

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

CAP 1397



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## Executive summary

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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 10<sup>th</sup> 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

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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 10<sup>th</sup> 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)<sup>1</sup>.

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

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<sup>1</sup> [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

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## Options considered

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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

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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