FORMAL WRITTEN SUBMISSION TO THE HEALTH, SOCIAL CARE & SPORT COMMITTEE

From: *Tina McCaffery (on behalf of NMAC and Skin Religion Aesthetics)*
**Non-Medics Aesthetics Committee (NMAC)*
Regarding: *Non-Surgical Cosmetic Procedures (Licensing) (Scotland) Bill – Stage 1*
Date: *07/12/2025 (Tuesday 2nd Dec 2025)*

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1. Introduction

Thank you for the opportunity to provide supplementary written evidence to address questions I was unable to answer due to technical difficulties during the Committee meeting.
I strongly support proportionate, effective regulation that genuinely improves public protection. However, the Bill as drafted raises significant concerns around equality, access, prescriber dependency, and Healthcare Improvement Scotland's (HIS) capacity to regulate a large commercial sector it was never designed for.

My answers below follow the order of the questions raised during the session, up to the point where my separate equalities and enforcement submission begins.

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2. GENERAL VIEWS ON THE BILL (Emma Harper MSP)

I support the principle of regulating non-surgical cosmetic procedures, especially those involving injectables and medium- to high-risk modalities. However, the current Bill risks creating:

- **A structurally exclusionary model** that disproportionately affects women-led microbusinesses, who make up the majority of the sector;
- **A geographic imbalance**, particularly for rural and island communities; and
- **A regulatory model dependent on HIS**, an organisation already operating at capacity.

Regulation must be proportionate, evidence-based and deliverable. If it is not, it will not improve safety—it will simply reduce access to legitimate providers while unintentionally strengthening the unregulated and black-market sector.

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3. TRAINING, QUALIFICATIONS & PUBLIC INFORMATION (Emma Harper MSP)

Safety begins with clear, nationally recognised qualifications.
I fully support mandatory training mapped to SCQF/Ofqual levels, with Level 7 (or

equivalent) as the standard for higher-risk procedures. Lower-risk treatments should sit within regulated Level 4–5 qualifications.

There are already Ofqual-regulated Levels 4, 5, 6 and 7 qualifications in aesthetic practice available within the UK education framework. These qualifications are formally quality-assured, externally assessed, and mapped to nationally recognised standards. They are explicitly designed to meet the competency, governance and patient-safety expectations outlined in guidance produced by voluntary regulatory bodies such as the Joint Council for Cosmetic Practitioners (JCCP).

A significant and ongoing challenge within the aesthetics industry is the widespread misunderstanding between regulated qualifications and Continuing Professional Development (CPD). Short CPD courses are intended to supplement existing competence, not to confer core eligibility to practise. However, a proliferation of short courses — often delivered by inexperienced or poorly governed training providers — has led to CPD being incorrectly marketed as a "qualification", sometimes accompanied by misleading references to "levels" that have no regulatory standing.

This misrepresentation creates confusion for practitioners, consumers and regulators alike. It can result in individuals believing they are suitably qualified to carry out complex or higher-risk procedures when they have not completed any regulated qualification, undergone external assessment, or demonstrated competence against national occupational standards.

While legitimate, regulated training centres are already undertaking extensive work to educate learners on the distinction between CPD and formal qualifications, this alone is insufficient without a clear statutory framework. The absence of explicit legislative recognition of regulated aesthetic qualifications allows poor-quality provision to persist and undermines public safety, professional standards and confidence in the sector.

A coherent regulatory model must therefore formally anchor practice eligibility to recognised regulated qualifications, with CPD positioned correctly as an adjunct for skill extension and updating — not as a substitute for foundational training.

Ofqual-regulated aesthetic qualifications are developed under strict conditions requiring clear learning outcomes, independent assessment, external quality assurance, and qualification oversight by an awarding organisation approved by the Office of Qualifications and Examinations Regulation (Ofqual). By contrast, CPD courses are not regulated, are not standardised, and do not require externally validated assessment of competence. This distinction is already recognised within JCCP guidance, which explicitly links practitioner eligibility and scope of practice to the completion of appropriate regulated qualifications, not CPD alone. Failure to embed this distinction clearly in legislation risks perpetuating unsafe practice, misleading advertising, and inconsistent enforcement across the sector.

Ofqual – Regulated Qualifications Framework (RQF): Guidance on regulated qualifications, levels, assessment and quality assurance.

Joint Council for Cosmetic Practitioners (JCCP) – Guidance on education, training and qualification standards for cosmetic practitioners.

To protect consumers, Scotland needs:

- a **single public register** of licensed practitioners and premises;
- standardised **pre-treatment information** and consent; and
- a public-facing **national safety campaign**.

If the public are to make safe choices, we must give them **clear, consistent information**, not a fragmented landscape of registers and training routes.

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4. DATA, COMPLICATIONS & PRESCRIBER AVAILABILITY (My earlier points)

Scotland currently lacks:

- a **national complications reporting system**;
- a **unified qualification standard**; and reliable **data on prescriber numbers and accessibility**, particularly outside the central belt.

We cannot build a prescriber-dependent regulatory model without first understanding whether Scotland has enough prescribers to meet the Bill's requirements, particularly in remote areas.

Prescriber Availability in Scotland – Capacity, Regional Disparity and Systemic Impact

A central assumption underlying the Bill is that sufficient prescribing clinicians are available across Scotland to support a model requiring medical oversight or physical prescriber presence within aesthetic clinics. Current evidence strongly suggests that this assumption is unsafe and unworkable.

1. Prescriber workforce size and distribution

Scotland's prescriber workforce relevant to non-surgical aesthetics is limited and unevenly distributed. The prescribing base largely consists of:

- General Practitioners
- Independent Nurse Prescribers
- A small number of pharmacists holding prescribing rights

The overwhelming majority of these prescribers are employed within the NHS, where prescribing capacity is already under sustained pressure.

Available workforce data and industry analysis indicate:

- The **vast majority of prescribing clinicians are concentrated in the Central Belt**, primarily Greater Glasgow, Lothian, and parts of Lanarkshire.
- **Rural and island areas** (Highlands, Western Isles, Orkney, Shetland, Argyll & Bute) have *very limited* prescriber coverage, with some areas relying on a small number of clinicians covering vast geographic regions.
- Many existing aesthetic prescribers already work at or near capacity and provide **remote or sessional support**, rather than being physically present full-time.

This geographical imbalance means that a regulatory model requiring on-site or constant prescriber presence is **structurally incompatible with large parts of Scotland**.

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2. Real-world impact on aesthetic businesses

Requiring physical prescriber presence or exclusive HIS-registered clinical environments would have immediate commercial consequences:

- Clinics in urban centres may survive by competing for a **scarce and increasingly expensive prescriber workforce**.
- Clinics in rural and semi-rural areas may be left **unable to operate at all**, regardless of practitioner competence or qualifications.
- Prescriber costs are already reported by businesses as ranging from **£600–£1,200+ per day**, depending on location and demand.
- These costs are passed directly to clients, reducing access and pricing out lower-income groups.

For many safe, established non-medic clinics, particularly women-led microbusinesses, the result is **forced closure rather than non-compliance**.

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3. Consequences for NHS capacity

Diverting prescribers from the NHS into mandatory private-sector compliance roles presents a serious unintended consequence.

- Scotland already faces **GP and nurse workforce shortages**, acknowledged repeatedly by Audit Scotland and the Scottish Government.
- If prescribers are financially incentivised to spend additional time physically present in private aesthetic clinics, this may:
    - reduce NHS appointment availability,
    - increase waiting times,
    - and exacerbate pressure on primary care services.

This risks creating a situation where **NHS capacity is indirectly reduced** to sustain a regulatory model for private aesthetics — an outcome that runs counter to public interest.

4. Safety paradox and regulatory risk

Rather than improving safety, a prescriber-dependent model risks creating a safety paradox:

- Legal clinics close due to lack of prescriber access.
- Prices rise sharply in remaining clinics.
- Clients seek unregulated, underground providers.
- Complications increase and present to the NHS anyway — but **without traceability or regulatory oversight**.

This is particularly likely in rural Scotland, where travel distances, cost, and workforce scarcity already limit access to regulated services.

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5. Evidence-led conclusion

At present:

- There is **no published prescriber workforce modelling** demonstrating that Scotland has sufficient prescribing clinicians to support the Bill's requirements.
- There is **no regional needs assessment** showing how prescriber coverage would be maintained equitably across urban, rural and island communities.
- There is **no impact analysis** on NHS workforce displacement.

Until these data gaps are addressed, assumptions about prescriber availability **cannot be relied upon as a foundation for statutory regulation**.

Recommendation

Before implementing any model that relies on increased or mandatory prescriber presence, the Scottish Government should:

1. Publish a **national prescriber capacity assessment**, broken down by region.
2. Assess **impact on NHS service delivery**.
3. Explore **alternative safety models**, including:
    - remote prescribing with robust governance,
    - risk-tiered clinical oversight,
    - mandatory advanced qualifications in complication management.

Safety must be grounded in *what is deliverable in practice*, not what works only on paper. We have already submitted a paper that details prescriber numbers and our findings and are happy to resubmit should it be required.

5. COMPLICATION RATES IN SKIN PEELS – INCLUDING THE 3.8% CITED BY DR GULHANE

During the session, Dr Gulhane referenced a **3.8% complication rate** for superficial chemical peels.
It is important that this figure is understood **accurately and in context**.

5.1 Where the 3.8% comes from

The 3.8% figure corresponds to a **single retrospective clinical study** of 473 superficial chemical peels in a dermatology setting, which recorded 18 complications (mainly crusting, transient erythema, and post-inflammatory hyperpigmentation).

This is a legitimate published statistic **but only within the context of that specific study**.

5.2 What the 3.8% does *not* tell us

Crucially:

- The study does **not distinguish practitioner type** (doctor, nurse, non-medic, aesthetician).
- It does **not represent national complication rates** across the sector.
- It is **not reflective of mixed clinical environments**, diverse populations, training backgrounds, or real-world practice across Scotland.
- It cannot be used to claim that medically trained providers have lower complication rates than non-medics—or vice versa.

5.3 Why this clarification matters

Using a single study as a blanket benchmark risks:

- overstating its applicability;
- implying practitioner-type causality where no data exists;
- introducing bias into discussions between medics and non-medics; and
- ignoring the reality that **complication rates are influenced by training, product selection, skin type, aftercare, and procedural suitability—not solely professional background**.

In fact, published reviews consistently state that superficial and medium-depth peels have *relatively low complication rates* **when performed correctly** by properly trained practitioners, regardless of title.

5.4 How this supports the case for proportionate regulation

The correct takeaway is not “3.8% means non-medics are unsafe” or “medics are safer,” but rather:

We urgently need a national, practitioner-neutral adverse events database.
Regulation must be based on training, competency, and premises standards—not practitioner title.
Policy-making must avoid assumptions unsupported by data.

This reinforces the need for Scotland to develop a **central mandatory complications reporting system**, mapped to practitioner training and procedure risk-levels, so regulation is shaped by evidence rather than assumptions.

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6. ENFORCEMENT & ROGUE PRACTITIONERS (Sandesh Gulhane MSP)

I agree completely that **rogue practitioners cannot be allowed to operate**.
However, over-burdensome regulation risks creating a larger and more dangerous underground sector.

To prevent this, enforcement must be:

- **intelligence-led**;
- **multi-agency** (HIS, Trading Standards, MHRA, Police Scotland);
- supported by **product-supply chain controls**;
- underpinned by a **national reporting portal**; and
- focused on those who deliberately evade regulation—not those trying to comply.

A fair approach must distinguish between:

- practitioners who are **trying to meet standards**, and
- practitioners who **intend to act illegally**.

Criminal sanctions should target the latter.

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7. MEDICAL OVERSIGHT & PRESENCE (Brian Whittle MSP)

A blanket requirement for a medic to be **physically present at all times** is:

- disproportionate for low- and medium-risk procedures,
- practically unworkable in rural Scotland,
- unsupported by complication data,
- impossible to staff with the current prescriber workforce.

Safety comes from:

- robust, regulated qualifications;
- correct treatment selection;
- clear clinical governance;

- local and rapid access to a prescriber; and
- emergency pathways—not a mandatory on-site medic.

A **risk-tiered** clinical oversight model is far more realistic and safer. Please see answer 4

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8. PROFESSIONAL IDENTITY & CROSS-BORDER REGULATION (Joe FitzPatrick MSP)

The Non-Medics Aesthetics Committee (NMAC) represents trained, insured, and qualified non-medical practitioners across Scotland and the wider UK.

Divergence between Scotland and England poses risks:

- inequality for Scottish practitioners;
- commercial displacement to England;
- increased client travel;
- confusion for UK-wide training providers;
- barriers to women-led businesses.

Regulation should align with UK frameworks where sensible and must recognise regulated qualifications regardless of professional background.

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9. IMPACT ON SMALL & HOME-BASED PRACTITIONERS (Paul Sweeney MSP)

A large proportion of Scotland's aesthetic sector consists of sole traders and home-clinic providers. If regulation is tied exclusively to HIS premises standards:

- many of these microbusinesses will not survive;
- rural provision will collapse;
- prices will rise; and
- clients may turn to unregulated alternatives.

This is a direct safety risk.

A **tiered premises model**, transitional support and proportionate standards are essential to avoid unintentionally wiping out safe local providers.

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10. MENTAL HEALTH, BODY IMAGE & BDD

We support mandatory training in:

- mental-health screening;
- BDD recognition;

- safeguarding;
- advertising restrictions that prevent exploitation.

This is already incorporated within the OFQUAL regulated qualifications currently available. However, this must be explicit in the regulatory framework moving forward.

11. CONCLUSION

We firmly support regulation that improves public safety. However, to succeed, the Bill must:

- adopt **proportionate, risk-based requirements**;
- recognise current **regulated qualifications** for both medics and non-medics;
- address **HIS capacity constraints** before expanding its remit;
- support **rural and island access**;
- strengthen **advertising and mental-health safeguards**;
- create a **national adverse-events reporting system**;
- prevent black-market growth through **realistic compliance pathways**.

Scotland now has the opportunity to build a world-leading, safe, fair and evidence-based regulatory system.
But this can only be achieved by grounding legislation in **data**, not assumptions; in **training and competency**, not titles; and in **workable enforcement**, not theory.

I am very grateful for the chance to contribute further to this process.

QUESTIONS I WAS UNABLE TO PRESENT – FULL RESPONSES

Below are my full written responses to the questions I was unable to answer due to technical issues.

PATRICK HARVIE – EQUALITIES IMPACT

Will raising standards have a positive impact for marginalised groups as the Government suggests?

I agree that consistent standards are essential to protect the public, particularly groups who may be more vulnerable to harm — including young people, women experiencing appearance-based pressures, LGBTQ+ individuals, and racialised communities who face Eurocentric beauty norms.

However, whether the overall equalities impact is *positive* depends entirely on **how regulation is delivered** in practice.

The Bill, as drafted, concentrates delivery almost exclusively within Healthcare Improvement Scotland (HIS)-registered, medically led settings. That model creates *uneven* impacts across demographics, geography, and income.

Firstly, the non-surgical aesthetics workforce is overwhelmingly female and dominated by women-led microbusinesses. Consultation evidence summarised by SPICe highlighted that many respondents warned the proposals could disproportionately impact women-led businesses, rural practitioners and lower-income groups — not because standards aren't important, but because of the financial and logistical barriers associated with HIS registration.

Secondly, for rural and island communities, the impact could be particularly negative. The Government's own Island Communities and Equality & Fairer Scotland Impact Assessments acknowledge that distance, affordability and workforce shortages already limit access. If HIS becomes the sole gateway to legal treatment provision, those barriers increase significantly.

Thirdly, some marginalised groups — for example trans people or those with past healthcare trauma — often feel safer in smaller, community-based clinics operated by experienced non-medic practitioners. If those clinics close because they cannot meet the HIS model, we reduce not only access, but emotional safety and choice.

These concerns become even more serious when we consider not only HIS's current operational capacity but also the proposed involvement of Environmental Health Officers (EHOs) in enforcement under local authority licensing.

HIS Capacity Constraints

Healthcare Improvement Scotland (HIS) was established to regulate hospitals, hospices, independent clinics and care homes — not an entire commercial aesthetics sector which, based on insurance, training and industry data, contains **over 6,000 practitioners operating across Scotland**.

- HIS carried out **just 129 inspections** last year across *all* service types.
- HIS currently employs approximately **40–50 inspectors** to cover the entire health and social care landscape.
- If thousands of aesthetic providers require registration, the inspection burden would increase by **500–700% overnight**, an operational leap that cannot realistically be absorbed without major structural expansion.

HIS already reports registration delays of **12–20 weeks** for some independent clinics and services. Under this Bill, delays of **6–12 months** are foreseeable, particularly for rural applicants.

The EHO Issue — a Parallel Capacity Problem

The Bill implies that **Environmental Health Officers** (EHOs) may play an enforcement role under civic licensing — yet EHOs are **not trained or qualified in clinical aesthetics**, nor in the assessment of:

- aesthetic infection-control standards,
- injectable procedure risks,

- complication management pathways,
- emergency protocols specific to cosmetic medicine.

EHOs are public health professionals, but their remit and expertise lie in:

- food safety inspections,
- housing standards,
- noise and nuisance complaints,
- environmental protection,
- health and safety in non-clinical environments.

They are **not clinical regulators**, nor do they hold experience in assessing facial anatomy risks, dermal filler emergency kits, prescriber oversight arrangements, or suitability of products and protocols used in aesthetic medicine.

How many EHOs are there in Scotland?

There are approximately **900–1,000 Environmental Health Officers and technicians** across all Scottish local authorities.

However:

- Only a fraction of these are fully qualified EHOs (the rest are technical officers).
- They already cover thousands of premises across food, housing, private landlords, retail, manufacturing, waste, public health, and environmental protection.
- Many councils report **chronic shortages**, high attrition, and difficulties recruiting EHOs — highlighted repeatedly by the Royal Environmental Health Institute of Scotland (REHIS).

Adding thousands of aesthetics premises to their workload would require EHOs to inspect an entirely new sector in which they have **no recognised clinical training or competency framework**.

Negative impacts of relying on EHOs for aesthetics enforcement

1. **Safety is not improved by inspectors who are not clinically trained.**
   EHOs cannot assess treatment protocols, dermal-filler emergency procedures, product legitimacy, or clinical governance.
2. **Inconsistency across 32 local authorities.**
   Each council has different staffing, budgets, and enforcement approaches. This would create a postcode lottery of regulation.
3. **Significant new workload pressure.**
   If even 3,000–4,000 aesthetic premises required inspection or follow-up visits, EHOs would face a dramatic, unsustainable expansion of responsibilities.
4. **Risk of superficial compliance inspections.**
   EHOs may focus on building layout, sinks, cleaning logs, or surface hygiene — not procedural safety — giving a **false sense of safety** to the public.

5. **Disproportionate impact on small clinics.**
   EHOs might apply commercial premises standards designed for food or industrial settings to small home clinics, leading to inappropriate enforcement decisions.
6. **Potential increase in appeals and legal disputes.**
   Practitioners may challenge EHO decisions if inspections overreach beyond their expertise, creating administrative burden and delays.

Combined HIS + EHO capacity concerns = systemic regulatory risk

When HIS's limited clinical inspection capacity is combined with:

- EHO shortages,
- their lack of aesthetics competence, and
- the vast number of potential premises,

it becomes clear that the current regulatory model is **not operationally deliverable**.

Impact on Equalities and Access

The communities the Government aims to protect — women, minority groups, disabled clients, low-income individuals and those in remote areas — may instead face:

- **fewer legal providers**,
- **far higher treatment costs**,
- **longer waiting times**,
- **loss of local access**,
- **increased reliance on unregulated providers**,
- **a widening of health inequality gaps despite good intentions**.

Conclusion

Raising standards can have a positive equalities impact — *but only if the regulatory bodies responsible for enforcement are capable, properly trained, and adequately resourced*.

Under the structural model currently proposed:

- HIS cannot meet the required clinical inspection burden.
- EHOs are not clinically competent to regulate aesthetic medicine.
- Local authority capacity is already stretched before aesthetics are included.
- Operational delays and bottlenecks are inevitable.
- Inequalities will widen, not narrow.

Unless HIS and EHO capacity, training, and remits are addressed directly, the Bill risks **creating a system that appears strong on paper but fails in practice**, ultimately undermining the safety outcomes it seeks to achieve.

What mitigations should be put in place to maximise positive equalities impacts and minimise negative ones?

For the Bill to deliver a genuinely positive equalities outcome, several **key mitigations** are essential:

1. Proportionate, tiered regulation that includes qualified non-medics.
If only HIS-registered, medically led clinics can operate, entire regions — particularly rural and deprived areas — may lose local provision. A tiered system allowing competent non-medics with regulated qualifications to operate safely would preserve choice and access while still raising standards.

2. Geographic and financial mitigation measures.
These could include:
• scaled regulatory fees for microbusinesses;
• shared or hub clinical spaces recognised as "permitted premises" in remote areas;
• support for low-cost supervised training clinics to reduce financial barriers for patients.

3. A realistic, funded transition period.
Existing practitioners need:
• affordable bridging qualifications;
• business support; and
• transitional timelines that reflect HIS's actual processing capacity.

4. Safeguarding and advertising controls addressing cultural pressures.
Prohibiting body-shaming, gendered or racialised messaging and strengthening BDD/mental-health assessment training will directly protect groups most vulnerable to coercive beauty standards.

5. Ongoing equalities monitoring and rapid regulatory adjustment.
We should not *assume* the impact is positive — we must measure:
• which communities lose or gain access;
• how long HIS applications take in different regions;
• where closures occur;
• where the black market rises to fill gaps.

A critical mitigation is addressing HIS's operational capacity.
Before passing a Bill that makes HIS the regulator for thousands of premises, Scotland must ensure HIS has adequate staff, inspection capacity and funding.

Without major expansion — potentially **doubling or tripling** inspector numbers — HIS will not be able to deliver equitable regulation, and disparities will worsen. This is not a theoretical concern; HIS has explicitly acknowledged resource limitations in past evidence sessions.

Mitigation is therefore not just helpful — it is essential to prevent widening health inequality across Scotland.

ELENA WHITHAM – OFFENCES, ENFORCEMENT, ROGUE PRACTITIONERS, BLACK MARKET

Do you support the offences and penalties proposed in the Bill?

I support offences and penalties for deliberate or reckless malpractice — for example using counterfeit products, injecting minors, or knowingly practising without training.

However, the Bill currently does not differentiate sufficiently between:
• practitioners making minor, fixable errors; and
• individuals knowingly operating dangerously.

For the first group, improvement notices and education must be the starting point.

For the second group, strong sanctions — including criminal offences — are appropriate.

A key concern is that HIS, as the enforcement lead, currently lacks the inspection scale and investigative infrastructure to apply penalties consistently across Scotland.

If the enforcement body is under-resourced, we risk a situation where:
• compliant practitioners experience heavy scrutiny and long delays;
• rogue operators remain invisible because they never engage with the system.

That outcome would not improve safety; it would simply reallocate risk.

Is your concern that rogue practitioners won't be caught because they won't enter the system?

Yes — that is precisely the issue.

Rogue operators thrive in informal, hidden environments — private homes, social media groups, mobile services. They do not register, they do not advertise openly, and they are unlikely to submit to licensing.

If HIS is already operating at capacity, the regulatory energy will focus on the practitioners who *try* to comply, not those who hide.

HIS's limited inspection bandwidth means that unregistered activity may go undetected for long periods.

To address this, Scotland needs:
• intelligence-led enforcement involving HIS, Trading Standards, MHRA and Police Scotland;

• stronger controls on supply chains (pharmacies, prescribers, wholesalers);
• public whistle-blowing mechanisms;
• proactive monitoring of online activity.

Without this multi-agency structure, the Bill will regulate the *visible* segment of the market while the highest-risk actors remain untouched.

Could raising standards create a safety paradox — pushing people into the black market?

Yes, there is a very real risk of a safety paradox.

If regulatory compliance becomes expensive or logistically difficult — especially with HIS delays of 12–20 weeks, potentially rising to 6–12 months — then:
• fewer legal providers operate locally;
• costs increase;
• clients unable to travel or pay turn to informal, unsafe alternatives.

This risk is greatest in rural and island communities, where HIS inspection capacity is already stretched.

Combine this with HIS's acknowledgement that it lacks sufficient inspectors to cover all service types, and we risk creating a perfect environment for the black market to grow.

To minimise this:
• diverse providers must remain within the regulated system;
• HIS capacity must be expanded significantly;
• inspection timeframes must be statutory, predictable and equitable across regions;
• support must exist for low-income access routes such as supervised training clinics.

Without this, the Bill may inadvertently shift clients *towards*, rather than away from, unregulated practitioners.

Should improvement notices come first, and should there be a legal route of appeal?

Yes.

A fair, logical enforcement pathway would be:
1. Advice
2. Improvement Notice
3. Restriction / Prohibition Orders
4. Criminal sanctions (only for wilful or repeated non-compliance)

This ensures that the purpose of regulation — improvement of safety — is not overshadowed by punishment for administrative breaches.

A statutory right of appeal is also essential, particularly because HIS has limited staffing and long turnaround times. Without clear, rapid appeal mechanisms, small clinics — often women-led — could be suspended for months while waiting for re-inspection.

Given HIS's current capacity constraints, appeals could otherwise become another bottleneck contributing to business closure and inequality.

Tina McCaffery
Teacher Assessor Lead IQA and Health and Safety Consultant