Civil Aviation Authority

The future structure of the CAA's Medical Department – Update consultation

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Foreword

Purpose of consultation

1. The purpose of this document is to provide an update to the progress made on our review of the Medical Department, and to seek the views of interested parties on the current proposals outlined for the future structure of the medical department.

Next steps and how to respond to the consultation

2. The consultation will begin on 29 September 2015 and will run for four weeks until 5pm on 27 October 2015.
3. Stakeholders are invited to email their comments to Consultations3@caa.co.uk. Comments made after the deadline may not be considered.
4. Once all comments have been received, the CAA will publish a summary of comments and consider these views as part of its decision making process about the future of the medical department.
5. When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear who the organisation represents, and where applicable, how the views of members were assembled.

Freedom of Information

6. Information provided in response to this consultation, including personal information, may be subject to publication or disclosure in accordance with the Freedom of Information Act 2000 (FOIA) or the Environmental Information Regulations 2004.
7. If you would like the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals with, amongst other things, obligations of confidence.
8. In view of this, it would be helpful if you could explain to us why you regard the information you have provided to us as confidential. If we received a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the CAA.
9. The CAA will process your personal data in accordance with the Data Protection Act 1998 (DPA).

Introduction

1. Between 16 October and 15 December 2014, we held a public consultation to ask stakeholders for their views and opinions concerning the future of the Medical Department. Three primary reasons were provided for carrying out the consultation:

   1. to ensure that the medical department is fit for purpose in the future
   2. cost and
   3. the issue of a regulator providing regulated services.

2. The consultation document and our response to the consultation are available on our website at www.caa.co.uk.consultations.

3. Our response to the consultation outlined that we would continue to investigate outsourcing the Aeromedical Centre (AeMC) from the CAA, and that any outsourcing would only take place where we were convinced that the outsourcing provided value for money and represented an improvement on current capability.

4. Since the consultation response was published in February, we have further reviewed and considered all of the comments received as part of the external consultation, and noted the responses provided. In addition, we have taken into account a number of external factors which have occurred since our response was published. All of the above have developed and shaped our thinking. These external factors are:

   - The emergence of new AeMCs for provision of initial medicals
   - The capability and appetite of other organisations to provide core advisory and assessment services. This capability and appetite was highlighted by organisations during the market testing process we undertook
   - Reflections following the Germanwings accident and the need for National Aviation Authorities (NAAs) to have expertise and good administrative systems.

5. The Germanwings accident has brought additional focus to the work of the project review team and the medical department itself. We have contributed to the task force established by the European Aviation Safety Agency (EASA), and contributed to the recommendations, which we are working towards implementing alongside our international partners to ensure the pilot medical assessment process is as robust as possible.

6. The purpose of this document is to provide an update to the progress made on our review of the Medical Department, and to seek the views of interested parties on the current proposals outlined for the future structure of the medical department.

Update

7. The responses to the consultation were grouped together by themes we believed were highlighted by the responses; our responses to each of these points were laid out in the response document (www.caa.co.uk/cap1276). The primary issues raised in the consultation remain of concern to us:

   - **The regulator should not also be a service provider**: As described in the original consultation, the AeMC carries out a range of clinical services (which are all regulated by the Authority Medical Section (AMS).). European regulations have defined that one of the medical department's functions is to issue and oversee the AeMC's approval to act as an AeMC and to remove that approval if necessary. Because of this we are now responsible for regulating ourselves as an AeMC, which we believe could give rise to potential conflicts.
   - **The cost of the medical department exceeds its income**: The majority of the medical department's work is funded by UK charge payers (approximately £4.3m annually). Further details of the costs of the department are available with the consultation document (www.caa.co.uk/1276). Currently, the cost of the department is borne by Air Operator Certificate (AOC) holders, Air Navigation Service Providers (ANSPs) and En Route Safety Regulation charges.
   - **The medical department should be fit for the future**: We wish to be in a strong position to influence and develop European and global medical policy and practice. In addition, the current auditing activity and the lessons learned from the Germanwings accident has indicated that there is potential for us to improve standards across the UK aviation medical community; we need to ensure that we are able to drive improvement and maintain and evolve standards.

Progress since the consultation

8. We recognise that the charges made by the AeMC are included in the CAA Scheme of Charges, which have historically also been applied to AeMC services supplied by non-CAA providers, which has resulted in the suppression of market growth. We also recognise that feedback from the consultation shows that the appetite for transparency on the costs of the department outweighs the requirement to rectify any cross subsidies at this time.

9. The Germanwings accident in March 2015 brought additional focus to the review of the medical department. A task force was established by EASA following the

accident, and we provided support to this task force, which met between May and July. A number of recommendations of work for EASA, NAAs and industry were proposed, which have further emphasised the need for a robust core aviation medical function and the need to raise capability and standards in the UK aviation medical community.

10. We continue to believe that it is best practice to separate the regulator from the service delivery function; this is well established across the CAA, Europe, ICAO and other UK Regulators.

11. Our objective is to continue to enhance our ability to be able to influence by being more efficient so that we can ensure that the department has more focus on core responsibilities such influencing policy.

12. Since the initial consultation was published in October 2014, we have continued to review the capabilities of the private sector and options for competition, through further market engagement opportunities. In addition, at the time that the review was started, there were only 2 non-CAA AeMCs providing Initial Class 1 and 3 Medicals. Since then, one new AeMC has opened (in London) and we are aware of other interest in setting up a new AeMC. The growth of the market has now allowed us to consider further options for the provision of this service.

13. Further consideration has also been given to set up a subsidiary company (similar to CAA International). While this option has the potential to create a profitable business, we believe that this option does not provide the clarity of separation of the service from the regulator and a possible conflict of interest will remain. In addition, the costs involved in setting up a subsidiary company make this option prohibitive.

14. The medical department has a set of statutory duties (set out in the original consultation document www.caa.co.uk/cap1214, pages 8-10). We will continue to perform all mandatory functions at all times; any changes to the current system will be with a view to carrying out these functions in a more efficient and effective manner. Any activities which may be ceased will be non-mandatory functions. The definitions of mandatory functions and non-mandatory functions used continue to be those described in the consultation document (www.caa.co.uk/cap1214, pages 8-10).

15. Public safety continues to be our primary duty. We continue to believe that quality can be maintained with any changes in the structure of the medical department. We will continue to provide valuable training to AMEs and our access to expert specialist advice will also continue. We believe that we can assure safety and quality by ensuring that the department is focussed on core regulatory activity and influencing policy in Europe and internationally.

16. We have taken into account the views expressed in the consultation with regards to the funding structure of the medical department; we continue to believe that the

department needs to be proportionate in what it spends, but we also understand that there is a requirement for transparency over the costs of the department.

17. During the consultation, we also received a number of comments related to the medical department's IT systems, and we continue to acknowledge that this is an issue and is under review.

18. Our view regarding whether we can benefit from selling our skills to other NAAs remains as described in the response to the consultation published in February 2015 (www.caa.co.uk/cap1276).

Our current thinking

19. Having considered all of the responses to consultation, the results of the market engagement exercises and the recommendations from the Germanwings accident in March 2015, we have identified the following outcomes for the review of the medical department:

    - The regulator should not also be an aviation medical service provider
    - There should be transparency on medical costs
    - The Authority Medical Section (AMS) should be an efficient operation
    - We should be promoting a more effective aviation medical community in the UK, with a clear picture for the role of the department in that community
    - We should be providing enhanced CAA capability to oversee the UK aviation medical arrangements.

20. Each point is discussed in further detail in the following paragraphs.

The regulator should not also be an aviation medical service provider

21. As discussed in the response to the consultation published in February, we continue to believe that it is best practice to separate the regulator from the service provider. We believe that it is currently difficult for us to be able to defend our position should questions be asked about our dual role as both regulator and provider of medical services, and whether it is appropriate or sufficiently objective for us to be overseeing our own performance.

22. In our previous response, we highlighted that we were minded to continue to investigate options for outsourcing the AeMC. This decision was based on the available AeMC market at the time and that there were no AeMCs in the private sector of a similar size and scope. Since the beginning of the review, further AeMCs have now emerged in the market (one new AeMC has opened in London and we are aware of other interest in setting up a new AeMC). The growth of the market now allows us to investigate the option of closing the CAA AeMC without outsourcing the service. This would involve the ramp down and cut off of

performing Class 1 and 3 medicals within an agreed timescale and some of the regular clinical assessment activities where the assessments are routine and apply well-established criteria (e.g. eye clinics, respiratory clinics, general medical and some cardiology clinics). The assessment of borderline cardiology and neurology cases, together with conditions which require close supervision by the regulator, e.g. Insulin-treated diabetes, drug and alcohol problems and psychiatric cases requiring medication or special assessment, will need to be retained in the CAA.

23. We recognise that the charges contained in the CAA's Scheme of Charges have been applied to AeMC services provided by external providers, which has had the effect of suppressing market growth. We further propose to release the charges for Class 1 and 3 medicals which are contained within the CAA Scheme of Charges, allowing AeMCs to develop the market without the constraint of the CAA's charging scheme.

Transparency on medical costs

24. The majority of the medical department's work is funded by UK charge payers (approximately £4.3m annually), with direct income received from two sources:

- AeMC charges to certificate applicants and holders of approximately £0.8m annually, which is lower than its costs (£1.3m)
- AMS charges to AMEs (approximately £0.5m). These fees include AME approval charges and an indirect charge to licence holders for the administration of their medical certificates by the CAA.

25. Feedback from the consultation showed that there is an appetite for transparency on these costs. We are minded to agree on this point and propose to introduce clear and transparent information on the costs of the department and the cross-subsidies.

Creating an efficient AMS

26. We propose that increased support should be offered to raise the capability of AeMCs and AMEs, through auditing and providing enhanced guidance and training. This would allow AeMCs and AMEs to conduct appropriate assessments and facilitate high quality decision making. To support this, we will need to improve the IT systems and provide enhanced guidance and training material to AeMCs and AMEs. AeMCs and AMEs will be encouraged to network more, and introduce peer support and continuous professional development to share examples and best practice.

27. This would allow us to provide enhanced oversight of AeMCs and AMEs, and to begin to develop a performance based oversight approach so that we can work in partnership with AeMCs and AMEs to address the higher risk areas.

28. In order to support this, we propose that:

- We provide enhanced guidance and training material for AeMCs and AMEs to raise the capability
- The AMS concentrates on the core regulatory activities, specialist clinics, liaison and influencing internationally, enforcement etc.
- The IT systems for the department are improved
- An effectiveness and efficiency programme is undertaken across the department

Promoting a more effective aviation medical community in the UK

29. We propose that the UK aviation medical community in the UK should have enhanced decision making capability, so that cases which are referred to the CAA are those where there is a statutory case to do so, where there are cases which require CAA expertise and experience, and appeals of AME/AeMC decisions. To do this, we propose encouraging AeMCs and AMEs to network more, to encourage peer support and continuous professional development, to share examples and best practice.

Providing enhanced CAA capability to oversee UK aviation medical arrangements

30. Through the promotion of a more effective aviation medical community, we will be able to start developing enhanced oversight processes and a Performance Based Regulation approach, working in partnership with those who we regulate to provide focus on the high risk areas.

Conclusion

31. We have reflected fully and carefully on the future of the medical department, including on the issues raised during the consultation, the developments in the external market and the recommendations from the Germanwings accident, recognising that we need to be mindful of retaining expertise and access to specialist support.

32. Having reflected in detail on the points raised in this document, we are minded to:

    - Separate regulated services from the regulator to allow us to focus on core regulatory duties by stopping providing AeMC services to industry in a phased manner and within an agreed timescale (6-12 months for initial Class 1 and 3 medicals, 12-18 months for the migration of clinics).
    - Release the CAA Scheme of charges for medical assessments as soon as possible to allow the market to grow further
    - Target our core regulatory activity in enhancing the performance of AeMCs and AMEs through enhanced decision making, maintaining our expertise so that we can focus on the high risk and more complex cases, in line with the recommendations from the Germanwings review
    - Release the regular clinical assessments that are routine and apply well established criteria to the market, allowing us to concentrate on the clinics which require direct regulatory oversight, such as diabetes, drugs and alcohol and psychiatric cases
    - Undertake an efficiency and effectiveness improvement programme across processes and IT which will include:
        - Introducing better cost control and transparency
        - Improving IT systems
        - Implementing process improvements across all medical department processes
        - Developing our capability to oversee UK aviation medical arrangements to allow for development of a Performance Based Regulation approach

We are seeking the views of stakeholders on the proposals contained in this document and we would welcome any comments on the information contained in this document, particularly in respect on the effects on users of services and providers of services.