

Comment response document: UK Private Pilot Licence and National Private Pilot Licence medical requirements

CAP 1397



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Executive summary

In keeping with our new approach to make the regulation of General Aviation (GA) more proportionate and less burdensome, while still seeking to protect third parties, we launched a public consultation to propose that the medical requirement for a UK Private Pilot Licence or a National Private Pilot Licence holder is to meet the current DVLA Group 1 Ordinary Driving Licence (ODL) standards with no General Practitioner (GP) or Aeromedical Examiner (AME) intervention required, in the majority of cases (See [CAP 1284](#)).

This consultation closed on 10th July 2015 and resulted in 1,823 responses, which is one of the highest responses we have ever had to a public consultation. The vast majority of responses (96%) agreed with the proposal to reduce the medical requirements for private pilots. This document identifies the approach we now plan to take, the next steps and also includes a summary of all the responses received to the consultation questions.

In summary, we plan to reduce the current medical requirements for private pilots, so that those with a UK Private Pilot Licence (PPL) or a National Private Pilot Licence (NPPL) will only be required to meet the Group 1 Ordinary Driving Licence (i.e. private driving) medical standard with no routine requirement to attend a medical examination. Each pilot will be required to complete an on-line CAA form once prior to the age of 70 (and then every three years after the age of 70) to make a legally binding statement that they meet this standard. For balloon pilots, the same revised medical requirements will apply for the UK PPL(B) and UK Restricted CPL(B). In making these changes, we will remove the NPPL medical system. Anyone who does not meet the driving licence medical requirements will be required to hold a LAPL medical certificate.

This new more proportionate approach should reduce both the amount of time and money spent on medical examinations and tests by UK private pilots while having little impact on overall safety standards. It is estimated it will save approximately £1M and 10,000 hours per year overall for private pilots. There are other benefits, which are detailed within this document. However, it should be noted that currently, UK

PPL holders are able to fly EASA aircraft using the privileges of a LAPL. This is anticipated to change in 2018, at which point the benefits of this change in medical requirements will decrease.

The focus of our new approach is on UK licence holders and EASA PPL holders flying non-EASA aircraft; we aim to influence EASA in considering reviewing the medical requirements for EASA licence holders flying EASA aircraft. It is therefore important for us to, where possible, work with the GA organisations and individual private pilots to gather evidence to provide a safety case to enable us to influence EASA in considering reviewing the medical requirements for EASA licence holders.

It should be noted that none of these changes affect pilots flying in air displays. As detailed in [CAP 1371](#) – UK Civil Air Display Review: Actions that impact on UK civil air displays in 2016, with effect from 1 April 2016, a display authorisation will only remain valid for pilots of aircraft registered in the UK or abroad who hold an EU medical certificate issued by an AME.

Background

Existing medical requirements for private pilots are considered to be disproportionate, costing private pilots both time and money unnecessarily, when compared to the benefit they provide. This issue was raised as part of the Government's General Aviation Red Tape Challenge of 2013 with a recommendation that the requirements could be reduced to that of a private driving licence standard. The CAA's public commitment to only regulate where we must, to do so proportionately and deregulate where we can, has led us to change our approach to the medical requirements for the UK Private Pilot licence and National Private Pilot Licence.

We launched a public consultation in 2015 to propose that the medical requirement for a UK Private Pilot Licence or a National Private Pilot Licence holder is to meet the current DVLA Group 1 Ordinary Driving Licence (ODL) standards with, in general, no General Practitioner (GP) or Authorised Medical Examiner (AME) intervention required. ([See CAP 1184](#)). The consultation closed on 10th July 2015 with 1,823 responses, which is one of the highest responses to any CAA public consultation. 96% of the responses were in favour of this change, although there were differing views relating to the specific details and these are addressed later in this document.

NPPL privileges allow the holder to fly UK registered aircraft of up to four seats, with a maximum take-off mass (MTOM) of 2,000kg and with a maximum indicated airspeed (IAS) of 140 knots within UK airspace. Operations are currently restricted to flying under Visual Flight Rules (VFR), however there is a separate consultation on the UK Air Navigation Order where the privileges of the NPPL will be reviewed. NPPL holders may also currently fly EASA aircraft within the restriction of a Light Aircraft Pilot Licence (LAPL)¹.

The UK PPL licence is an International Civil Aviation Organisation (ICAO) compliant licence, valid for life, and enables the pilot to fly non-EASA aircraft with additional

¹ [EASA LAPL](#)

class/type ratings and EASA aircraft within the privileges of a LAPL (at the time of writing).

The current medical system requirements are:

- NPPL: This is a medical fitness declaration by the pilot which is countersigned by a GP who has access to the pilot's medical records. The standards against which the pilot is assessed are the UK DVLA Group 2 professional driving standards, where a pilot wishes to carry passengers and the UK DVLA Group 1 Ordinary Driving licence standards if the pilot proposes to fly solo or with another qualified pilot. (See [DVLA driving medical standards](#)).
- UK PPL: An EU Class 2 medical is required ([EU Class 2 Medical](#)). The validity of the medical declaration or medical certificate is dependent on age and varies from one to five years, or only once for an NPPL holder until they reach the age of 45.

EASA is also taking a new approach to GA and the UK is taking a leading role in enabling more proportionate and better regulation. The focus of our new approach is on UK licence holders and EASA PPL holders flying non-EASA aircraft; we aim to influence EASA in considering reviewing the medical requirements for EASA licence holders flying EASA aircraft. It is therefore important for us to, where possible, work with the GA organisations and individual private pilots to gather evidence to provide a safety case to enable us to influence EASA in considering reviewing the medical requirements for EASA licence holders. The consultation document considered the potential risks incurred by introducing this change and these are summarised below:

a) GA fatal accidents with potential medical causes

GA fatal accidents which may have a possible (not conclusive) medical cause are uncommon. Over a 10 year period from 2004 – 2013, there were a total of 151 GA fatal accidents of which 20 had possible medical causes. These included factors such as hypoxia, fatigue, dehydration, alcohol and suicide. However, there is a degree of uncertainty in these statistics as the cause of the accident is often unconfirmed and a medical cause only suspected. Given the uncertainty in the medical cause data and the wide range of causes covered, not all of which would be affected by the change in medical

standards, it was decided to focus the risk analysis on serious incapacitation in flight.

b) Third party risk

History shows that the probability of a GA accident causing injury to people on the ground is extremely low. Over a 10 year period from 2004-2013, out of the 151 GA fatal accidents, there were a total of six GA accidents involving third parties on the ground. Only two of these resulted in fatalities and both of these involved third parties involved in aviation activities rather than being uninvolved third parties. There were no fatalities to a third party as a result of serious incapacitation of the pilot.

This proposal has been assessed using the [GA Policy Framework](#) which is our method to assess the risk of changing regulation on third parties with no significant increased risk to third parties identified.

c) Risk of incapacitation in flight

Consideration was given to the risk of incapacitation in flight by looking at the likelihood of different medical conditions occurring which could result in pilot incapacitation. The focus was on conditions which could result in sudden incapacitation (e.g. heart attack, seizure) where the pilot may be unaware of symptoms at the start of the flight. This is based on an assumption that private pilots do not generally take part in recreational flying if they feel unwell and this is supported by feedback from the consultation.

Based on the maximum number of private pilots who could possibly take advantage of this new proposal, it is estimated that there could be a total of approximately two acute medical incapacitations events in-flight per year compared with approximately one at present.

Whilst the risk of pilot medical incapacitation is increased, the absolute risk of a medically caused accident is assessed to remain very low.

The way forward

Options considered

Three options were considered:

1. The option of 'do nothing' was considered. However, this was discounted as the existing medical requirements for private pilots are considered to be disproportionate and this approach would not match the CAA's public commitment to only regulate where needed and to regulate proportionately.
2. Other options surrounding the detail of the proposal presented in the next section were also considered. This included imposing an age limit, excluding flight instructors, and further limiting the number of passengers that could be carried. However, since those falling outside of our proposal would be required to hold a LAPL medical (rather than an NPPL medical under the current system) feedback from the GA Partnership (which includes representation from all GA organisations in the UK) indicated that overall this could be seen to be more prescriptive than the existing process, which would not be in line with the overall strategy to deregulate GA where possible. In addition, we considered requiring pilots to self-declare and submit information on a regular basis to the CAA (as opposed to once prior to the age of 70). However, this was also considered to be more prescriptive than was needed and so will not be implemented.
3. Our new approach, as detailed in the next paragraph, is we believe the most appropriate. It maintains high levels of safety for third parties, and is the most deregulatory option considered. This is broadly in line with consultation feedback and has, in the majority, received positive feedback from GA Partnership members who represent over 20 GA organisations.

Our new approach

We will reduce the current medical requirements for private pilots, so that those with a UK Private Pilot Licence (PPL) or a National Private Pilot Licence (NPPL) will only

be required to meet the Group 1 Ordinary Driving Licence (i.e. private driving) medical standard with no routine requirement to attend for a medical examination. The pilot will be required to complete an on-line CAA form once prior to the age of 70 (and every three years after the age of 70) to make a legally binding statement that they meet this standard. For balloon pilots, the same revised medical requirements will apply for the UK PPL(B) and UK Restricted CPL(B).

In making these changes, we will remove the NPPL medical system. Anyone who does not meet the new medical requirements will be required to hold a LAPL medical certificate.

This new more proportionate approach should reduce both the amount of time and money spent on medical examinations and tests by UK private pilots while having little impact on overall safety standards.

The specifics of this new approach are detailed below.

Driving Licence (Group 1 Ordinary) medical standard

There will be no requirement to hold a driving licence.

The requirement will be to meet the Group 1 Ordinary Driving Licence medical standard and the pilot will be required to complete an on-line CAA form to make a legally binding statement that they meet this requirement. Additional caveats will be included to advise the pilot to seek advice from their GP or AME if they are unsure as to whether they meet these requirements.

Applicants with, or with a history of the following must apply to an AME for an EASA LAPL medical certificate with supporting medical reports from their GP/specialist(s):

- Medication for any psychiatric illness
- Bipolar disorder, psychosis or a diagnosis of personality disorder
- Drug abuse or alcohol misuse or addiction (or conviction for drink/drug driving)
- Medication treatment for angina or heart failure
- Cardiac surgery including cardiac device implantation
- Recurrent fainting or collapse (syncope)

- Unexplained loss of consciousness
- Insulin treatment
- Chronic lung disease with shortness of breath on exertion
- Any neurological condition requiring medication
- Epilepsy
- Significant functional physical disability likely to impair safe operation of normal flight controls

Even under the current system, these conditions are considered to be the highest risk and are highly likely to result in a discussion with a Medical Declaration Advisor (MDA) or recommendation to an AME for a medical. This is also in keeping with the responses from the consultation regarding psychiatric disease and all these conditions are of significant aeromedical concern (over and above driving).

Flight instructors

The medical requirement for flight instructors will be reduced - the requirement will be for them to meet the Group 1 Ordinary Driving Licence medical standard.

This is in keeping with the EASA principle of flight instructors having the same medical standards as the pupil.

It relies on the principle of Informed Consent, and will rely on this message being appropriately communicated to the GA community and student pilots.

Age limit

There will be no maximum age limit imposed.

Once a pilot is over the age of 70, he will be required to self-declare online (to the CAA) every three years, in line with the existing DVLA standard.

Aircraft weight limit

There will be a limit of 5,700kg, in line with consultation feedback.

In line with consultation feedback, the number of passengers will be limited to three.

Consideration was given to reducing the 5,700kg limit to 2,730kg, in line with the US approach and some comments made in response to the consultation. However, as we believe the risk to 3rd parties to be low and that there are only 281 (38 of which are balloons) out of almost 18,000 UK registered aircraft which fall into the

2730-5700kg bracket, we believe the increased risk of a 5,700kg limit (compared to 2,730kg) is negligible. It is also in line with the weight limit used by the CAA in its definition of aircraft falling under the responsibility of its GA Unit.

Pilots who will fall outside of the proposed new system

The following people will fall outside of the new proposed system:

- Those with significant pre-existing medical conditions will require a LAPL medical with an AME (This is considered proportionate in view of the increased flight safety risks that need managing);
- Those who wish to fly under the privileges of a full IR will still require a EU Class 2 with audiogram;
- Those who wish to fly at night will still require a colour vision test.

Self-declaration

We propose that pilots only self-declare on the CAA system once (during training prior to first solo or before flying under these rules for the first time) until they are 70, and it is the onus on the pilot to ensure they are fit to fly before each flight.

After the age of 70, it is proposed that pilots re-self-declare every three years (in line with DVLA Ordinary Driving Licence requirements).

We will promote the 'fit to fly' principle, both initially when launching this change to the medical requirements and as part of our wider engagement with the GA community.

Collating evidence to validate the new system and influence Europe

We will look at employing a record keeping system to collate evidence which will be used to influence EASA to follow a similar route.

This will be to ensure the system is validated and will require private pilots to submit information on an annual basis to the CAA documenting such things as:

- age, type of flying, hours flown in last year, total hours.

The details and requirements will be developed as we introduce this new medical declaration system.

Pilots will be encouraged to use the CAA safety reporting/whistleblowing system if they are aware of private pilots who they do not believe are medically fit to fly.

VFR/IMC/Night

The proposal will be for VFR or when exercising the privileges of an IMC or Night rating.

Full instrument flying will not be permitted (as additional medical requirements are needed).

Extension to EASA PPL holders flying non-EASA aircraft in the UK

In light of the consultation feedback, we will extend this proposal to EASA PPL holders flying non-EASA aircraft in the UK but the main focus of this consultation is on the privileges of UK licence holders.

Benefits

The proposal will require a change to the Air Navigation Order and this in turn will require a Regulatory Impact Assessment (RIA) to be completed and a cost benefit analysis to be undertaken.

Based on feedback from the consultation and our own analysis, this change in medical requirements is estimated to save approximately £1M and 10,000 hours per year overall for private pilots. It could also enable slightly more people to fly who have currently been excluded from taking part in recreational flying by the higher medical standard currently applied. This can be achieved with a negligible impact on overall safety standards and negligible impact on the overall risk to third parties.

Currently, UK PPL holders are able to fly EASA aircraft using the privileges of a LAPL, however this is not expected to be the case from April 2018. At this point, it is anticipated that the benefit of this change to medical requirements will reduce significantly.

In addition to the cost and time savings which would be realised by private pilots, the most widely identified benefit was the breaking down of barriers to participation in GA. In particular respondents argued that a reduction in the complexity of regulation

and lower expenses would encourage participation from the general public to the benefit of the wider GA community. The reduction in medical requirements is in line with the GA Red Tape Challenge and our commitment to only regulate where necessary.

The reduction in the administrative and regulatory burden and an alleviation of the threat of inadvertently voiding insurance due to lapsed medicals, were other benefits, which were observed by pilots.

It is also hoped that this change will encourage a culture of personal responsibility amongst GA pilots leading to honest self-assessment. Based on the feedback we received, there is an argument that our change in medical requirements would increase safety in GA.

The only dis-benefit, which has been identified, is the business lost to GPs and AMEs as a result of fewer pilots requiring GP or AME intervention. However, there is the argument that the change in medical requirements will benefit the NHS relieving the burden on GPs allowing for a better allocation of increasingly squeezed resources.

Next steps

Our next steps to implement these changes include:

- Develop a detailed communication plan to ensure the changes are understood and there is clarity on the additional limitations which would be imposed on the privileges of the UK Private Pilot Licence (e.g. restricted to UK flying only).
- Develop targeted communication to passengers and student pilots through flying clubs and training organisations to ensure they are aware of the change in medical requirements, in line with our 'Informed Consent' principles.
- Develop a system which would enable private pilots to self-declare and the CAA to have appropriate oversight and enforcement powers.
- Develop an exemption to the ANO to change the legal basis and ensure this is captured in the GA ANO review for implementation in August 2016.

Collating evidence following implementation

It will be important to collect evidence post implementation to confirm the safety analysis assumptions.

A record keeping system will have to be established to monitor the effects of implementing the new proposal. This will request private pilots submit information on an annual basis to the CAA documenting such items as: age, type of flying, hours flown in last year, total hours. The evidence collected will also be used to influence EASA to follow a similar route.

Pilots will be encouraged to use the CAA safety reporting/whistle-blowing system if they are aware of private pilots who they do not believe are medically fit to fly.

Consultation response

Feedback and our response

NOTE: The responses marked as being from organisations are those received from known ‘formal organisations’.

When percentages are quoted, they are quoted to the nearest significant figure.

1. Do you agree that private pilots do not generally take part in recreational flying if they feel unwell?		CAA response
Summary of feedback		CAA response
Yes: 1,531	No: 21	
<p>99% of respondents answered yes to this question.</p> <p>Most respondents who answered yes to this question made general observations regarding GA pilot’s cautious attitudes towards self-policing.</p> <p>Of the minority of respondents who answered no to this question, a number cited personal experiences of pilots flying under the influence of alcohol. Some observed pressure from passengers sometimes resulted in pilots flying when they felt unwell and there was also the observation that pilots who fly when unwell are likely to do this regardless of whether they have a medical or not.</p> <p>All of the formal organisations who responded to this consultation answered yes to this question.</p>		<p>Private pilots should conduct a self-assessment of their health prior to any flight and in general, it is expected that pilots would consider a decrease in their medical fitness prior to any flight (where it is clear to them) and not fly if they not feel well enough. Removing the need for UK PPL and NPPL holders to have a medical places the onus on the private pilot to assess whether they are ‘fit to fly’ each time they go flying. We will ensure that the need for ongoing ‘fit to fly’ assessment is communicated to private pilots as part of our wider Safety Promotion work in addition to any further communications, which accompany the change in medical requirements.</p> <p>It should be noted that some consultation feedback to this question suggested that placing the responsibility on the private pilot could actually increase safety.</p>

2. Do you agree that private pilots do not generally take part in recreational flying if they feel unwell?		
Summary of feedback		CAA response
Yes: 1,533	No: 20	
<p>99% of respondents answered yes to this question.</p> <p>Of those respondents who answered no a number stated that they believed the risk to be low but not extremely low.</p> <p>A small minority of respondents stated that they were unable to respond to this question citing either a lack of knowledge or a lack of reporting of incidents.</p> <p>All formal organisations who responded to this consultation believed that the probability of pilot incapacitation in flight is extremely low.</p> <p>One respondent cited the current medical requirements as an effective “filter” for GA pilots to prevent pilot incapacitation whilst flying and two respondents caveated their ‘yes’ response by stating that there was an increased risk amongst older pilots, although acknowledged that the probability of a third party fatality remained extremely low.</p>		<p>Consideration was given to the risk of incapacitation in flight by looking at the likelihood of different medical conditions occurring which could result in pilot incapacitation. The focus was on conditions which could result in sudden incapacitation (e.g. heart attack, seizure) where the pilot may be unaware of symptoms at the start of the flight. This is based on an assumption that private pilots do not generally take part in recreational flying if they feel unwell and this is supported by feedback from the consultation.</p> <p>We believe that introducing this new proposal could result in a slight increase in risk of pilot medical incapacitation. However, the absolute risk of a medically caused accident is assessed to remain very low.</p>

3. Do you believe that we should proceed with the proposal to allow private pilots with the UK PPL or NPPL to fly provided they meet DVLA Group 1 Ordinary Driving Licence medical standards, with no GP or AME involvement in the process?

Summary of feedback		CAA response
Yes: 1,484	No: 64	
<p>96% of respondents agreed with the proposal to allow private pilots with the UK PPL or NPPL to fly provided they meet the DVLA Group 1 Ordinary Driving Licence medical standard, with no GP or AME involvement in the process.</p> <p>Of those respondents, a number referenced the proven track record of self-certification in the USA and within the field of hang gliding. One respondent cited the relatively low risks of GA in comparison to driving.</p> <p>Of the minority who answered no to this question a number argued that GP or AME involvement was a necessary and useful safeguard and a number of those cited concerns about undeclared medical conditions whilst others argued that DVLA Group 1 Medical Conditions were insufficient to protect against flight specific risks.</p> <p>All the formal organisations who responded to this consultation, agreed with this proposal.</p>		<p>Based on our commitment to GA to only regulate where it is essential, to do so proportionately and deregulate where we can, in addition to taking account of the feedback to this consultation, we will proceed with the proposal to only allow private pilots with the UK PPL or NPPL to fly, provided they meet the DVLA Group 1 Ordinary Driving Licence medical standards.</p>

4. (a) To minimise the risk of pilots not being fit to fly (through illness or degeneration of senses) do you believe that pilots should be required by the CAA to self-certify themselves through, for example, signing a form?

Summary of feedback		CAA response
Yes: 1,157	No: 381	
<p>75% of respondents believed that pilots should be required to self-certify themselves through, for example, signing a form.</p> <p>All formal organisations who responded to the consultation were opposed to self-certification by the signing of a form. Two organisations were of the opinion that self-certification in this way would amount to an unnecessary bureaucratic burden with little corresponding safety benefits.</p>		<p>We will develop a system which would enable private pilots to self-declare and the CAA to have appropriate oversight and enforcement powers. We considered requiring pilots to self-declare and submit information on a regular basis to the CAA but, based on feedback received from several GA organisations, this was considered to be more regulatory than was needed and not in line with the principles of the Red Tape Challenge.</p> <p>We will therefore require pilots to self-declare on the CAA system once (during training prior to first solo or before flying under these rules for the first time) until they are 70, and the onus will be on the pilot to ensure they are fit to fly before the flight.</p> <p>After the age of 70, pilots will need to re-self-declare every 3 years (in line with DVLA Ordinary Driving Licence requirements).</p> <p>We will promote the 'fit to fly' principle, both initially when launching this change to the medical requirements and as part of our wider Safety Promotion strategy.</p>

4. (b) Do you believe they should submit this information to the CAA at regular intervals aligned with the validity of current medicals? (e.g. 5 year, 2 years or 1 year, dependant on age)		CAA response
Summary of feedback		
Yes: 1,066	No: 465	See response to question 4 (a) above.
70% of respondents answered yes to this question. This question elicited no notable comments.		

5. Based on the evidence presented, or other evidence which you can reference, do you believe an upper age limit should be imposed on the proposed change to the medical requirements for private pilots?

Summary of feedback		CAA response
Yes: 416	No: 1,109	
<p>The majority of respondents answered no to this question.</p> <p>Of those respondents who answered yes to this question the majority of comments stated that any upper age limit should be 70 in line with DVLA Group 1 Requirements. Other alternative age limits were also suggested which ranged from 45 to 85.</p> <p>Those respondents who answered no to this question generally argued that an arbitrary upper age limit was inappropriate on the basis that age itself has little bearing on fitness to fly.</p> <p>Of the four organisations who responded to this consultation one thought that an upper age limit of 70 should be imposed whilst two organisations felt that an upper age limit of 70 should be imposed only where passengers are carried. One organisation did not believe there should be a fixed upper age limit.</p>		<p>The special senses such as vision, hearing and balance are a vital element of safe flying but all can be affected by ageing, degeneration and acute and chronic disease. A pilot should always ensure that they have no impairment to these senses prior to a flight and should self-declare themselves prior to any flight.</p> <p>We considered whether an age limit should be imposed with or without carrying passengers and concluded that provided the pilot can meet the DVLA Group 1 medical requirements, they should be considered fit to fly.</p> <p>To ensure additional rigour, we will require all pilots over the age of 70 to self-declare every three years (which is in line with the DVLA requirements).</p>

6. Do you believe that private pilots who have a history of significant psychiatric condition (i.e. that requires medication) should be assessed by their GP rather than use a self-certification system?

Summary of feedback		CAA response
Yes: 1,304	No: 223	
<p>The overwhelming majority of respondents answered yes to this question. This question solicited the most comments of all of the questions. A significant proportion of responses indicated that GP assessment was a necessary safeguard whilst a smaller number believed that assessment by an AME was more appropriate.</p> <p>The responses indicated a wide range of concerns. The most prevalent arguments concerned the monitoring and side effects of psychiatric medication and an inability for valid self-certification.</p> <p>A large number of responses also specifically mentioned Germanwings Flight 4U9525 or more generally a heightened risk of suicide. A small number of respondents asserted that a history of psychiatric illness should preclude flying altogether.</p> <p>A number of those respondents who answered yes to this question caveated their response indicating that further definition of the meaning of “significant” was required. Some respondents also</p>		<p>The effect of psychoactive medication and drugs including alcohol, as well as some mental health conditions can cause significant impairment and therefore threaten the safety of a flight. These are all examples of psychiatric disorders. Psychiatric disorders can be very difficult to diagnose and a patient’s insight into the severity of such illness may be lost, resulting in dangerous behaviour.</p> <p>We have reviewed and considered this risk and have concluded that those who have a history of a significant psychiatric condition (i.e. that requires medication) will not be able to participate in the new scheme which relies on pilots assessing themselves fit to fly.</p> <p>Those with a history of significant psychiatric condition will be required to gain a LAPL medical which will then involve assessment by a GP or an AME.</p>

questioned the meaning of “history” indicating that they did not believe that previous psychiatric conditions which had been successfully treated should preclude self-certification.

Of those respondents who answered no to this question the majority argued that the risk posed was less than, or the same as, that posed by drivers.

A number of other respondents argued that the consideration of psychiatric illnesses independently of physical illnesses was either unnecessary or discriminatory.

Of the four formal organisations who responded to the consultation three answered yes to this question. One organisation answered no the basis that GP and / or AME certification is ineffective and the risks remain relatively low.

7. (a) If the medical requirements are changed as proposed, should the number of passengers the pilot carries be restricted?		
Summary of feedback		CAA response
Yes: 672	No: 852	
<p>By a slim majority most answered no to this question.</p> <p>Of the five organisations who responded to the consultation 3 (AME, BBAC, LAA) were of the opinion that the number of passengers should be restricted to one passenger. One organisation (LAA) was of the opinion that the carriage of passengers should be unrestricted.</p>		<p>The exposure of third parties to the assumed small risk could be further minimised by limiting the number of passengers, which the pilot may carry. For example, the FAA sports pilot licence allows the carriage of up to five passengers.</p> <p>As we believe that the increased risk to the pilot is very low as a result of introducing these new medical requirements, we therefore concluded that the increased risk to passengers would also be very low. We have concluded that the number of passengers the pilot carries should not be restricted. However, there will be an automatic restriction on the number of passengers as a result of the weight restrictions we are imposing, see question 10.</p> <p>This feedback was in line with the majority of the feedback received from the consultation and the organisations that are members of the GA Partnership.</p>

7. (b) If yes, do you think this should the number of passengers be restricted to...?	
Summary of feedback	CAA response
<p>1 passenger: 142 2 passengers: 55 3 passengers: 323 4 passengers: 92 5 passengers: 96</p>	<p>See the response to question 7 (a).</p>
<p>The majority of respondents who answered this question stated that the number of passengers should be restricted to three.</p> <p>This question did not elicit any comments.</p>	

8. Do you believe that pilots taking advantage of our proposed change to medical requirements should have to fly with a safety pilot?		
Summary of feedback		CAA response
Yes: 59	No: 1,449	<p>A further extension of protecting passengers is to only allow the pilot to fly with a safety pilot. The presence of another pilot to intervene in the event of medical incapacity could reduce the risk to passengers.</p> <p>However, the anticipated benefits would be significant reduced if we mandated the need to fly with a safety pilot. We therefore concluded that we would not introduce an additional requirement to fly with a safety pilot.</p>
<p>Almost all respondents answered no to this question.</p>		

9. Do you believe that the medical requirements for flight instructors should be changed from the current system?		
Summary of feedback		CAA response
Yes: 512	No: 986	
<p>The majority of respondents answered no to this question.</p> <p>The survey did not allow for comments to this question however there were a number of email comments.</p> <p>Of the four organisations who responded to the consultation all were opposed to changing the medical requirements for flight instructors.</p>		<p>We have carefully considered our response to this aspect and used feedback from more than 20 GA organisations represented by the GA Partnership group. Under EU regulation, the medical requirement for flight instructors is the same as that for pilots who are undergoing private pilot training. So, we decided to apply the same principle: flight instructors will only be required to meet the DVLA Group 1 medical requirements and will assess themselves fit to fly, providing the self-declaration to the CAA as is required of private pilots.</p> <p>There is a further important point which influenced our decision: as we are now planning to remove the NPPL medical scheme, then if we were to require flight instructors to hold a medical, they would need to hold a LAPL medical certificate at a minimum. For those flight instructors (e.g. microlight flight instructors) who currently instruct with an NPPL medical declaration, requiring a LAPL medical would actually be more regulatory than the existing system. This would go against our principles of deregulation.</p>

10. Do you believe that the UK PPL holder wishing to take advantage of the proposed new medical requirements should be limited to flying aircraft with a Maximum Take-Off Mass of 5700 kg or less?

Summary of feedback		CAA response
Yes: 1,103	No: 382	
<p>The majority of respondents answered yes to this question.</p> <p>The survey did not allow for comments to this question however there were a number of email comments.</p> <p>All four organisations who responded to this consultation answered yes to this question. One specific maximum take-off mass of 2,000 kg was suggested by one of the organisations.</p>		<p>As discussed in the consultation document, history shows that the probability of a GA accident causing injury to people on the ground is extremely low (only aircraft weighing less than 5700kg were considered in the analysis). An aircraft of significantly more mass is likely to cause more damage in the event of an accident.</p> <p>A UK PPL holder can only fly EASA aircraft using the privileges of a LAPL, which automatically restricts the weight to 2000kg. Whilst this is self-limiting, we considered adding a limitation for UK PPL holders flying non-EASA aircraft. The majority of non-EASA are less than 5700kg, so we concluded that we would impose this additional restriction when we introduce the new medical requirements. This is in line with the majority of feedback received from the consultation and also places a natural restriction on the number of passengers who could be carried (see question 7).</p>

11. Do you believe that the UK PPL holder wishing to take advantage of the proposed new medical requirements should be limited to the licence privileges of an NPPL holder?

Summary of feedback		CAA response
Yes: 410	No: 1,069	
<p>The majority of respondents answered no to this question.</p> <p>Of the four organisations who responded to this consultation two answered yes to this question, one answered no and one organisation declined to respond.</p>		<p>Following on from question 10, this was an alternative suggestion to limit the third party risk to the public on the ground. Limiting the privileges to that of an NPPL holder would mean that, in addition to other restrictions, the UK PPL holder would be limited to flying aircraft of 2000kg or less were they to take advantage of our new medical requirements. We felt that this would be too regulatory and so decided that that a UK PPL holder wishing to take advantage of the proposed new medical requirements would not be limited to the licence privileges of an NPPL holder.</p>

12. Do you believe that the medical requirements for the CPL(B) should be changed?		
Summary of feedback		CAA response
Yes: 227	No: 1,018	
<p>The majority of respondents answered no to this question.</p> <p>The responses demonstrated that the overwhelming majority of respondents felt that any form of commercial aviation should be subject to more stringent medical requirements. In particular respondents indicated that the carrying of fare-paying passengers should impose a higher medical standard.</p> <p>Those respondents who answered yes to this question generally argued that evidentially similar low risks meant that medical requirements should be brought in line with the proposed changes regarding self-certification. Other respondents were of the opinion that uniformity of regulation would prevent confusion.</p> <p>A significant proportion of respondents indicated that they would have preferred to answer “don’t know” to this question on the basis that they lacked the requisite knowledge of CPL(B) requirements or associated risks. These responses were discounted from the sum of yes or no responses.</p>		<p>As the vast majority of the responses did not believe the medical requirements should change for the full CPL(B) holder, it was concluded that we would not consider change them at this time.</p>

<p>Of the four organisations who responded to this consultation two declined to respond to this question. Of those organisations who did respond two felt that the requirements for the CPL(B) should be changed.</p>	
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13. Do you believe the proposal to change the medical requirements for UK PPL and NPPL holders should be extended to EASA PPL holders flying non-EASA aircraft in the UK?

Summary of feedback		CAA response
Yes: 1,379	No: 105	
<p>The majority of respondents answered yes to this question, because it would enable more pilots to take advantage of the new medical requirements. Of those who responded no, some felt that this would result confusion amongst pilots and some accidentally breaking the law through misunderstandings.</p>		<p>Whilst the focus of the consultation was on holders of a UK PPL or an NPPL, it would be possible, under the Air Navigation Order to extend this proposal to include EASA PPL holders when flying non-EASA aircraft.</p> <p>The majority of respondents were keen for this to happen. We will look at making the relevant changes to the Air Navigation Order, and will accompany this with careful communication so that these changes can be communicated effectively.</p>

14. Do you have any other specific comments which you would like to be considered as part of this consultation?

Summary of feedback	CAA response
<p>This question elicited a wide-range of responses and a number of suggestions were made.</p> <p>In particular a large number of respondents advocated the extension of the proposal to EASA LAPL(A) Licence Holders.</p> <p>Other specific suggestions included:</p> <ul style="list-style-type: none"> • A compulsory eye test for all NPPL / UK PPL Licence Holders • A provision for pilots who do not hold Driving Licences • The introduction of a reporting obligation for GPs to inform the CAA of any notifiable medical conditions • Extension of the proposal to IFR flights <p>Many respondents used this section to express general support for the proposal and a number expressed concern about complex and confusing regulation in other areas of GA.</p> <p>A small number of respondents used this section to criticise either the proposal or the consultation and others set out further comments to previous questions in the consultation, which have been captured above.</p>	<p>All of the 1823 responses and comments were carefully considered and were used to help shape the changes to the medical requirements for the UK PPL and NPPL holder in the UK. After we have introduced the changes in the UK, we will be collecting evidence so we can try and influence EASA to make changes to their regulation.</p> <p>Pilots will need to meet the DVLA Group 1 medical standard and make a self-declaration to the CAA. They will not need to hold a driving licence.</p>

15. Do you believe that the figures used to describe the time and cost benefits are accurate for the average private pilot?		
Summary of feedback		CAA response
Yes: 1,282	No: 82	
<p>Whilst the overwhelming majority of respondents answered yes to this question those respondents who answered no generally argued that the time estimates failed to account for varying travel times. In particular a number of respondents stated that the low density of AMEs considerably increased travel time.</p> <p>A number of other respondents also argued that the time benefit estimate failed to account for time taken to book the appointment and waiting time.</p> <p>A number of respondents also argued that the cost benefit estimates were understated. As regards any alternative cost benefit estimations the responses did not demonstrate any discernible trend but pointed towards high levels of variation from GP to GP.</p> <p>Of the four organisations who responded to this consultation three answered yes to this question with one answering no. This organisation argued that the cost and time estimates failed to account for both travel time and any additional costs associated with follow-up investigations.</p>		<p>The information provided by those who responded was very useful for the CAA in trying to quantify the benefits, which is needed for the Regulatory Impact Assessment to change regulation.</p> <p>Whilst the majority of responses believed the time and cost benefits were accurate, those who disagreed, predominantly felt that we had underestimated the time and cost savings.</p>

16. Do you have any other specific comments which you would like to be considered as part of this consultation?

Summary of feedback	CAA response
<p>This question elicited a broad range of comments.</p> <p>The most widely identified benefit was the breaking down of barriers to participation in GA. In particular respondents argued that a reduction in the complexity of regulation and lower expenses would encourage participation from the general public to the benefit of the wider GA community.</p> <p>A significant number of respondents also stated that the proposal would extend the flying life of existing GA pilots who might otherwise be prevented from continuing to fly due to minor medical conditions or otherwise deterred by “non-flying expenses” or cumbersome regulatory and administrative requirements.</p> <p>A large number of respondents also identified cost and time benefits for pilots. Other benefits for pilots which were identified included a reduction in the administrative and regulatory burden and an alleviation of the threat of inadvertently voiding insurance due to lapsed medicals.</p> <p>A number of respondents identified benefits to the NHS stating that the</p>	<p>We appreciate the feedback provided and agree that with all of the benefits listed.</p>

proposal would relieve the burden on GPs allowing for a better allocation of increasingly squeezed resources.

Other respondents argued that self-certification would engender an ethos of personal responsibility amongst GA pilots leading to honest self-assessment. A number of respondents were of the opinion that this would increase safety.

A number of respondents used this section to praise the proposal for reducing bureaucracy or “red-tape” whilst a small number stated that the proposal demonstrated no discernible benefits at all.

Of the four organisations who responded to this consultation two stated that the primary benefit of the consultation would be to reduce barriers to participation and one organisation stated that the proposal would reduce paperwork and administration and associated costs.