-mandatory functions** The provider / regulator split has been covered in option 1, above. There are no appropriate AeMCs out there at present and outsourcing would substantially weaken what would be left of the AMS. The opportunity would be likely to be high-jacked by some private clinic motivated by profit alone. It would cut across other objectives including the responsibility of the AMS in making difficult specialist regulatory decisions. Specialist physician training and available expertise would be lost. The CAA might reduce its own costs by shedding the AeMC as many of its charges are too low. Not all comparable Authorities are on a cost recovery basis. The give-away to the AMEs was extraordinary and needs to be reconsidered. ▪ **Option 3 – outsourcing.** Paragraph 50 is written as if the CAA has no skill base and no ideas. The obsession with the non-problem of the AeMC being regulated by the AMS is revisited. There is no market out there so there will no competition and profits will rise at the expense of the industry. If the CAA is capable of running a tight ship, which it used to be, that will be most efficient means of containing costs. Paragraph 51 -if the CAA medical presence is reduced to a rump it will not have the skills or capability to give to an external provider. Influence is not born of reduced core mass as our armed services are demonstrating to their cost. Paragraph 52 – Staff disruption will cost and have to be kept in the equation. **Answers to questions** 1. If the CAA is to retain a substantial influence in Europe and the wider world it should have a demonstrable presence which includes an AeMC as have some other European states. The AeMC with its attached and advising consultants is an entity which educates the

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	AMS and facilitates good decision making and policy development. There is scope for significant improvement at little or no cost 2. The CAA Medical Department gave away a significant part of its budget and it would probably be difficult to recover this. If it believes in the market place it is common sense that it charges a market rate for its services in the AeMC. If it did so it would almost certainly be in profit. To refuse to permit charges which match the market, create a loss and then wind it up sounds like sabotage. The present difficulty has arisen from ancient policy that the CAA may not raise its charges by more than inflation. It should identify the historic problem and rectify it. 3. It is very much in the interest of the industry that the CAA continues in its role of aeromedical policy and practice development. In the mid 1970's the professional licence attrition rate from cardiovascular cause was 4.6 / thousand licence holders / year. Now it is of the order 0.08 which is a substantial saving in terms of retention of strategic personnel. There are a number of reasons for this but at least part of the story is due to work in progress on complex issues in cardiology in the context of flying. 4. I support option 1 but modified by a thorough audit and significant improvement in the performance of the Medical Department. At present some of it is barely fit for purpose – response times to correspondence, variability of the decision making process, inadequate supervision of AMEs. 5. I believe Option 1 preserves core mass and provides an environment for education, change management and development which should be of value to the Board. Pilots fly the airplanes that the whole edifice exists to regulate. It may not be CAA policy but I feel we should maintain our European and International stance as we have so much to offer. We cannot do this without clinical and specialist input. The CAA would lose control if it outsourced the AeMC and that would be an abandonment of its responsibilities. It is fanciful that it could contribute usefully and profitably to an external AeMC. 6. Bearing in mind the constraints of EASA the CAA should seek to change the means whereby the sub-sectorial committees develop Standards. At present there is little or no specialist representation or involvement; this unsound, unprofessional and potentially dangerous. 7. The core criteria should be implemented by good leadership and rigorous application of the existing arrangement. 8. I believe that the risks are insurmountable if the Medical Department is to be split up. It has been denied the wherewithal (market place fee structure and its own action with regard to ECG scrutiny fees) to be self-sustaining and corrective action needs to be taken. There needs to be a thorough revision of its working practices with proper definition of the limits of individual responsibility and identification of the boundaries of professional relationships. Its governance needs a thorough review. **In conclusion**

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<tr><td></td><td>The present structure with an in house (though not necessarily contiguous) CAA based AMS / AeMC should continue. The reasons include:
The Medical Department has been, and still could be a centre of excellence; it should nevertheless be lean and efficient.
Belief in the market place is an article of faith but it is usually costly, inefficient and in health, often rigged.
The Departmental budget is a minute part of the overall cost of the aviation industry but holds the responsibility for the health of the pilots who fly the aircraft and are directly responsible their safety.
The present appeals procedure is faulty and the pilots need to be protected from sub-optimal advice as a result of the new adversarial approach. Contracting out will worsen the situation.
The Department gave away 10% of its budget and still insists on undercharging the market rate for the services it provides. Correction of this is preferable to sheading responsibility and contracting out (i.e. get real).
The concern about the AMS regulating the AeMC is specious. There are numerous differences around Europe and EASA should be told that this is the way (external audit by an EASA or RCP delegate) that the UK will fulfil its obligations.
The AMS function, unsupported by an AeMC in house will contain a few non-clinical doctors who will be in no position to make difficult regulatory decisions in the absence of specialist advice and will have to resort to external opinions. This failed in the past and there is little reason to believe that it would not fail in the future.
The core mass of the expertise of the Department, built up over a generation, has been of great value to aviation safety, nationally and worldwide. Maybe, in keeping with our diminished world status, the CAA is right to wind its neck in as it seems to be running out of leadership and ideas.
The Medical Department may need a maroon under it along with much of the organisation but that should not blow away the AeMC. As a nation we are doubtful of experts and doctors may not seem to fit easily into the scheme of things. Distancing itself from specialist medical advice in personnel licencing in my opinion reflects no credit on the CAA. The bath water may be in need of a change but that is no reason to get rid of the baby.</td></tr>
<tr><td>3</td><td>Information gathering
XXXX comprises 15 CAA (UK) Approved Medical Examiners who work and reside in XXXX.
The Chairman and the Honorary Secretary have sought views by 'phone, e-mail, post, and by personal contact.
Six took part in an all day meeting.
Aviation Medicine experience in XXXX
Twelve Members have given details of their years of service. (See separate page on Credentials and Experience) This ranges from 1 to 49 years,</td></tr>
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	with a mean of 22 years. Five also have military aircrew medical examination experience having served in the RAF, RNR, RAuxAF, RCAF, and the Egyptian Air Force. One has a BSc Hons in aeronautical engineering and is an aircraft builder. One was awarded MBE for years of rescue work with HM Coastguard. Several have extensive experience as pilots in civilian and military aircraft. **General opinion** XXXX is disappointed by the lack of business information, definitions and detail in CAP1214 or after direct requests to the CAA. Fuller explanations of the need for this exercise and of the changes envisaged could have been given. The terms, "mandatory" and "non-mandatory" require amplification as items so labeled might also be classified as essential. The Medical Department is an effective organization with many functions, including regulating aircrew medical certification in the UK. Relationships between AMEs and the Medical Department have always been admirable – more cordial than in some other European states. This relationship assisted management of the medical aspects of the massive development of civil aviation in the last 30 years. It is difficult to imagine division of the Medical Department which is working well. Separation of AMS and AeMC is being floated on a conjecture that there could be adverse consequences of cohabitation. The AMS and the AeMC should continue to function closely to form a model working arrangement – a centre of excellence. Separation would cause inconvenience, at least. Outsourcing any part of the Medical Department would remove essential functions, weakening the ability to respond to or promote future regulatory changes. To continue to be a force in international aviation, the most compact and comprehensive Department should be retained. Fragmentation will introduce inefficiency as work which should be integrated will be on at least two sites – never helpful. If there is a £3 million shortfall in funding, there is no information in CAP1214 about how this arises, how it is accounted for or how it may be rectified. If the Medical Department is to achieve its purposes and have continuing impact, internationally, appointments should be sufficiently valuable to retain top quality staff. Outsourcing could shift small amounts from the balance sheet (not provided in CAP1214 or in CAA's Annual Report) but consumers/service users would probably be no better off as fees would still have to be paid to whomsoever. The CAA's Annual Report does not have any information about the Medical Department but it records a profit for the parent Safety Regulation Group. Could the Medical Department's funding be presented and its origins shown? Without this information, it is not possible to understand a need for change. **Consultation questions** **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 compenent authority under EASA rules?**

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	CAA should be a service provider. The aviation medical examination is a core function. Initial Class One and Euro Class Three examinations should not be contracted out. These examinations use techniques and advanced equipment available only in prime centres. Revalidation and renewal medicals are, at present, "contracted out" to AMEs who have been appointed on the strength of their interest, experience and qualifications. There is adequate and convenient provision for the needs of clients. Contracting out to other agencies could jeopardize the safety of specialist aviation medical decisions and could have liability consequences. EASA's rules were created with the advent of EASA. The rule that AMS and AeMC should be separate should be examined to see whether there has been any adverse consequence of the two being on the same site in this or other nations. Their separation would lead to inefficiency and could not be done without expense. Regulation of AeMC by AMS should ensure quality as valuable interactions would promote good management. It is difficult to imagine what disadvantages would follow if the two remained on the same site. AeMC staff experience should be shared with AMS staff. Before EASA, the UK CAA always had the functions of the two entities working together without AMS/AeMC artificial distinctions. There is some confusion in the staffing structure given in CAP1214 as there are advisory functions in both areas. Sharp distinctions seem to be undesirable. AMS and AeMC staff should rotate to promote good relations and to maintain expertise across the Department. Training of CAA staff and AMEs would be assisted by cohabitation. **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?** Why do the costs exceed the income? There is insufficient business information and no financial justification on which to base an opinion. There are 44 staff appointments listed in CAP1214 but there are additional appointments, not shown – CMO's PA, clinical specialists – which will be in the wages total. CAA's Annual Report, CAA 2014, p107 gives an average employee cost of £81,330 for 2013-14. This, applied to the Medical Department's structure, does not give a good fit but shows that, as expected, the main cost of the Department is the cost of staff. No business plan, annual report or balance sheet has been provided. CAP1214 states that the cost of the Department for 2013-14 was £4.3 million and that the income declared was £1.2 million. The deficit is presumed to have been made good from CAA's income from the Department for Transport, HM Government, AOC Holders, and navigation services providers. AMEs, independent by conditions of service, do not cost the Department much. There should be CAA expenses for providing training for AMEs – an EASA mandatory function. Unless a change comes in medical certification requirements, the same work will need to be done in-house in the AeMC, by AMEs or outsourced. Retention by CAA of as many medicals as possible should be the aim, to maintain a centre of excellence.

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	Fees charged by the CAA could be substantially increased to equate with private medical fees for specialist services. Presently, some major aviation employers attempt to control AMEs' fees by using CAA's tariff as the industry standard. AMEs have to abide by HMRC rules on setting their fees independently. CAP1214, p38, mentions occupational health services. It is doubted whether these need to be on the Medical Department's budget... **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 future?** There is insufficient information to allow useful answers. The only financial points in CAP1214 are the £4.3m cost and the £1.2m income. It is usual to have functions cover their costs. If the only realizable products are the medical certificates, quadrupling the charges would fill the gap. This would put the average price of an annual medical near £1,000.00p! Other products of the Department are Guidance Documents which could be made chargeable. These have been carefully prepared and are regularly updated. They would be of use to other nations and institutions. They could be marketed individually or in book form as a medical manual. Statistics and research may have income possibilities if government, manufacturers and legal offices request data. Government requests have to be answered but there should be cost implications when staff are diverted to complete responses (as with all of the above). There is a government grant to CAA (£1,734,000.00p for 2013), a proportion of which might be due to the Medical Department. At present, the staff of the Medical Department is insufficient to complete all of the work comfortably. In CAA's Annual Report (pp105, 106) the Safety Regulation Group (which includes the Medical Department) had, for 2013, a total revenue of £59,858,000.00p with a profit of £12,747,000.00p. The Medical Department oversees medical certification for 16,000 commercial and 30,000 private pilots (CAA PN6014). Acme does 2,000 – 2,500 pilots' medicals, per annum, netting £700,000.00p. Approximately 10% of an AME's charge is paid to CAA, bringing £500,000.00p. These activities could possibly stand increases but not enough to cover the income gap unless the CAA's charges were to be increased to equate to private medical fees. AOC Holders might be able to stand reasonable increases in charges. **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?** Totally. CAA should continue to strive to promote the Medical Department as an internationally respected prime mover.

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	CAA must seek and retain the highest caliber staff – and enough of them. The Aero Medical Advisers are of inestimable worth. CAA should develop profitable links with aircraft and equipment manufacturers. In the development of policy and medical standards, the Medical Department has always been a world leader. There have been many changes from the military origins of medical certification and many innovations have been made: Discarding photic stimulation and EEG testing of initial Class One applicants. Colour vision assessment and diagnosis test (CAD). Realistic exemption/flexibility policies. Disabled applicant policies. Managed policies for diabetic pilots. Policies for pilots who have been prescribed anti-depressants. **5. What are your views on each of the options considered in this consultation?** Option One is the status quo. There is not much wrong with the way we presently work, apart from the reality of the funding gap which could be, partly, relieved by increasing CAA's fees. There does not seem to be any inappropriate work at Gatwick but further experienced staff would ease the throughput of case work and the timeous resolution of contentious situations. No disadvantage is seen in retaining the AMS and AeMC together but we suggest that there are advantages in the convenience of close association and the sharing of facilities. XXXX strongly supports the status quo with appropriate financial management. "Outsourcing" is neither defined nor described. It is not clear what might be outsourced or with what benefit. A risk would be loss of control of an essential, core function with the need for expensive oversight provision. **6. Which of the options outlined should caa prefer for the future of the medical department ? What are your reasons? Why have you rejected them?** Option One The Medical Department of the CAA is an envied, successful, established entity. It should be maintained and improved by staff augmentation and computer system development. Among authorities commanding such reverence are the FAA (USA) with much smoother computer on-line facilities and a vastly greater number of pilots, and Transport Canada which does not have an on-line data entry system for AMEs. NB In Option One, para 47 seems illogical. The AMS/AeMC matter is not seen as an issue. They should be on the same site. Having them

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	together would enhance the capability of a centre of excellence to influence policy. **Why have you rejected other options?** Option Two The division of tasks into, "mandatory" and "non-mandatory" is unsound. Some items listed as, "non-mandatory" are essential functions which can not be separated from other functions. For example: AMS non-mandatory – advisory service to applicants and license holders ▪ contributing to rule making ▪ managing AME-on-line AeMC non-mandatory - Initial Class One and some revalidation medicals ▪ specialist services (cardiologists, psychiatry, etc) How could these be accomplished outside a compact Medical Department? Fragmentation would bring inefficiency and likely lead to more referrals to the currently overstretched AMS and Medical Assessors. Our opinion is that the key to retention of the functions of this renowned Department is the preservation of a compact unity. If the above functions were to be outsourced, who could take them on? Option Three EASA should reassess the need to separate AMS and AeMC units. Separation is not necessary. Few EASA states enjoy the good relations we have between AMEs and the Medical Department. It would be retrograde to have AMEs calling to different locations. Separation of functions would be confusing, disruptive and unnecessary. How outsourcing could be achieved is difficult to imagine. Aviation Medicine is a specialty recognized by the College of Occupational Medicine. Where would experienced, qualified doctors emerge from? No business case has been presented for this option – no Departmental Report, no accounts. **7. Are there alternative options that meet the CAA's core criteria and which you think the CAA should consider?** The Medical Department, comprising AMS and AeMC should remain much as it is: there is little wrong with its efficiency and effectiveness. Why change it? Staff augmentation should be considered (Aero Medical Advisers and Medical Staff) to facilitate case completion and to allow for thought and research.

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	In spite of many requests to the Finance and Medical Departments of the CAA, no detailed, audited accounts or performance reports have been released. This impairs suggestions for budget improvements. Funds are disbursed to the CAA by HM Government and the Department for Transport but the portions due to the Medical Department have not been declared. These should stand against running costs and requirements to provide researched answers. The CAA's contracts department should evaluate opportunities for exploiting the potential of Intellectual Property (Guidance Material, Protocols, Forms). Some of these items could be brought together and supplemented to make a medical manual. There is also commercial potential in responding to requests from manufacturers and the aviation industry. The core function of Medical Certification should be re-priced to align with private specialist medical fees. In-house medical specialists' consultations should be charged for. Air Operator Certificate holders and Air Navigation Service Providers who rely on the safety given by the overall medical service could have their charges increased. The above is summarized: 1. Declare funds available to the Medical Department from HM Govt and DfT. 2. Realisation of IP potential 3. Increase CAA's fees for medical examination 4. Charge for in-house medical specialists' services. 5. Remove occupational health from the Med Dept's budget. 6. Charge for researched answers to HM Govt, manufacturers, etc. 7. AOC holders and Air Nav Service Providers charges might be increased. **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?** The main purpose of medical certification is the management of risk. There should be a comprehensive approach to the maintenance of the quality of the service and the meaning of corporate responsibility. All AMEs have to have medical defence insurance cover. This should be enough for their own actions but responsibility extends to the interface with specialists by referrals and the decisions of CAA Medical Assessors. The present arrangements provide a safety back-stop for AMEs from CAA medical experts. The safety net might have a wider mesh if "opted out". Continuity of service provision will have to be ensured with retention of experienced staff. If outsourcing is implemented, transfer of key staff, such as the Aero Medical Advisers, to new employers would have to

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	follow. In any future system for medical certification, replacement of the on-line computer facilities should be a prerequisite. There are too many faults in the present computer provisions but these will be the subjects of a separate communication to the Chief Medical Officer and Chief Executive. Consultation with all users would be essential. Functionality, speed, reliability, and coding facilities require attention. For any revision of the computer systems, there will have to be realistic training of all users. It is realized that replacement would be expensive.
4	These comments are based on my experience as a Consultant Cardiology Advisor to the CAA Medical Department over the last 15 years. They address the questions raised in the Consultation document with specific reference to the Cardiology Services. **Costs** At present the AeMC significantly undercharges for the Cardiology services it offers. All consultation and test fee are considerably lower (sometimes by a factor of 50%) than those charged in the open market. The Medical Department could significantly increase its revenue by abolishing its restricted charges policy and bill at the market rate. This will undoubtedly happen, in any event, if the service is outsourced. **Conflict of Interest** At present, the Consultant Advisors in Cardiology and other specialties offer an independent informed view on a pilot's fitness to fly, unbiased by any pecuniary or other confounding interest. If the work of the AeMC is outsourced, then almost certainly, this view will be sought from the pilot's treating Private Cardiologist. With the best will in the world, this will place the Cardiologist in a very compromised position. A significant conflict of interest immediately arises between a treating clinician's role as a patient's advocate and the provision of a regulatory opinion on their fitness to fly as a pilot within the strict regulatory framework. This is particularly difficult where the Cardiologist has performed a procedure where either the result of the procedure or other concomitant disease may not have given the hoped for outcome and the pilot's livelihood is at risk. This level of conflict of interest is an order of magnitude greater than that which applies under the current system. **Influence in international policy making** At the present time the CAA Medical Department has a preeminent role in policy making within Europe and has significant indirect influence on Aeromedical policy making not only in the English speaking world but beyond. For cardiology the current EASA rules are based largely on the original work of Professor XXXX XXXX a long time CAA Consultant Cardiology Advisor. Outsourcing the work of the AeMC will result in a major loss of expertise. Other Aeromedical Authorities will continue to look to the CAA for guidance initially, until they realise that this valuable expertise is no longer available. In time the hard won international reputation of the CAA Medical Division will be lost.

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	Flight Safety In standard clinical Cardiology practice it is accepted that the annual serious cardiac event rate in most patients will exceed 1%, sometimes by a wide margin. In Aeromedical practice the maximum acceptable annual risk of incapacitation is set at 1%. Delivering this more stringent standard in Aeromedical practice requires a subtle but difficult recalibration for the Cardiologist. If cardiac assessments are transferred to Cardiologists without aeromedical expertise there will be a gradual drift in standards towards those used in clinical practice. This will inevitably lead to higher rates of cardiac incapacitation in pilots, which has the potential to seriously compromise flight safety. **Recommendation** For the above reasons the CAA should, in my opinion, decide on Option 1 i.e. to maintain the current structures and activities of the Medical Department but adopt a more realistic and business like fee structure, particularly for the AeMC. The other proposed options involve dismantling a Medical Department with a high international standing while providing no discernable benefits to flight safety.
5	Thank you for the very brief analysis of the income and costs of the Medical Division. This is not the sort of financial analysis any of us across the Industry had in mind. What is required is a complete breakdown of the costs and income. A structural layout of staff and their costs, what is the Dept.'s annual rent of CAA House or what is its proportion of such costs; heat, light, water, printing, IT, telephones, etc. I have mentioned only a few of the accountable items. The Canteen is subsidised to all CAA staff, so there is a cost benefit to the medical staff, how much? This will need to be an add on if outsourced etc. There are a lot of fulltime/part time medical and ancillary staff, exactly how many and what are their costs/wages/pensions. A schematic diagram is needed showing all staff and their position within the Division/Dept. from the CMO downwards. How much is the pension's bill. Where will the money come from for already awarded pensions? If the Dept. is franchised or outsourced, who and what will be left in a reduced Medical Division/Dept.? How much will that cost the Industry? None of us can apply any sort of professional financial analysis without seeing a total breakdown of the costs. We are all aware that if outsourced it will cost the Industry more money than it does now. Some of us know already how much it will generally cost to outsource. We need to prove that the costs will be lower to maintain the status quo, with perhaps enhanced income from other sources. How is the income divided across all medical depts.? Where exactly is the income derived from? Will any of this income be available to an outsourced agency? A lot more detailed information is required if there is to a proper financial consultative process. Is there an annual balance sheet for the medical dept.? The information given so far is meaningless, as it has no substance.

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6	In response to the request for submissions to the consultation process on the future of medical services at the CAA, we would like to make some observations about the provision of consultant cardiology expertise and the dangers of outsourcing vital highly skilled services. There are a great number of strengths in the provision of highly specialised senior cardiological skills at the CAA itself. The five consultant cardiologists working at the CAA are all senior consultants with a great deal of specialist cardiological expertise but also with a great deal of understanding of the aviation medical issues that affect pilots and flight crew as well as the licensing and infrastructural issues which are so important. This concentration of experience allows for timely and expert opinion that would be lost if this important task were to be delegated out to general non-aviation trained cardiologists around the country – some of who would be dealing with cases infrequently and with no training or understanding of the specialist issues pertaining to aviation. The main issues reflect problems with the core tenet of good medical practice that is clinical governance and can be summarised under the headings of the pillars of governance. **Education and Training** All of the current CAA consultants have a specific interest in aviation cardiology which would not be the case if there was outsourcing. All have now worked at the CAA for over 2 years with a great deal of experience in aviation cardiology and a high volume caseload with many hundreds of pilots having been seen. There is important understanding of the workings of the CAA and the medical implications for licensing. **Clinical Effectiveness** There are many facets of the current centralised system that allow for a high quality and clinically effective service which would be lost if this were disbanded. The specific fact of seeing a pilot as a CAA advisor rather than as their own cardiologist allows for a fairer and more balanced and independent opinion without the risks of partiality or bias. It removes the possibilities of pressure from the pilots or from industry. The ability to have face to face discussions with consultant colleagues and with other members of the Authority Medical Section allows for a timely and comprehensive review that would give a much inferior quality of service were it to be lost. Similarly, the ability to review the PIMS MARS system, old records (cardiological and non-cardiological) and investigations such as ECGs allows accurate focussing of pilots medical issues and also prevents over investigation and exploitation. It also allows safer and higher quality medical care. It is undoubted that providing services to pilots via deregulated general consultant cardiologist would increase the cost burdens on the pilots themselves as private costs are approximately double those at the CAA. There would be scope to increase the charges paid by pilots as these are currently below market rates. There would also be a decrease in flexibility to the pilots as well as making it more difficult for them to seek specialist aviation speciality help possibly increasing delays and decreasing their availability for flying. Provision of clinical governance through the established forum would also be lost and there would be no way of quality assurance of the aviation work

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	of untrained practitioners. There also may be medico –legal issues regarding the provision of specialist advice by non-specialists. At the moment there is a dynamic and valuable synergy between to AMS and the AeMC. This risks being lost to the very major detriment of the pilots and the standard of aviation medical care offered by the CAA and delivered in the UK. **Risk Management** There is good comprehension of the importance of risk and of concepts such as the 1% rule and of how this applies with different cardiological conditions. There is familiarity with the background and implementation of the flow charts and accurate risk assessment and management could not be guaranteed in the event of disbanding the current service. **Clinical Audit / Research and Development** The provision of specialist services via the CAA allows for audit of quality of care which would not otherwise be possible. Similarly it facilitates the possibility for independent and collaborative research which would be extinguished. Currently the CAA medical department also provides an international profile for the CAA with many pilots using it for their aviation medical needs and for appointments as well as the facilities such as ECG over-reading. Any downscaling of current practice would effectively lose this valuable benefit and would serve to make the CAA less of a perceived major hub in the aviation world. In summary, we feel that changing the current situation of provision of advice by a small number of highly skilled senior trained experts would be transforming a service of excellence into a much inferior service in terms of quality of care, fairness, timeliness, safety and accountability and should not happen.
7	I am writing as a consultant in XXXX to the CAA. I have held a clinic at Aviation House since 2002, before that and from about 1996 I assessed pilots for the CAA at one of my NHS offices. I occasionally assess pilots at home when my clinic is full several weeks ahead. I therefore have considerable experience both doing assessment at Aviation House and in other places, which is where assessments would have to take place if the aviation medicine clinics were to close. The advantage of holding my XXXX clinics at Aviation House is that other medical staff are available both to discuss the cases and who are able, if appropriate, to make a temporarily unfit pilot fit. Making a pilot fit would involve a delay if I saw the pilot at another location, had to get a report typed and sent to the CAA and approved by the CAA doctor, who may have questions, issues, he/she wanted to discuss with me. There are overlaps in specialities, for example stress can cause symptoms like cardiac symptoms and cardiac problems can cause stress. Dr XXXX is usually doing a clinic the same day as mine and we are able to discuss these crossover cases. The Aeromedical Centre is making a loss. The pilots I see are charged £115 for a consultation which lasts between 45 minutes and one hour. I do not do private practice but I suspect that such a consultation would cost 2 or 3 times as much. As an example, XXXX consulted a neurologist privately in

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<tr><th>No.</th><th>Comments</th></tr>
<tr><td></td><td>Brighton a few months ago for XXXX, the consultation lasted 20 to 30 minutes with no investigations and the fee was £270. Maybe the CAA should raise its fee.
My own speciality, XXXX, involves no specialist equipment, just a room and dictating machine, so no expensive equipment to provide and maintain. Maybe this is an argument to keep the XXXX clinics which I and Dr XXXX and Prof. XXXX do.
Your consultation argues for the separation of regulator and service provider but I wonder how well the service provider would be monitored if the provision was outside the CAA.</td></tr>
<tr><td>8</td><td>The great strength of the system we have in the UK for aeromedical examinations is it's responsiveness to our pilot's needs. This seems to contrast markedly with arrangements in other European states; French pilots in particular say how client friendly our system is.
For the AME network to function satisfactorily and safely we need the backup of our skilled and very supportive colleagues in the CAA. I cannot see how this could be replicated in a safe or efficient way with an arrangement that subcontracted this function. To try to do so would threaten the service that our pilots (and the aviation industry generally) has come to rely upon.
I urge very strongly that Option One be adopted.</td></tr>
<tr><td>9</td><td>Our response is below. It was drafted by the committee of the XXXX and sent to each individual member for comment (total 162). No adverse comments were received. Many comments expressing support for the response were received.
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?
Aviation Medicine is an integral part of flight safety, with the human forming an essential component of the overall flight system. Regulation of the AeMC by the competent authority has ensured continuation in the UK of the internationally recognised highest standards of human aspects of flight safety. This option would have a devastating effect upon the support that is provided to Aeromedical Examiners in the UK, and the leadership and influence of the UK CAA in aeromedical matters both in Europe and the rest of the world. It would send a very dangerous message that the CAA is more interested in saving money, than it is in flight safety. It is difficult to understand how the CAA would meet its statutory oversight functions.
The CAA benefits from a 'critical mass' of medical expertise as a result of its service provider role and statutory regulatory role. There is mutual benefit from the dual provision and co-location, and if there is any evidence of the theoretical or perceived risks of inappropriate collusion, examples should be provided.
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?</td></tr>
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	The paucity of information provided in the consultation document makes it difficult to understand or support this statement. A full financial analysis would need to be provided to ensure that only costs which are exclusively incurred by the Medical Department have been counted. Specifically, the lack of any estimate in the document of the cost of the UK CAA meeting its statutory obligations, make the whole process a flawed one. We believe that, on this point at least, any outcome, except the status quo, is open to legal challenge. **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?** In principle costs should be incurred by those who receive or benefit from a service. Whilst it may be simple to identify those who receive a service, the concept of those who benefit is more difficult. The CAA medical department makes a valuable contribution to global flight safety through its European and worldwide reputation. It contributes to the knowledge base of aerospace medicine in ways that are difficult to quantify in financial terms. The importance of influence is acknowledged in the document but no attempt is made to ascribe a financial value to it. On these grounds it is reasonable that there is an element of general financial support from the aviation industry as they, and the travelling public are beneficiaries. Significant taxes are levied upon air passengers, and in view of the large passenger numbers it would require only an insignificant increase to resolve the perceived financial shortfall for medical services. **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?** This is essential. The CAA medical department has historically been recognised as leading pragmatic aeromedical opinion, particularly in Europe. It supports evidence based decisions, and actively contributes to the evidence base. Flight safety has benefited from evolution of standards which have ensured the continuing certification of many experienced licence holders. This stance does not always make friends in some member states, some of whom are more comfortable with a less flexible, entirely rules-based approach, often to the disadvantage of the individual pilot or controller. Without this influence the balance would tip in this direction very rapidly. **5. What are your views on each of the options considered in this consultation?** It appears that the document is biased towards option three, as this is the only option that it is considered will balance the budget. It is very hard to understand how an outsourced private provider, with a need to make profits, could reduce costs. An outsourced private provider would have no interest or incentive in leading the continuing evolution of licence medical standards, for the benefit of the industry. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** The CAA should prefer option one. **What are your reasons for this view?**

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	This would maintain the CAA position as a leader in aeromedical matters in Europe and the world. The CAA needs to explain the statement in 47 that this would not contribute to influence. The reality is that option 3, outsourcing, would reduce its influence, as reputations built up over years if not decades, would be difficult to replicate by a private provider. At best, such a reputation and influence would take many years to be re-established. **Why have you rejected the other options?** **Option 2**, ceasing all non-mandatory functions would destroy the UK CAA reputation, bringing the UK to the level of other member states who do not have the rich heritage of aerospace medical expertise that we, as a country, have invested in, and built up, over decades for the benefit of flight safety. XXXX represents a great many professionals with vast experience and the highest ethical standards; they care passionately about the quality of their work in maintaining aircrew health and flight safety. It is likely that many AMEs would feel obliged to withdraw from participating in a service that they might perceive to have lost its moral compass and sacrificed its ethical standards. **Option 3**. This option is likely to cause disruption in the short and medium term, and loss of reputation and influence in the medium to long term. It can be assumed that this would be the desired option of EASA; it meets their flawed perception of the desirability of the separation of functions, which fail to acknowledge that the services are provided by ethical professionals who are well aware of the boundaries of their different roles. Certain other member states will applaud the change, as there will be a loss of influence and leadership from which the UK CAA may never recover. Aeromedical expertise in the UK is in short supply, particularly at senior level. It is unclear where the CAA believes it will find sufficient expertise, of appropriate quality, in an outsourced provider. Change should not be driven by the envy of others. We believe that the CAA is exhibiting the classic trait of knowing the cost of everything but the value of nothing. **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** The CAA should maintain its current pattern of provision. It should celebrate the high quality and global reputation of its medical services, and not apologise for them. It should seek to maintain its level of investment in the service on the grounds that it is of benefit to overall flight safety. The CAA should consider the revenue raising opportunities that could arise from appropriate marketing of various policies and procedure pioneered by the medical department. For example the comprehensive guidance material produced in response to EASA Part Med is freely available to other member states via the website. This is inappropriate, and should be charged for. **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**

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	services? The CAA should pay attention to the rights and welfare of individual staff members if Options 2 or 3 are pursued. Morale is already at rock bottom, and this could have adverse effects on efficiency and consistency, particularly if there is a long period of uncertainty. The CAA must be mindful of the reputational risk that could arise from the loss of the current medical expertise. The XXXX is particularly concerned about the real risk of loss of support to its AMEs in complex medical cases. This could result in pilots being declared unfit because of lack of adequate decision making support from the CAA medical services, which in addition to being difficult for an individual pilot, is likely to have adverse consequences for the industry.
10	The group met on the 19th of November 2014 to consider the UK CAA document "Consultation on the Future Structure of the UK's Civil Aviation Authority's Medical Department" CAP 1214, which had been published on 16th October 2014 and also to consider the response report to that document from the Committee of the XXXXX and a response document issued by XXXXX). All present applauded the response document from the XXXX and were fully in agreement with its findings and recommendations. There was also support for the views of the XXXX which were very similar to those of the XXXX. The following questions which had been listed in the CAA document were considered and additional comments to those detailed by the XXXX were agreed. 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?** ▪ The members of the XXXX were unanimous in condemning any suggestion that the CAA should cease its AeMC function which has worked very well for the benefit of airlines, flight crew and AMEs for many years. It seemed to the group that to dismantle this valuable and successful service on what appears to be largely financial grounds was extremely misguided. The group also did not see that a possible conflict of interest between the Regulator and the AeMC had ever become an issue or had ever influenced its decision making process. ▪ The international reputation of the UK CAA was second to none and had always been extremely highly regarded not only in Europe but internationally as well. The benefits of the dual function vastly outweighed any potential disadvantages and also allowed for cost savings. Separating the Regulator and the AeMC into two separate organisations would risk duplication and increase costs as well as leading to potential conflict and misunderstandings. 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?** ▪ XXXX agreed that this situation cannot continue but stated that it was necessary for a detailed financial breakdown of all aspects of income

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	generation and costs need to be published. The group wished to know for how long had this imbalance between income and expenditure been a fact? Was this a recent phenomenon or has it always been the case? The group suggest that External Auditors should be appointed to produce a financial report and the income and costs of all the other departments in CAA SRG should be included to see how these costs relate to the Medical Department. This would help to identify where cost savings could be made and new income generated. **3. What are your views on the manner in which the costs referred to in Question 2 are currently distributed? How should they be distributed in future?** ▪ The answers to this question would depend on an independent external auditor's detailed financial report. Once all the financial details for income and costs are more clearly known then it will be possible to make appropriate recommendations. ▪ XXXX agreed with the XXX that more income should be generated from those who benefit from what has become the safest form of mass international travel and that this could easily be achieved by a very small levy or tax on passengers through ticket prices. The group realise that this would require government legislation but hold the view that some income from the Exchequer ring fenced for CAA purposes is essential and morally justified. ▪ The CAA should also have more realistic charges for the services it provides including charging for non contact advice given to individuals and to airlines. **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 aero-medical policy and practice in the years ahead?** ▪ The CAA has historically been a world leader in the development of aviation safety through its work not only as a regulator but also as being actively involved with grass-roots work such as performing initial Class 1 medicals and advising through its range of experts and experience. This service is of inestimable value to pilots, the aviation industry and to all AMEs. To lose this would be detrimental and extremely foolish. ▪ The CAA has also taken a valuable lead in stressing the importance of evidence based medicine when assessing and developing what aspects of a flight medical examination are of value and what investigations are important. Examples of this are the abolition of the routine EEG and CXR for initial Class 1 medical examinations and the abolition of many routine blood investigations. ▪ The CAA's role in the selection, training, appointment, auditing, re-selection and continuing professional development of Aviation Medical Examiners has been essential and must be continued and developed. ▪ The value of the role of the CAA Aviation Health Unit also should not be underestimated. Giving advice on aviation health issues is of particular value to the general medical profession and to the public. The unit also acts as a link between the CAA and the Government of the day through its relationship to the Minister of Transport. This is a valuable link.

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	▪ The XXXX group view is that this role should be strengthened by ensuring a sound financial foundation so this work can be continued and developed. **5. What are your views on each of the options considered in this consultation?** ▪ The XXXX are firmly of the view that **Option 1 is the only choice**. To select the other options threatens the effectiveness of the CAA and diminishing its leadership role in the promotion and development of flight safety. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the medical department?** ▪ **Option 1 is the only option that should be considered**. To destroy years of experience and the close and essential relationship with UK pilots and UK AMEs, which would inevitably follow choosing Options 2 or 3, will be detrimental to efficiency and considerably diminish aviation safety in the UK. Why have you rejected the other options? ▪ Option 2 would have the effect of undermining the effectiveness and prestige of the CAA. We do not see why there should suddenly be concerns over a conflict of interest between the regulator and the CAA's role in non-mandatory work? There has, as far as we can tell, never been any conflict of interest in the past and we regard this attempt to separate the Regulator from the AeMC as misguided. EASA has failed to understand the strengths of the present combined role which has existed successfully for many years in the UK. Just because the UK system is not mirrored in other EASA states does not justify changing the UK system purely to comply with what transpires in other states. ▪ Option 3 would be disastrous. If this is the choice purely because of an attempt to make cost savings then in our view it would have the opposite effect. There have been several examples in the past when government or national bodies have outsourced activities to a private provider and in almost all cases this has resulted in increased costs and decreased value and efficiency. An example of this occurred following the privatisation of the railways which led to a reduction in passenger and employee safety after outsourcing had been introduced. Private providers are interested and motivated by profit and by satisfying their share holders and not in providing an efficient and enhanced service. If the AeMC functions of the CAA are to be outsourced where is there in the UK any organisation with the necessary aero-medical expertise and experience to be able to provide the service? Would Initial Class 1 medical examinations for instance be carried out by a medical practitioner with no experience of Aviation Medicine? Who would advise AMEs and Pilots on day to day medical issues? What happens to flight safety then? **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should continue?** ▪ The CAA should strengthen and develop its present role having introduced a more realistic method of raising revenue through its charges to providers, including the Airlines and by receiving additional income from the Exchequer following legislation to use part of airline ticket taxes

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	for Aviation Safety purposes. In our view it is extraordinary that Aviation Safety is not partly funded from Government sources. **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?** ▪ The work of the CAA medical advisers and staff particularly the excellent Aero-Medical Advisers needs to be strengthened and encouraged. The valuable support particularly for AMEs of the AMAs cannot be underestimated. ▪ The CAA also should consider reversing its policy which now prevents pilots from direct telephone access to the CAA medical section. Whilst it is correct that pilots should look in the first instance to their AME to assist with medical queries and to report illnesses and significant medical events no thought appears to have been given to what a pilot can do if his or her AME is away on holiday and is not contactable. In theory the pilot can contact another AME but that AME is handicapped by not having any previous knowledge of the pilot and not having access to the pilot's medical records at the CAA. The present restrictive system which prevents an AME accessing the on-line medical records unless that pilot is already registered with a particular AME needs to be changed. ▪ The importance of the CAA's role in complex medico-legal cases when assessing fitness of a commercial pilot to hold a Class One medical certificate cannot be underestimated. This vital role needs to be strengthened and not diminished which would happen if Options 2 or 3 are introduced. ▪ The CAA on-line medical system is now 14 years old and needs significant improvement and modernisation. It is cumbersome and at times difficult to use especially the Contact Management and Case Management parts of the system. ▪ The system should also be usable via I-pads, Tablets or I-phones. This would be of great benefit to the AME when away from home on leave or other activities. ▪ The CAA should re-consider its refusal to act as an AME's Responsible Officer in relation to Revalidation. It is extraordinary that an organisation responsible for selecting, training, appointing, inspecting and auditing AMEs will not act in this role. ▪ **Conclusion** The XXXX group urge the CAA to completely reject Options 2 and 3 and to choose option 1. At the same time the CAA must research ways to correct its financial problems and strengthen and expand its vital role as a world leader in promoting and developing aviation safety which is of paramount importance to us all.
11	**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?** Aviation Medicine is an integral essential part of flight safety, with the human being forming an essential component of the overall flight system.

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	Regulation of the AeMC by the competent authority has ensured continuation in the UK of the internationally recognised highest standards of human aspects of flight safety. This option to cease being the service provider would have a devastating effect upon the support that is provided to Aeromedical Examiners in the UK, and to the leadership and influence of the UK CAA in aviation medical matters both in Europe/EASA and the rest of the world. It would send a very dangerous message to all others, that the UK CAA is more interested in saving money, than it is in flight safety. It is difficult to understand how the UK CAA would then meet its statutory oversight functions. The UK CAA benefits from a 'critical mass' of medical expertise as a result of its service provider role and statutory regulatory role. There is mutual benefit from the dual provision and co-location. If there is any evidence of the theoretical or perceived risks of inappropriate collusion, examples should be provided for further general discussion, and before any final decision is made. **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?** The lack of information provided in the consultation document makes it difficult to understand or support this statement. A full financial analysis would need to be provided to ensure that only costs which are exclusively incurred by the Medical Department have been counted. Specifically, the lack of any estimates in the document of the costs of the UK CAA meeting its statutory obligations, make the whole process flawed. I believe that, on this point alone, any outcome, other than the status quo, is open to legal challenge. **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?** In principle costs should be incurred by those who receive or benefit from a service. Whilst it may be simple to identify those who receive a service, the concept of those who benefit is more difficult. The UK CAA Medical Department makes a valuable contribution to global flight safety through its European and worldwide reputation. It contributes to the knowledge base of aviation medicine in ways that are difficult to quantify in financial terms. The importance of influence is acknowledged in the document, but no attempt is made to ascribe any financial value to it. On these grounds it is reasonable that there is an element of general financial support from the aviation industry, as they, and the travelling public are beneficiaries. Significant taxes are levied upon air passengers, and in view of the large passenger numbers it would require only an insignificant increase to resolve the perceived financial shortfall for medical services. **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 aviation medicine policy and practice in the years ahead?** This is essential. The UK CAA Medical Department has historically been recognised as probably the leading aviation medical opinion, particularly

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	in Europe. It supports evidence based decisions, and actively contributes to the evidence base. Flight safety has benefited from evolution of medical standards which have ensured the continuing certification of many experienced licence holders. This stance does not always go well in some member states, some of whom are more comfortable with a less flexible, entirely rule based approach. This often causes disadvantages to the individual pilot or controller. Without this influence the balance would tip to this less flexible direction very rapidly. **5. What are your views on each of the options considered in this consultation?** It appears that the document is biased towards option three, as this is the only option that it is considered will balance the budget. It is very hard to understand how an outsourced private provider, with a need to make profits, could reduce costs. An outsourced private provider would have no incentive in leading the continuing evolution of license medical standards and proper regulation, for the benefit of the Industry. Flight safety is paramount, not profits. I have explained below about the problems besetting outsourced providers. **6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?** The UK CAA should without any doubt prefer option one. **What are your reasons for this view?** This would maintain the UK CAA position as a leader in aviation medical matters in Europe and the world. The UK CAA needs to explain the statement in 47 that this would not contribute to influence. The reality is that option 3, outsourcing, would reduce its influence, as reputations built up over years if not decades, would be difficult to replicate by a private provider. At best, such a reputation and influence would take many years to be re-established, if at all. **Why have you rejected the other options?** Option 2, Ceasing all non-mandatory functions would destroy the UK CAA's reputation, bringing the UK to the level of other some other member states who do not have the rich heritage of aerospace medical expertise that we, as a country, have invested in, and built up, over decades for the benefit of flight safety and education, not just in this country but everywhere. Many AME's have a great deal of experience and the highest ethical standards; they care passionately about the quality of their work in maintaining aircrew health and flight safety. It is likely that many AMEs would feel obliged to withdraw from participating in a service that they might perceive to have lost its moral compass, and has sacrificed its ethical standards for the sake of money. Option 3. This option is likely to cause major disruption in the short and medium term, and result in a major loss of reputation and influence in the medium to long term. It can be assumed that this would be the desired option of EASA; it meets their flawed perception of the desirability of the

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	separation of functions, which fail to acknowledge that the services are provided by ethical professionals who are well aware of the boundaries of their different roles. Certain other member states will applaud the change, as there will be a loss of influence and leadership from which the UK CAA may probably never recover. Aviation medical expertise in the UK is in short supply, particularly at senior level. It is unclear where the UK CAA believes it will find sufficient expertise, of an appropriate quality, in an outsourced provider. This discussion is about the safety of human beings, not airframes and engines. Outsourced providers both in the UK and across Europe have a great problem now in finding enough qualified general occupational medicine professionals at all levels of experience, to service the contracts that they have acquired. It is difficult to comprehend where they would expect to find any/enough aviation medicine qualified practitioners to service such a contract at all levels of experience. Who would guarantee that the service provider would be from the UK? EU rules expect open tendering for such contracts. Has anyone thought through the consequences for our own UK flight safety, if someone from outside the UK was to provide the service. In the general occupational medicine area, we find some Senior Occupational Medicine Physicians carrying out very junior roles, as there are very few juniors. This puts the costs up out of all proportion to reality. It is estimated that there is an overall shortage of some 3500 such physicians throughout the UK alone. In some areas only one physician, in the wrong pay grade, is available to do the work of 3 or 4 such doctors. To attract the right sort of qualified practitioners the levels of salary offered have gone up almost month on month. £100,000 per annum might find someone for 3 days a week. This is now becoming the norm. The adverts are there for all to see. I get 3 or 4 such job offers' in my emails every week. Change should not be driven by the envy of others. I believe that the UK CAA is exhibiting the classic trait of knowing the cost of everything, but the value of nothing. 7. **Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** The UK CAA should maintain its current pattern of provision. It should celebrate the high quality and global reputation of its medical services, and not apologise for them. It should seek to maintain its level of investment in the service, on the grounds that it is of benefit to overall flight safety. The UK CAA should consider the revenue raising opportunities that could arise from appropriate marketing of various policies and procedures pioneered by its medical department. For example the comprehensive guidance material produced in response to EASA Part Med is freely available to other member states via the website. This is inappropriate, and should be charged for. 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?**

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	The CAA should pay attention to the rights and welfare of individual staff members if Options 2 or 3 are pursued. Morale is already very low, and this could have adverse effects on efficiency and consistency, particularly if there is a long period of uncertainty. This area of uncertainty exists now as no one is sure where the UK CAA Medical Dept. is going. The UK CAA must be mindful of the reputational risk that could arise from the loss of its current medical expertise. I am particularly concerned about the real risk of loss of support to its AMEs in complex medical cases. This could result in pilots being declared unfit because of lack of adequate decision making support from the UK CAA medical services, which in addition to being difficult for an individual pilot, is likely to have adverse consequences for the whole industry, and for flight safety. The thought of this service being provided by people trained outside of the UK must be morally wrong. I, as a senior aviation medicine Consultant, have watched the UK CAA Medical Dept. grow and mature almost since its inception. It has a high standing in the world, not just in Europe. I have witnessed its high standing in the JAA and now EASA medical proceedings over the last 20 yrs. Any attempt to dismantle it would be detrimental to all those involved, and would in my professional opinion be a very grave mistake, as it could never be recovered. I have seen no argument to counter this statement.
12	**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 EASA rules?** I believe that this option would effectively remove support for the UK's AMEs and lead to the UK CAA Medical Department ceasing to have an effective voice on the world stage, and particularly in Europe. Moreover, it would imply that the CAA no longer prioritises Flight Safety and that it is willing to abandon its time-honoured role in protecting the public. Furthermore, it would invite the travelling public to believe that their safety has no financial value. **2. What are your views on the current situation by which costs of the functions performed by the CAA Medical Department exceed income?** Is this actually the case? What is being measured and how is this measured? And, where is the evidence for this statement? The CAA has an obligation in law. Hence, I question whether the department has been allocated sufficient budget to maintain its statutory obligations. **3. What are your views on the manner in which the costs referred to in Question 2 are currently distributed? How should they be distributed in the future?** Politically, I cannot see how a price can be placed on Flight Safety. The UK and the CAA are leaders in aeromedical opinion across the world, a

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	position that has been widely acknowledged for many years. Is this to be completely discarded? Once expertise and confidence have been lost they may never be recovered. The benefit of ensuring the health and well-being of aircrew has implications for the entire population as well as for the travelling public. It seems most improbable that public opinion would recognise the merit of threatening to reduce the medical standards for those at the controls of the aircraft on which they travel with their families nor the controllers who guarantee their safe passage. Hence, it is reasonable to spread the burden of cost between government, the travelling public and the airlines. It is likely that a very tiny charge of 1-2 pence per passenger journey could readily solve any perceived financial shortfall for the medical department; I believe that the public would welcome such a surcharge if the reasons were made clear to them. **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?** Most definitely – yes. As I stated in Q3, The CAA's medical expertise has always influenced improvements and policies relating to enhancing standards of health and flight safety across the world. Furthermore, the AME network is regularly updated and supervised in the implementation of these standards with the aircrew whom they review regularly. Experience is shared between the AMS and the AMEs to mutual benefit all with the aim of maintaining the physical and mental health of personnel and optimising the human factors pertaining to flight safety. It is of fundamental importance that the CAA maintains high levels of expertise and that it remains a respected leader in the developing policy. If the CAA adopts the lowest common denominators relating to costs without valuing the wealth of experience and history that has been developed over many years the service will inflexible, protocol-driven, un-respected, and much poorer than the one provided today. **5. What are your views on each of the options considered in this consultation?** My interpretation of this document is that the whole emphasis has been placed on 'option three' in order to save money. As stated in Q2, it is highly questionable whether the costings have any valid basis since we do not know what aspects of AMS work has been recognised as having a financial value. My personal experience of out-sourcing and re-organisations within the NHS have convinced me that the process usually results in disruption, distrust, and generally a poorer service is created and increased cost. I suspect that this is exactly what will happen unless 'option One' is adopted, even if money has to be obtained from a levy or from generation of income through private activity. **6. Which options outlined in this consultation should the CAA prefer for the future of the Medical Department?** **Option One is the preferred option.**

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	The Medical Department is one of the 'jewels in the crown' of the UKCAA. I believe that it's integrity and effectiveness will be destroyed by out-sourcing with resultant loss of respect and influence in medical arenas globally. Once lost, this would never be re-gained. One question that may not have been considered because it has no measurable financial value:- Why would well-qualified and experienced AMEs wish to work for a medical organisation that has lost the respect of its peers and its focus as the advocate of aircrew health and flight-safety? **7. Are there any alternative options that meet CAA's core criteria, and which you think CAA should consider?** The CAA would be well advised to recognise that the Medical Department is highly acclaimed around the world. The UK's reputation for maintaining high standards and working to enhance flight safety throughout the world is well-recognised. These attributes should not be discarded. It may be that a very small tariff should be applied to ticketing prices and directed solely towards the enhancement of flight safety; it would be legitimate for Medical Department to receive a proportion of this budget. It would also be reasonable to charge fees to governments and airlines for access to some of the guidelines and algorithms that are developed by the medical department. **8. What risks should the CAA seek to manage and pay special attention to as part of the implementation of any option for its services?** This consultation must be generating huge levels of uncertainty among the staff of the AMS. This is very bad for morale and it is likely to lead to increasing inefficiency. Such an environment is likely to lead experienced people to look for employment elsewhere with resultant spiralling downwards of the organisation. Option One is the only one that can maintain the credibility of the Medical department as a leading standard-setter on the world stage. As an AME, I fear that I may lose the umbrella of support from experienced and respected colleagues; this can only devalue the service, frustrate the aircrew, and potentially endanger the travelling public. Once credible costings are published for the public to view, we can assess whether we believe that the true value of our Aeromedical Section has been considered. I suspect that this is not the case since it is much easier to know the cost of something than to attribute a realistic value to it!
13	I write as an AME also a GP and as a consumer of Airline services. I am concerned that the options proposed apart from option 1 will have a deterioration in air safety standards as the role of the AeMC is very uesful to the AMEs and the Pilots to enable the flight safety to be established in an environment free from any bias and soley focused on the saftey of the pilot and the travelling public. When this service is separate and based on a fee for service there will be pressures to make a pilot fit in borderline cases as teh opportunity to have a reveiw at the AeMC at the CAA will not be there. The current system has proved to be succesful and works well. The proposed service of

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	separating the medicals for pilots is a poorer service which others in the aviation community my accept but I do not think the UK should. There is nothing wrong with providing a better service. The separation of these services I believe will increase the regulation and testing for Pilots as the more remote role of the AMS will require greater detail to try to maintain the saftey of passengers and to try to standardise the examinations at a larger number of sites. My prefered option would be Option 1 which any shortfall being borne partly by the pilots and the general costs of the CAA. The pilots are not charged VAT by theCAA and so the costs to the pilots from any other provider would be at least 20% higher and I believe that the CAA should see this service as one which adds value to the service to the Aviation industry and is worth supplementing. If the drive is to separate the functions of the AeMC from the CAA then the only logical other option would be Option 2 which separates the function. Option 3 will have the link between the CAA and the contractor and so be a poorer service but still not separating the roles completely Public saftey is the prime concern and I believe Option 1 will deliver this the others will jepodise the saftey of the public.
14	This is my response to the consultation document CAP 1214, it is not confidential and given as an individual in my capacity as a consultant advisor to the CAA. I have no objection to the publication of my name and my association with the CAA. I have addressed the paragraphs as numbered in the document. 15. The CAA estimate of the costs of the Medical Centre critically depends on the multiplier used. It seems that the CAA has used a larger figure than is usual in commercial firms, exaggerating the true cost of the Centre. 16. It is disingenuous of the CAA to emphasise the discrepancy between the income derived from clients attending the Centre and the cost of providing this service. The CAA currently charges £115 for a consultation. The current charge in central London is £185, this is kept low because of competition from the CAA. In the private sector, the charge for a private consultation with a neurologist is over £200 an hour. If this service were to be provided solely by the private sector, the charge to clients will immediately rise to current commercial rates. I have raised this issue at the CAA in the past and was told that the Medical Centre has been expressly forbidden to increase its charges. An increase of charges to current private practice rates would be born by clients attending any AeMC, including the CAA, and not directly by the current charge payers. 19 & 20. I agree that there is no reason for the CAA to undertake routine Class 1 medical examinations and indeed I think that this function is inappropriate for a regulator. 22. This is a very important point; the CAA must maintain and enhance its influence on European and global aeromedical policy and practice. 26 & 27. These are also critical issues. The CAA must retain and build on its experience to provide evidence for best aeromedical practice. 33. There is no need for the CAA to provide an advisory service to certificate holders and applicants, although this is very much appreciated.

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	The request for any such advice should be first addressed to their AME, who can then contact the CAA if necessary. 33 & 34. I was amazed to read the rest of this section on non-mandatory activities: 'contributing to European and ICAO rulemaking and standardisation, also engaging with and positively influencing the European Aviation Safety Agency (EASA) and other international organisations'. This should surely be a mandatory activity. As one of the largest regulatory bodies in the world, and to whom many other countries turn for advice, it would be absolutely unacceptable to have regulations imposed by Europe, ICAO or EASA without the CAA's input. The CAA has often led the way on these matters in recent years.38 & 39. I see no reason why the CAA should provide occupational health services in house and there may be definite medical advantages to having this service provided by an independent outside supplier. 42.1 These activities must be an essential part of the CAA's role, but I see no merit in the idea to engage an international health care company, who would simply take CAA expertise for their own gain and with little benefit to the CAA. **Conclusion** It is unfortunate that none of the three options offer the best solution for the future of the CAA Medical Centre 54.1 The CAA should cease to undertake routine medical assessments, 54.2 & 3 See comment under 16. above 54.4 An absolute necessity 54.5 & 6 None of the options are optimal for the reasons already given 54.7 a. The CAA should retain its mandatory services. b. It must continue 'contributing to European and ICAO rulemaking and standardisation, also engaging with and positively influencing the European Aviation Safety Agency (EASA) and other international organisations' c. It must retain the facility to see pilots/ATCOs/applicants who present with particular problems that cannot be fairly evaluated by their AME or an external AeMC. A personal note: I started to advise the CAA on occasional neurological problems in 1983 and on a more regular basis from 2000. I see 45 – 50 clients a year, until recently they were all referred by CAA doctors. Recently the referrals have also come from NATS and external AMEs. Over 80% of cases require consultation with the referring CAA doctor to reach a reasonable decision, since hard data on the aeromedical risks often does not exist. The AMS has produced a number of algorithms as guidance for AMEs, but most of the cases referred to me do not fit with these protocols and an individual assessment is necessary. If strictly applied, many pilots would be denied certification, since such algorithms are necessarily conservative; to be otherwise would be a safety issue. Since the number of neurological cases is small, it is essential that the CAA sees most of

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	these clients in order to maintain its expertise. For example, we have recently presented our experience of a rare condition (myasthenia gravis) at an international conference, we have 10 cases and I understand that the New Zealand Civil Aviation Authority is about to present internationally their single case. We have published our UK CAA experience of transient global amnesia, another rare condition, with 11 cases. This publication was recently quoted and accepted in an Australian court case involving Australia's Civil Aviation and Safety Authority (CASA) as being the definitive paper on the aeromedical implications of the condition. These examples show how the UK CAA leads the way in formulating sensible aeromedical certification parameters. Distributing these cases around a number of AeMCs dilutes the expertise and depreciates the quality of advice that can be given. Clients often come with reports from their treating neurologist which express a biased view of their patient's suitability to continue flying, without any knowledge of the aeromedical risks. The CAA cannot maintain its reputation and influence in Europe and globally if this expertise is allowed to diminish.
15	These are my opinions on the consultation document regarding re-organisation of the CAA Medical Department. They are rather general. 1. If costs exceed income in a business then it is not viable other than short-term. As well as increasing charges therefore you could seek to reduce costs. I am certain this has been looked at, but, for example, the building in which you operate, whilst splendid in it's way, is hugely wasteful of space and must be costly to run. Maybe relocating to a more modest building off the airport would solve the problem. 2. Over the last 42 years has there ever been a suggestion that the regulator and provider roles in your different departments have caused a clash of interests? If so it has certainly not reached my ears as an AME since the early 80s. 3. Notwithstanding the above observations I feel sure that in the modern climate the correct option for the CAA is option 3. The document reads as though all class 1 and 3 initial examinations are still performed solely at the CAA, but I understood that a couple of other AeMCs had been established already, and certainly on your website Dr XXX XXX advertises this fact, in the Gatwick area. 4. I feel very strongly that in the event that option 3 is selected that one or more AeMCs should be established north of the M4 corridor. Whilst Heathrow and Gatwick dominate civil aviation in this country there are many other airports. The majority of the population does not live within reasonable travelling time of Gatwick and it follows from this that the majority of pilot and ATCO candidates do not either. 5. Maybe, radically, it could be time for experienced class 1 examiners to be allowed, obviously with careful protocols and supervision, to tender as AeMCs in their own right. In other words there might be 50 or 100 locations around the country for would be class 1 holders to obtain their initial class 1 medical certificate.

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16	I will address the points raised. 1. No evidence supporting the view that EASA have voiced disquiet at a regulator/regulated tension. Even if expressed, it is common practice in professions to erect a 'Chinese Wall'. This could easily be achieved. If needs be a stand-alone company such as CAAi perhaps, could undertake all of the functions of AeMC at arms length. This would achieve the twin aims of ensuring regulator distance and keeping and nurturing the clinical and administrative skills essential in permitting the CAA to maintain European leadership. 2./3. The financial argument has been blunted by the failure to provide adequate financial information. The lack of transparency, and the failure to reflect on the historical cross subsidy from FCL (running currently at an income/capital employed surplus), smacks of obfuscation. I would suggest the AeMC charges market rates for its services. If the inefficiencies referred to in option3 are real, then they should be addressed. Indeed the Board might well reflect on why they have not been addressed already. The effective 'M25 Corridor Subsidy', with free consultant reviews at Gatwick should be discontinued, and replaced, just as in other parts of the country, with commercial arrangements. By even a crude estimate of 1000 consultations at £200 each, this would be a major income stream to the CAA. It would retain the skill under a nuclear authority structure. 4. Only if there is a benefit to that industry can this be argued. It would certainly be much cheaper if the whole of the CAA were closed down and we simply became regulated from the centre of EASA. My instincts suggest this would be wrong, but industry must offer a view. The aeromedical question is inescapably entwined in the larger CAA function. 5./6. I favour the status quo but with an arms length regulator / regulated arrangements. This achieves continuity and if my financial observations in2/3 are observed, financial strength. Critically the knowledge and aeromedical skills are not dissipated. The outsourcing arguments are at best weak and display a touching belief in the 'efficiency' of the private sector. There should be recognition that a cost 'shift' is not the same as a cost 'reduction' in industry terms. The outsourcing of AMS support and sharing experience with another NAAs sounds like management talk. The 'generate future business opportunities' has a similar ring. 7. A stand alone AeMC with a sensible fee structure, perhaps within a stand alone organisation allied to the CAA, with meet the stated objectives, and retain the core skills and competencies. 8. The CAA should seek to be clearer in though and more transparent with the financial information offered. The thrust of the CAP1214 document seems designed to reduce the staffing costs come what may. This represents a shameful discarding of the main resource that is at the disposal of the Authority, under the allusion that the private sector or someone in another authority can do a better job. The Board must not be dazzled by the short term perceived gains in a Pontius Pilate approach ,but should actively seek to retain and develop the

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	current skills.
17	I reply to this Document as an interested AME XXXX. The Medical Department of the CAA is a highly professional body focused on flight safety. The advantages of a close working relationship between AMS and the AeMC must outweigh any unlikely conflict. The ground roots advisory and management service of the AeMC in conjunction with AME's may assist the CAA department to keep abreast of medical matters vital to global flight safety. It would be interesting to see evidence that the Medical Departments costs exceed its income. If this were so an organisation becomes disorganised and inefficient with inevitable ensuing low morale. On this alone should change be sought….. Direct income achieved by the AeMC is a significant proportion of the overall costs incurred by the Medical Department. My experience in the NHS suggests outsourcing responsibilities often becomes a cost negative exercise whilst fragmentation of the Medical Department from an AME's view point would be disastrous. Income from the Aviation industry and travelling public should be maximised. The latter are in increasing numbers and a small levy would provide a considerable and naturally augmented income over years. The CAA should very definitely be wholly involved in developing aeromedical policy for the future. It is in the interest of industry to handsomely fund the CAA in providing a service of the utmost importance to the continued development of flight safety in the broadest terms. Understandably finances have been pressurised and balancing the budget of concern. It is difficult to consider any body other than the CAA medical department who would have the necessary ability to act as an alternative service provider. Such organisations would be in competition and any anticipated cost cutting influence flight safety. Certainly in the short term there would surely be a worrying hiatus and at the very least a trial period could be considered. AME's receive excellent and vitally needy support from the AeMC and this must be readily available. Option One should be adopted. I believe fragmentation of the Medical Department by outsourcing would lead to a less effective service. Communication between the component parts of the medical department inevitably will suffer leading to disorganisation and low morale.. The present 'one roof' arrangement is desirable, providing close scrutiny of the service provider! Further, I do believe this does contribute to the CAA's ambition to have global influence (contrary to sect.47) How can one be sure outsourcing will reduce costs and increase efficiency when loss of significant income is also considered. An alternative provider will quickly increase the fee structure for the disgruntled licence holder. Perhaps the CAA needs to pre-empt this move? I believe the Medical Department risks losing grass root enthusiasm support and knowledge through out sourcing with consequent reduced influence in the global aviation industry. I believe the excellent service the Medical Department provides AMEs' will be lost resulting in an inferior service to licence holders, hence industry and potential reduction in flight safety.

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18	**Preamble** I am a CAA Aeromedical Examiner (AME) with 29 years experience of aviation related work as an AME and medical advisor to the aviation industry. This response is based on my personal views although I have also contributed to the SAAME response. I am a former chairman of the Scottish Association of Aviation Medical Examiners and XXXX. In addition I have 32 years experience in Primary Medical Care and 26 years in hospital medicine including medicine for the elderly and psychiatry. I have also significant business experience having run my practice (a SME) for many years. My response to the consultation is impeded by a significant lack of detail provided regarding the finances of the medical department which is astounding considering costs and funding are core elements of this consultation. The additional information relating to the medical department finances supplied at the last minute of the consultation process is again bereft on any detail and raises questions as to why there is reluctance to provide relevant financial information to inform a response. Fundamentally, medical input is a core element of the licensing process requiring particular expertise and training. The foundation of this process is safety. There is clearly a cost element to this process and revenues generated within the medical department are unlikely to ever match its costs. Currently industry sources fund the CAA and therefore an element of this funding has to be directed to the medical department. The medical department as an integral part of licensing should not be perceived as an entirely separate entity otherwise it is inevitable that safety will be compromised. Whilst the overall funding of the CAA is not part of this consultation process it is not clear whether it is politicians pushing for savings or industry pushing politicians to push for savings that has resulted in this review. Perhaps it is time to consider the funding model of the CAA as well. Should it still be industry or should the infrastructure of the CAA perhaps be funded from taxation such as the Air Passenger Duty (APD) tax and not have safety issues regarded as a possible conflict of interest between industry and the CAA? 1. **"What are your views on the proposition that the CAA ceases to be a service provider, via its AeMC, that it is regulated by the CAA as a competent authority under the EASA rules?''** This would be a very unwise proposition and its very suggestion reveals a total lack of understanding of what underpins the creation and maintenance of an essential element of the flight safety process. Aviation Medicine is a specialised area requiring adequate training and experience. In the past many of the staff within the medical department had a military aviation background but with defence cutbacks there are fewer suitably qualified individuals in the market. Civil aviation operators have also cut back on medical staff and in the wider occupational health field there are now considerable difficulties in recruiting staff. As a specialised area of medicine the CAA medical department including the AeMC is the only pool of expertise remaining. Should this be lost then inevitably this would impact on flight safety. The network of 230 or so Aeromedical

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	Examiners also requires specialist support. Furthermore the contribution to and reputation of the UK CAA in global civil aviation matters would be lost. Thus the co-existence of the AeMC within the hub of the medical department produces tangible benefits. There is no conflict of interest between the AeMC and other functions of the medical department. **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?"** The financial information provided in the consultation document is minimal at best and the supplementary financial information provided after repeated requests looks as though it was produced on the back of a cigarette packet. For the consultation to have credibility full detailed financial information would require to be provided. There is in fact very little evidence provided to support the comment in the statement above. Transparency is key to this consultation and unfortunately, at present, this is sadly lacking. The reality is however that the functions of the medical department attract a cost and, as mentioned in the preamble, it would be very difficult to recoup these costs on say an item of service payment for all functions. If this was attempted I doubt that all costs would be covered and there would be an increased administration cost in attempting to do so. Therefore there will always be a cost for the functions of the medical department unlikely to be met solely by income generation within the department itself. Perhaps the question should be how to reduce costs but accepting that the medical department is an essential element of the UK CAA and for it to receive a funding stream from whatever source the CAA derives its income. I do not consider that providing an occupational health service as mentioned in CAP 1214 is an essential function of the medical department. Funding of any form of occupational health service in any case should not be part of the medical department's budget and perhaps should come under the Human Resources Department's budget. **3. "What are your views on the manner in which the costs referred to in Question 2 are currently distributed? How should they be distributed in the future?''** Once again with an appalling lack of detail provided it is almost impossible to respond to this consultation question. As a general principle costs should be borne by service users but there is a limit to this referred to in my response to Question 2 above. One area where costs could be reviewed relate to charges made for medical examinations in the AeMC. These charges have fallen below the general market rate for such services, some more than others, over the years and a market adjustment would generate some much needed income. On my theme of the medical department being an essential and integral part of the CAA then it is reasonable to expect industry to cover at least a proportion of the costs. It would also not be unreasonable to expect a proportion of the costs to come from the Air Passenger Duty tax. In this way those who benefit from the safety function of a Competent Authority namely industry and the travelling public contribute to the costs of this service provision. It should not be forgotten that without an aviation public transport system there would not be taxes on aviation. Not all costs are tangible and one of the functions of the medical department is being part of a global community contributing to flight safety. This is difficult to measure.

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	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?'' This is fundamental and essential. However it is not without significant cost. In the first place it must retain its reputation as a centre of excellence. To do so personnel of the highest calibre must be recruited and retained. Realistic salaries and 'packages' for such individuals will not come cheap especially where there are a limited number of people available. It should be looked upon as an investment both for the maintenance and future of aviation safety as well providing expertise and intellect for sale to other countries. **5. "What are your views on each of the options considered in this consultation?''** It has to be Option One. There is so much to lose if one of the other options is chosen. I am certain that it is no accident that the Consultation Document is biased towards option three. It is clearly short sighted to think that an external provider would have any interest in offering an equivalent service for a reduced cost. Not only would they have recruitment problems quality standards would be difficult to maintain with lack of specialised experience. For a commercial provider the focus would be on the bottom line on the balance sheet. This is of no real benefit to aviation in the longer term. **6. "Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?''** Option One. **"What are your reasons for this view?''** The Medical Department of the UK CAA functions well but could be improved with proper investment. That is not likely to happen with the other two options. It is also a significant global player in influencing opinion. Option One should maintain this position provided there is recruitment and retention of class leading staff. Paragraph 47 in the Consultation Document however does not appear to make any sense. **"Why have you rejected other options?"** Option Two. There is blurring of issues in separating tasks into ''mandatory'' and non-mandatory''. It is not clear why this terminology exists and how interpretation of these terms has been reached. This is a dangerous precedent, is inconsistent and appears to be designed to destroy the fluidity of an established structure which is very functional. Option Three. Why is there a perceived requirement by EASA to separate functions? Considerable disruption would be created which is inefficient and increase costs to industry as well as potentially affecting safety. As mentioned elsewhere in this response recruitment is a major problem and external providers are unlikely to find appropriately trained staff in a hurry. It is also essential to consider the general political climate. There is the possibility of the UK leaving the EU and pressure is mounting for a referendum on this topic. Should this arise then what would happen with the relationship between the CAA and EASA? A diminished Competent

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	Authority would have difficulty in recovering to face the challenges which would arise should the UK no longer be a member state of EASA. 7. **"Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?"** Charges in the AeMC require to be reviewed and increased to be comparable with equivalent charges in the private medical sector. Charges for specialist appointments should be made because the current system favours pilots and ATCOs living in the South East. Perhaps more consideration could be given to the marketing of services to other countries to raise income. 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?''** Retention of excellent well trained staff. Consistency of decision making potentially leading to legal challenges if not maintained. This is a potential problem with outsourcing. Support for AMEs who perform a very large amount of work – the iceberg effect – is essential. Allied to this is replacement of an already outdated IT system. This would not be without significant cost and is urgently required. The functionality of the current system is poor and reliability decreasing. Costs of training for a new system should also not be underestimated. End user advice must be sought when considering the provision and design of a replacement system. Functionality, ability to code entries, searches and speed of operation are key for a successful system. A centralised records system is essential for continuity and for flight safety. There are already serious concerns that there is a lack of availability for viewing records of Class 2 pilots and this may well happen with Class 1 pilots as well.
19	I write from a perspective as a consultant providing specialist services to the CAA on psychiatric matters. My views are as follows: 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?** I think it would be a mistake and lead to fragmentation. I also have concerns about the ability of external providers to manage sometimes highly specialist medical issues that can arise, for example in my own field of psychiatry. For these specialist medical problems, the proximity of AMS and AeMC allows informed decisions to be made by direct discussion of cases between the specialists and AMS/AeMC doctors in more timely, and safe, manner than would be possible within a fragmented, outsourced situation. 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?** The CAA clearly undercharges massively for appointments with specialists. I estimate that even a modest provider would charge at least triple the cost for an assessment that my time is charged out at. A more specialist service, as I provide as a Professor in Psychopharmacology, would be even more expensive. Indeed, the CAA recovers less than the cost it pays to my employers for my time. It cannot charge more under the

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	current rules. I think much greater cost recovery for many medical services could reduce this deficit. 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?** Users (i.e. pilots or companies) should pay closer to market rates for the medical services provided, and thus bear a higher proportion of costs. 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?** Yes. 5. **What are your views on each of the options considered in this consultation?** I think option 1 with better cost recovery would be best. The other options would likely lead to fragmentation, poor governance, and a higher than anticipated administrative oversight burden (similar to the recent NHS changes in un bundling and outsourcing services that is widely regarded as a mistake). I think a centre that has expertise in the whole range of medical issues and how they apply to licencing is vital for a coherent approach to medical policy implementation. See also my answer to Q1. 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? As outlined above, I think Option 1 is best. I think that a specialist AeMC with a critical mass, expertise, and ability to interact effectively with specialists, is a preferable option to a fragmented, outsourced service. I think it is the more difficult areas, such as the wok I do, that will suffer. An analogy is the outsourcing within the NHS – discrete packages of work can be tendered to the private sector, but the ability to deal with difficult situations can be lost, and training and the development of expertise suffers. Safety could be compromised. 7. **Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** More autonomy for AeMC to develop its services. An analogy is the ability of NHS foundation Trusts to develop other sources of funding than NHS block funding. 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?** More complex medical conditions requiring specialist input. How to have a joined up and collaborative approach between AeMC/AMS doctors and specialists.
20	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**

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	competent authority under the EASA rules? This would be an appropriate development; with the introduction of the possibility of, and the actual development of 'privatised' AeMCs the existence of an AeMC provided by the regulator seems difficult to maintain, from a regulatory oversight and commercial, competition point of view. **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?** The tenet that the regulator needs to recoup its costs is a concept which completely ignores the fact that safety and regulation not only benefits those who are directly involved and arguably 'benefit' from the regulatory work but that society as a whole and the UK economy benefit greatly from the leading role the CAA has as regulator in the aviation industry and the medical department within that function. Although it may not be possible to reverse that view it should at least be borne in mind that not every single function within a regulatory body can be made to 'pay for itself' but that some cross subsidising within the organisation may be required. **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?** See under 2; it is reasonable for stakeholders to pay reasonable costs towards the sustainability of the regulatory functions of the CAA but a rise beyond the current direct charges will have an impact on industry and lead to a decline in discretional spending in the aviation business reducing its economic viability. The regulatory financial burden in the aviation industry is already unrivalled by any other industry with a similar function or safety requirements. **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?** Yes, not to do so would mean losing the influence in the regulatory and oversight processes in the context of EASA activity and likely lead to a system which will be less responsive to the needs of the UK Aviation Industry and its stakeholders. It is probably good to understand that the UK Medical Department has been instrumental in recent years in proposing and championing the progress for evidence based applied aviation medical regulation which has led to a liberalisation of safe aviation medical practise, reducing the regulatory burden, reducing costs to industry by enabling individuals to continue to fly rather than being retired/rejected from flying duties for longer periods of time or indefinitely as was previously the case. **5. What are your views on each of the options considered in this consultation?** Option 1 – untenable

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	Option 2 – preferred option; retain core functions and relinquish the non- core functions which are not essential for maintaining core activity (AMS support) Option 3 – outsourcing non core function; outsourcing implies retaining end responsibility as 'commissioner' which would mean that the conflicts as indicated under option 1 would still remain. **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? Option 2 – see above; clear delineation of role, responsibilities and activities; most likely to be financially sustainably **7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?** Nil **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?** Change management; lack of maintaining AeMC Capacity in the short term; drain of expertise from AMS/AeMC due to personnel/staffing retention and recruitment issues; transition of responsibilities from CAA to private providers/AeMCs/AMEs;
21	I am responding to the consultation document as an individual and a CAA employee within the Medical Department. I do not wish my personal views on the consultation process to affect any future employment I may have at the CAA and therefore wish to remain anonymous. I am therefore sending this through a colleague's account with their permission. I have worked in the medical department for many years and feel that I am in a good position to comment on the proposals. I would firstly like to take issue with the content and underlying tone of the consultation document. Whilst CAA staff have always been told that ExCo are open to all options on the future of the Medical Department and that no decisions will be made until the end of the process, it is very clear that ExCo want the AeMC/AMS support to be outsourced and if not shut down. To this end, the document does not present a balanced view of Medical Department and completely ignores many of the very strong and positive features of its current structure. I would strongly argue that the AeMC and AMS should remain together within the building and to maintain the close mutually beneficial relationship that has always been so successful. Although I recognise that EASA have previously raised the issue of the proximity of the AMS and AeMC, this issue has present since the inception of the Medical Department. Whilst not personally being resistant to change, I do feel that ExCo have used this as an excuse to push for the AeMC to be outsourced. It seems to me that the optimum solution to this issue would be for the AeMC to fall under the umbrella of CAAi where it can be released from the CAA's scheme of charges and be able to charge, for the first time, a realistic fee for medical

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	examinations. This would immediately boost income and ensure that the AeMC was not subsidised by other areas of industry. The Medical Department has, for many years, been at the forefront of civilian aviation medicine. It has been highly influential both in Europe and worldwide in the promotion of evidence-based medicine, the challenging of medical standards that are not based on evidence and the reviewing of standards with changes in disease management and treatment. This has been possible due to the close relationship between the AeMC and AMS. Nearly every member of staff within the AeMC provides support, in some way, to the AMS. Visiting consultants in the AeMC provide expertise to both AeMC and AMS in specialised areas of medicine. The ability to conduct research to provide the evidence-base to medical requirements is greatly enhanced under the department's current structure. Medical Officers within the AMS benefit from the interaction with current practicing clinicians and are able to ensure that their clinical skills are kept up to date by undertaking sessions in the AeMC. The AeMC staff benefit by having rule and policy makers on site to assist in the management of complex medical cases. If the AeMC and AMS support were outsourced or shut down, the UK CAA's medical department would be severely weakened. It would no longer be able to retain its status worldwide. It would be led by Europe rather than leading within Europe. Make no mistake, this will happen. The strength of both the AMS and AeMC comes from working together. Therefore, it is my opinion that option 1 should be followed. In the absence of any strong evidence in support of outsourcing or shutting down the AeMC and AMS support, I have been trying to assess the underlying reasons for this, quite frankly bizarre, recommendation in the consultation document. I can only conclude that either ExCo recognise the high level of customer service afforded to stakeholders attending the AeMC for medical examination (almost always their first contact with the CAA) and think that other areas of the CAA cannot hope to match this. Therefore, in order to level (and lower) the standard of CAA customer service, ExCo feel that the AeMC should be removed. The other explanation is that this is, and has always been, simply a process of reducing staff numbers.
22	I am a Consultant XXXX at the XXX XXX and XXXX NHS Foundation Trust and have been a visiting consultant to the CAA Medical Department since September 2010. This is my response to the CAA consultation on the future of the Medical Department. I run an all-day XXXX Clinic twice a month in the CAA Medical Department, where I see referrals and make recommendations to the Authority Medical Section as to the eligibility of these individuals to exercise the privileges of a Class 1 Medical certificate. Over these past 4 years I have been extremely impressed by the level of commitment, knowledge and expertise displayed by all the staff I have met and with whom I have worked. I am a very experienced consultant XXXX with long-standing and specific expertise in clinical and regulatory aspects of fitness to practise issues in doctors and dentists. Over the past 20 years I have assessed, treated and monitored over 200 doctors and dentists, supervising many through the General Medical and Dental Council regulatory procedures. The majority of doctors and dentists under my care have managed to turn around their lives and return to medical and dental practice. When I came to the CAA Medical Department in 2010, I had an interest in working with pilots and air traffic controllers, as I had previously worked

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	with Professor XXXX who set up the original XXXX Clinic in 2001. I then had to 'learn the trade', by which I mean assessing pilots and ATCOs, and I would estimate that it took me in the region of two years to master the range and complexity of the work. This is not work that can be done by an 'off the shelf' XXXX, or even a number of XXXX working independently and in isolation. It is onerous and demanding work and requires one to be at the top of one's game at all times when making decisions and recommendations. It is also work that cannot and should not be carried out in isolation. I appreciate and value the unique position in which I find myself. It is extremely important that I do not make recommendations lightly and without an understanding of the aviation as well as the bio-psychosocial context. The very fact that I come to the CAA to do my clinic and work alongside other experts, including those in the Authority Medical Section, is integral to an informed and robust decision-making process. I am sure that my work as 'part of the whole' contributes to the safety profile of the CAA. It is for this reason that I would counsel the Authority, in the strongest terms possible, against the break-up of its own Medical Department which is highly regarded world-wide and contributes to the reputation and safety profile of the CAA. The CAA Medical Department is a first class specialist unit of international repute. Other countries look to the department as the gold standard. It has a range of functions and a critical mass that is crucial in maintaining high-level expertise and flexibility. To break this up or to devolve parts of it to another organisation(s) would be very wrong and short-sighted. It would most likely have undesirable outcomes in the sphere of safety and could, in my view, damage the reputation of the CAA. The CAA Medical Department does not provide healthcare so the idea that the CAA might consider devolving its function to an "international healthcare company with experience of operating in a variety of markets" suggests that the core function of the department is not fully appreciated or understood. **Conclusion:** 1. The CAA Medical Department is already highly regarded internationally and influences policy. 2. The consultation recommends consideration of "an international healthcare company" to take over the function of the medical clinics as a cost-saving measure. However such a company would not have the expertise to take over this function, is very unlikely to be able to do the job any better, and may ultimately cost more. There are economies of scale in the current structure which also allows integrated working and a sharing of expertise quickly and on one site. In any case the department already has first class medical expertise which could not be bettered. I find it extraordinary that this is not recognised and celebrated. 3. The selling off of the non-mandatory functions (the medical clinics) would be travesty. Outside medical consultants value the experience of visiting the Medical Department to carry out consultations and also to have timely and appropriate and high level discussions which ultimately facilitate safety. This work is highly specialised and should not be subject to market conditions.

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	4. I would therefore strongly advise that the CAA jettison Options 2 and 3 and maintain the status quo.
23	Thank you for the opportunity to comment on these proposals. **Representing:** Self. I have extensive experience within the NHS and private health sectors. I am also an active private pilot. I am a consultant cardiologist practising in Wales and in 2013 joined the small team of specialists who work in the Aeromedical Centre at Gatwick and who advise the AMS on complex medical issues. **Response to consultation questions:** **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** I understand the concern about the CAA being both regulator and provider in this field. However I believe that the advantages of the current system outweigh these concerns and that these concerns should be dealt with by having an appropriate corporate structure with the AeMC operating as an independent business entity within the CAA. What are the advantages that I refer to? The Aeromedical Centre is able to concentrate expertise on aeromedical matters and make it available to both to the AMS in its regulatory role and to individual pilots with complex medical conditions. I would cite the pioneering role of the AeMC in facilitating pilots with Type I diabetes in obtaining Class I certification. It is most unlikely that such a development would have occurred in the absence of the synergy between AeMC and AMS. I believe that the separation of the AeMC and AMS function would increase the risk of unfair discrimination on health grounds. In my own speciality of Cardiology the general level of knowledge of the aviation industry and its particular safety requirements are poorly understood. The existence of specialists within the AeMC who are involved in the drafting of safety regulations, and their implementation ensures that regulation is applied in a consistent and fair way. In the AeMC we often receive information back from local Cardiologists which fails to answer or satisfy the requirements of safety regulation and further enquiry by the AeMC is necessary to resolve these issues. Separation of the AeMC and AMS is likely to complicate the communication chain and lengthen response times in complex cases. I know from my personal contacts with several AMEs that they feel they would not be able to cope with the assessment of complex medical without the support of the current AeMC/AMS structure. I understand that the consultation is much concerned with the costs of providing the AeMC and in particular how that falls on industry partners. The AeMC currently offers a highly cost-effective service to the pilots who use its services. The consultation should be aware of the hidden costs that would affect the industry as a whole if access to affordable assessment was denied to individual pilots. The costs of medical assessment,

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	particularly if AMS and AeMC are separated will rise as the cost of obtaining investigation and assessment through the commercial medical sector (generally Private Practice) is substantially higher. These costs will be passed to pilots many of whom will mark a hard economic decision to cease flying. The consultation has to consider the cost to the industry of training replacements and my personal belief is that the cost of this to the industry and ultimately the passenger will increase as a result. **2. What are your views on the current situation by which the costs of the functions performed by the CAA Medical Department exceeds its income?** The Aeromedical Centre currently provides its services at a bargain basement cost. I have listed the current costs below and the likely cost of commercial alternatives (in South Wales – around London they are more expensive still) Consultant review & follow up - CAA charge £115 (Commercial £250-£300) Exercise ECG with report – CAA charge £90 (Commercial £160-£200) 24hr ECG with review – CAA charge £90 (Commercial £160-£200) 24hrBP - CAA charge £69 (Commercial £100 -£150) Echocardiography is now provided by an external provider within the AeMC and has increase to £260 – similar to the commercial cost in the part of the world. I have outlined in 1 above why it might be useful to industry for the department to provide a cost-effective service but it is clear that one major reason for the costs of the department exceeding its income is the charging of non-commercial fees for services. Additionally, the Aeromedical Centre consultants provide regular advice to the AMS. During a day's work at the Aeromedical centre I would commonly spend 1-2 hours answering queries from the AMS. My understanding is that this work is not cross-charged for, and again this may contribute to the income/cost mismatch within the centre. **3. What are your views on the manner in which the costs referred to in Question 2 are currently distributed?** Answered above. **4. Do you agree that the CAA, which is funded by industry, should continue to retain and develop th expertise necessary to take an effective role in developing aeromedical policy and practice in the years ahead?** A resounding YES to this. I believe the current structure is the best way to achieve this and would again cite the CAAs role in changing regulations for pilots with diabetes as an outstanding example of this. **5. What are your views on each of the options outlined in this consultation?** Of the three options none is perfect. Options 2 & 3 might save the CAA money in the short term but cost industry, pilots and passengers more for

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	the reasons I have outlined above. These options would also be most unlikely to result in the CAA being able to "influence international and European policymaking", one of the core criteria in the assessment as it would have sent a clear message of disengagement from the provision of aeromedical services. **6. Which option should the CAA prefer?** Option 1 offers the best alternative of those on offer. **7. Are there any alternatives that meet the CAA's core criteria?** I believe a modified Option 1 with the AeMC and AMS operating as a commercial entity within the CAA (similar to the way that BBC worldwide operates in relation to the BBC) should be considered. **8. What risks should the CAA seek to manage and pay special attention to as part of the implementation of any option for its services?** There is currently no alternative AeMC provider in the UK that can offer the range of services and expertise provided by the AeMC. In attempting to transfer the AeMC service elsewhere the CAA should be very aware of the potential "train crash" scenario if a new provider fails to get a comprehensive service up and running effectively and promptly. A scenario where an increasing proportion of the pilot population is grounded because of their inability to get their medical issues dealt with could be highly damaging to the reputation of the CAA, and to the British aviation sector. In summary I would advise that you think very carefully before you change a system that has helped to maintain the outstanding medical safety record of British aviation over the last 42 years. As someone who has recently come to work in this field I am very impressed with the expertise and professionalism of the AMS and AeMC and the synergies of these activities with the regulatory role of the CAA should not be undertestimated. Proposals 2&3 would initially appear to save the industry money but I believe would increase costs to the industry overall.