OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 2 December 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 2 December 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
33rd Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lesley Blair MBE (British Association of Beauty Therapy and Cosmetology and Confederation of International Beauty Therapy and Cosmetology)
Victoria Brownlie MBE (British Beauty Council)
Louise Caithness (Zest Group Scotland)
Tina McCaffery (Skin Religion Aesthetics)
Douglas White (Consumer Scotland)
Lynsey Wilson (Scottish Aesthetics Safety and Standards)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 2 December 2025

[The Convener opened the meeting at 09:34]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 33rd meeting in 2025 of the Health, Social Care and Sport Committee. I have received no apologies for the meeting.

The first item on our agenda is for the committee to decide whether to take items 3 and 4 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill: Stage 1

09:34

The Convener: Under the second item, we will take oral evidence from two panels of witnesses as part of the committee's stage 1 scrutiny of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill. This morning we will focus specifically on part 1 of the bill.

Our first panel of witnesses comprises representatives of consumers and individual practitioners who are involved in the provision of non-surgical procedures that are covered by the bill. I welcome to the committee Louise Caithness, the founder and managing director of Zest Group Scotland; Tina McCaffery, representing Skin Religion Aesthetics; Douglas White, director of policy and advocacy at Consumer Scotland; and Lynsey Wilson, co-chair of Scottish Aesthetics Safety and Standards. We move straight to questions from Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning, all, and thanks for being here. I will kick off. What are your views on the bill and, specifically, on the proposed regulation of non-surgical procedures that has been set out in it?

Louise Caithness (Zest Group Scotland): It is a huge bill, so giving an opinion on it could probably take quite a long time. My overriding thought is that regulation has become quite a divisive subject, which is a challenge for the people who work in the industry. It has become a medic versus non-medic argument, which detracts from the overriding goal of the bill of ensuring public safety.

For the bill, the committee must consider a fair framework that ensures that we look really hard at robust training. Doing a general nursing, medical or dental degree is not a necessary prerequisite for the delivery of treatments that are less invasive. We must look at what the regulatory framework of training produces and ensure that people who want to work in the industry follow that particular framework, regardless of what their background is. There are practitioners working in the industry at the moment who are working very safely but who do not come from medical backgrounds, and they should not be unfairly disadvantaged because of a new bill. The bill should look at how we can bring everybody up to a similar standard to work safely and ensure public safety.

Douglas White (Consumer Scotland): Consumer Scotland welcomes the introduction of

regulation to bring greater protection, consistency, clarity and certainty for consumers, given the growth of the non-surgical procedures market and the evidence from a range of sources about the potential for consumer harm to occur. At the same time, we do not underestimate the challenge that would be presented to many small businesses across Scotland in having to meet the new regulations or the risks that that would present due to potential negative consumer outcomes such as the risk of higher prices or of loss of services.

We will obviously get into lots of the detail during the discussion, but, as a high-level response to your opening question, we think that there are three key steps to making regulation work in practice. First, the public need to know about regulation and understand what it aims to achieve for them, which includes, crucially, providing them with the information that they require to make informed choices about the treatments that they choose to receive.

Secondly, small businesses need the right support to help them to make the journey to regulation. It is very important that the Government works with industry to achieve that and looks at how the good businesses that want to comply and adhere to the standards that are being set can do so. That is important for businesses and for consumers—it is good for consumers if good businesses are brought along on that regulatory journey.

Thirdly, if regulation is to be meaningful, it is essential that appropriate resources are provided for enforcement. Otherwise, there is a risk that the system would be undermined—it could create a higher level of risk for consumers if there were a significant number of businesses operating outwith the new regulatory system. It will therefore be essential that there are sufficient resources to enable the new system to be enforced.

Lynsey Wilson (Scottish Aesthetics Safety and Standards): Safety should be the main concern, and we support regulation that is proportionate and will provide safety for all people seeking out non-surgical cosmetic procedures. It is clear that the majority of complications that arise come from unqualified and untrained professionals or injectors and not from qualified aesthetics practitioners.

For a number of years, there has been an influx of training academies offering substandard one and two-day training courses, which has resulted in a rise in complications across the industry. We believe that it is important to introduce training and qualifications to ensure that practitioners offering the treatments are competent, qualified, knowledgeable and able to offer safe treatments.

The regulation poses quite a disproportionate situation to non-healthcare providers. The regulation in relation to Healthcare Improvement Scotland clinics would mean that non-healthcare practitioners could not register their business without a healthcare professional. The Scottish Government does not currently have any data to suggest how many qualified prescribers there are in aesthetics that could facilitate the number of clinics that would need that oversight.

We believe that it is important to create a regulation that is fit for the practicalities of the industry and not just good in theory. We need to understand the diversity of the practitioners who have been in the industry for numerous years providing safe treatments. We look forward to being able to find a regulation model that is fit for purpose.

Emma Harper: I remind everybody that I am a registered nurse and that surgery was my specialty in clinical education. If safety is your number 1 concern, what do we need to do to make sure that appropriate steps are taken to support people to obtain appropriate qualifications to ensure safety?

There are also consumers who seek invasive non-surgical procedures that are at different levels. How do we support consumers to be better informed?

Lynsey Wilson: There is a level 7 Government-approved qualification in aesthetics practice. Obviously, training has not been included in the bill, but many practitioners hold that qualification, which ensures that they have the competency, knowledge and skills to deliver these treatments safely. It is important that anyone seeking such treatments knows that every practitioner that they go to has that level of qualification. Perhaps there could be a tiered approach to regulation in terms of what the treatments are and who delivers them. There are more invasive non-surgical cosmetic procedures that I do not believe are appropriate for certain practitioners without a medical background. Making sure that the need for qualifications and training is implemented by the bill will give consumers the confidence that their practitioner of choice has a qualification and is able to deliver treatments safely.

Douglas White: I will separate Emma Harper's question into two parts. They are clearly related, but I will address them separately. The first part is about training and qualifications. At the moment, we have a range of different levels of qualifications in the market. We have regulated healthcare professionals delivering procedures, we have practitioners who have undertaken a lot of training and gone through specific qualifications to deliver procedures, and we have other practitioners who

have very limited or even no training in delivering procedures.

From a consumer perspective, it is clear that that system is far from ideal, because it is often not straightforward or easy for consumers to know what type of qualifications different practitioners might have and to understand what that means in terms of undergoing a safe procedure.

The bill allows ministers to specify detailed requirements in relation to training and qualifications in secondary legislation, and we very much support that being taken forward. Given the range of ways in which ministers could specify requirements, progressing that through secondary legislation makes sense, because it would allow proper consideration of the different options and models that could deliver effectively for consumers.

09:45

I agree that public awareness is extremely important and one of the fundamentals for making the bill work effectively. Public awareness-raising materials and campaigns are needed to let the public know about the new regulatory system, the standards that are being set and what that means for different procedures and who is able to provide them.

There is an opportunity to go a little bit further with the bill and give ministers the opportunity to specify information that providers must give to consumers when they come to undergo a procedure. Many practitioners already do that, but making it part of the regulatory system would make the information consistent across the board. If providers were required to give consumers information about the level of risk that is involved in a procedure, the aftercare instructions, success rates, staff qualifications, how to make a complaint if something goes wrong and any other information that is vital to help consumers make an informed choice about the procedure that they want to undergo, that would be a really important step towards ensuring that consumers and the public are well informed.

My third point is about the need to work with the Advertising Standards Authority to ensure that advertising procedures are accurate, do not mislead and do not make consumers feel pressured into making choices. That is an important third plank of the public awareness work.

Tina McCaffery (Skin Religion Aesthetics): Thank you to the committee for inviting me to give evidence. I agree with what Lynsey Wilson and others have said. I represent various non-medical practitioners across Scotland and England. Although we all fully support the regulations and agree that the industry needs to be regulated, it needs to be done fairly, and public safety must be paramount. For regulation to work, it has to be evidence based, proportionate, enforceable and accessible across Scotland, including in rural and remote regions.

At present, Scotland has no centralised adverse event reporting system, national register, minimum training or qualification standards or data on the real scale of complications or illegal practitioners. That means that we are trying to regulate without a really accurate picture of the risk, which is unsafe for the public.

I also want to highlight the issue of prescriber access, which is uniquely challenging in Scotland. In some areas of the Highlands, for example—

The Convener: We will come on to some of those themes further on, Ms McCaffery, so can you contain your remarks to the questions that have been asked?

Tina McCaffery: Okay—I will leave it at that for now.

The Convener: Thank you. Sorry, it was difficult to get your attention because you are online.

Emma Harper: I will let others come in, because I am sure that information regarding data, adverse reaction tracking and other such things will be picked up on.

Sandesh Gulhane (Glasgow) (Con): I make a declaration of interest that I am a practising national health service general practitioner.

Thank you very much for coming in. I have a number of questions. Louise Caithness, your clinic offers mole reduction.

Louise Caithness: It does.

Sandesh Gulhane: How do you ensure that there is no cancer?

Louise Caithness: We perform very thorough consultations. As part of our training, we also identify which moles or blemishes are safe for us to treat within our scope of practice and which are not. Training is very comprehensive, and we have access to additional clinical oversight through programmes such as Map My Mole and Spotcheck, which give us direct access to dermatologists who we refer our clients to if we are not confident that we can correctly and safely identify a blemish.

Sandesh Gulhane: Do you have only one nurse who is registered to do that?

Louise Caithness: We do not have any nurses.

Sandesh Gulhane: Oh, right. On your website, there is somebody who is a member of the British Dermatological Nursing Group.

Louise Caithness: Correct. Through our association with the British Institute and Association of Electrolysis, we deliver advanced electrolysis treatments. It is not our regulatory body as such, but we work closely with it to ensure safe standards and training across all of our treatments. As we are members of that institute, we can be associate members of the British Dermatological Nursing Group as well, and we can access its training material.

Sandesh Gulhane: Is there not a nurse, a doctor or somebody who is trained in skin care?

Louise Caithness: No, that is not necessary for such treatments.

Sandesh Gulhane: Are you one of the bigger clinics?

Louise Caithness: Yes.

Sandesh Gulhane: What safety mechanisms are in place in other places that offer those treatments to ensure that people are not doing things to cancerous moles?

Louise Caithness: We hope that those who are delivering the treatments are appropriately trained, as they are in my clinic, and that they are appropriately insured. We have the skills to identify blemishes that show the potential signs of not being stable and therefore not safe to treat. We would refer those clients to dermatology.

We have got a track record of doing that. Numerous clients who we have referred have come back to us to thank us after having sought medical advice or treatment. They tell us whether they have had the mole or blemish that we identified as not being safe to treat removed in a medical context or whether it proved to be benign.

Sandesh Gulhane: Douglas White, I will turn to you. You spoke about a significant risk to the public if clinics operate outside the legislation that might come into force. That would be illegal. Why should even a single clinic operate outside the legislation? If it does, surely it should be sanctioned by the police.

Douglas White: We would require the resources to identify where that happens.

Sandesh Gulhane: Forgive me, but you said that a significant number of clinics could operate outside the legislation. It would be easy to trace if there were significant numbers.

Douglas White: I was posing a hypothesis about what would happen if there were not sufficient work to ensure that businesses are brought on the journey to be regulated. We want them to be brought on that journey. We want consumers to be able to access treatments in safe places and understand, through the consistency and clarity of the standards, what those who are providing them will offer.

As with any kind of industry where new regulation is coming in, we are concerned that some people will choose to continue operating outside the legislation, and that that could pose risks for consumers. We are in favour of the regulation, but we are thinking through what risks could occur that we need to mitigate.

One of the things that we are saying is that good, sufficient enforcement powers and resources are important to ensure that we pick up on where those people who operate outside the regulation are so that appropriate action can be taken against them to protect consumers from the harm that they could cause.

As to what form the enforcement could take, that would be whatever is appropriate, but it is important that attention is paid to that to ensure that providers do not operate outside regulation, and therefore consumers are appropriately protected.

Sandesh Gulhane: My next question is for Lynsey Wilson, although Douglas White might want to come in on it too. What mechanisms exist at the moment to hold aesthetic practitioners to account for things that go wrong?

Lynsey Wilson: Currently, it is their insurance. Regulated professionals are under the Nursery and Midwifery Council or the General Medical Council. They have regulatory bodies, but through no fault of our own, non-healthcare practitioners do not have that. We are looking to find ways to demonstrate accountability in the industry, but right now, we rely on insurance.

Sandesh Gulhane: Does any mechanism at all exist right now?

Lynsey Wilson: Right now, I do not believe so. If a client had any complications, I would hope that they would return to their injector. If that complication needed oversight from a medical professional, we would refer it to prescribers, with whom we work collaboratively. There are HIS-registered clinics across Scotland that offer complication support. They have ultrasound and other mechanisms in place, so that they can ensure that any clients with complications are treated by medical professionals. Right now, there is no body for non-healthcare practitioners, and I believe that a governing body should perhaps be put in place. There should also be a mandatory complications database.

We see that complications are not being recorded across the board although healthcare practitioners are saying that they are treating complications. We sent a freedom of information request to Healthcare Improvement Scotland

regarding complications for dermal fillers. There were three reports in 2023 and two in 2024. That evidence suggests that complications that are being treated are not being recorded.

We need to have a mandatory system in place, and we need to create accountability for all practitioners. I believe that it is down to the Scottish Government to try to create that system. Healthcare Improvement Scotland does not conduct any audits, and it does not do any follow-ups on complications. The paperwork is filled out, so the matter has been recorded, and that is the end. There is never a process to find out whether the client has been treated successfully. I believe that we have to create some kind of governing body to ensure accountability across the board for all practitioners offering aesthetics.

Sandesh Gulhane: It feels a bit like the wild west in the industry compared with healthcare, where complications are very much looked at, and there is an entire mechanism and process.

Louise Caithness, in your submission, you spoke about how it is "nonsensical" to include skin peels and so on. What is the complication rate for skin peels?

Louise Caithness: The complication rate for skin peels is incredibly low.

Sandesh Gulhane: What is it?

Louise Caithness: I do not know the exact figures.

Sandesh Gulhane: It is 3.8 per cent.

Louise Caithness: In my own business we have zero issues with skin peels, because they are such superficial treatments. I think it is nonsensical to regulate products and treatments that consumers can purchase and deliver themselves at home. In the consultation, it was grey and woolly as to what the treatments would look like. There is skin needling, for example. We have just had a black Friday weekend, where people were awash with products and treatments of that sort to purchase, without any training or guidance, to use them at home. You refer to the "wild west", and I would agree that that exists in any industry, but what seems to have happened in this conversation around regulation—

Sandesh Gulhane: Sorry—are you saying that there is a wild west in medicine?

Louise Caithness: No. You referred to the "wild west", and I agree that that exists in any industry. There are certainly elements of that in the non-medical aesthetics arena—there is no doubt about it. What seems to have happened is that there are those who are delivering the "wild west" treatments—and I am not totally sure how that looks; there are then those who do not come from a medical background, but who are suitably trained and qualified and are delivering treatments safely; then, there are those who have come from a medical background who are delivering treatments.

To put those with a non-medical background into one category with those who are defined as "wild west" is very unfair and nonsensical. We should consider the delivery of the treatments that are ultra-low risk. What is called a "skin peel" by name does not, by design, peel the skin at all, and the same can be said for skin needling. Those are very superficial, non-invasive treatments that pose an ultra-low risk. They are elective and non-medical.

Sandesh Gulhane: The complication rate is 3.8 per cent.

Louise Caithness: Okay. To what particular peels are you referring?

Sandesh Gulhane: That is for superficial peels, and the rate goes up for medium and deep peels. The complications seem to end up with general practitioners, who have no idea about the chemicals that have been used. That is one of the concerns that I was asking Lynsey Wilson about.

I will leave it there, as other people want to come in.

10:00

Brian Whittle (South Scotland) (Con): Good morning. I just want to extend that line of questioning a little bit. I completely accept that there are those in the industry who deliver a proper and thorough service, as opposed to those whom we are considering, but my concern is that healthcare, as a science, is inexact. We never know when, or why, a complication might arise.

Surely, therefore, it is important to have a medically trained person on the premises, specifically to deal with any complications that are not foreseen. Why would you not have a medical professional on site for that?

Louise Caithness: If the individual delivering the treatments had complication management training, which is built into the regulatory framework for training, there would be no such requirement.

As we have said, 3 per cent of people have reported complications in relation to skin peels. That means that 97 per cent of people are not experiencing complications. It is absolutely not necessary to have a medical individual present on site for certain procedures; after all, they are not medical treatments. You would not have a medical professional present on a building site just because someone could fall from the top tier.

Brian Whittle: I am sorry, but I do not accept that analogy.

Louise Caithness: There is risk in every industry. However, when we are talking about ultra-low-risk, non-invasive treatments—

Brian Whittle: Four out of 100.

Louise Caithness: Sorry?

Brian Whittle: We are talking about four out of 100 people, in relation to one of the most basic procedures. I am not here to give you a hard time—

Louise Caithness: Absolutely. We do not necessarily agree on this.

Brian Whittle: —but my point is that healthcare is an inexact science. If the most basic procedure that you do leads to four out of 100 people experiencing complications, surely to goodness you need somebody on site. If you are not a medically trained person, you will not know or understand what all the possible complications might be. All that I am doing is exploring the thought that there should, potentially, be somebody medically trained on site.

Louise Caithness: In relation to those four out of 100 people, the question is: were those treatments delivered by untrained or non-medically trained individuals?

Brian Whittle: I do not know.

Louise Caithness: We do not know either. It brings me back to the issue that I have just raised, which is that we are categorising those who are non-medically trained together in a bucket with people who are not trained—full stop—and that is not fair.

Brian Whittle: I totally accept, and understand, that. I am coming at this from a layman's perspective.

I also have to say that the suggestion that needle procedures are non-invasive does not wash with me. Again, I am not here to—

Louise Caithness: No, no—this is what is so important—

Brian Whittle: I totally appreciate that there are many people out there who are delivering a very good service. My question is this: what happens if there are complications? What happens in those situations?

Louise Caithness: Those who deliver treatments are trained to manage complications. Indeed, complication management is built into the regulatory framework through what was the Scottish Qualifications Authority, the Office of Qualifications and Examinations Regulation, or Ofqual, and the Hair and Beauty Industry Authority, or Habia. The framework for what anybody who delivers those treatments should do, if a complication should arise, is already in place and exists.

Lynsey Wilson: On qualifications and training, the level 7 qualification can take a number of years to complete. People do advanced facial anatomy; management of complications training; first aid and anaphylaxis; injection techniques; and pharmacology of products. There is a range of different providers, but each training framework is Ofqual regulated and individually assessed.

Lots of complications can happen. Most are mild, with bruising, swelling and some injection redness. People do experience more severe complications, but they would generally come from unqualified practitioners.

The data that I have been able to gather shows an estimated 1 per cent or lower risk of vascular occlusion being caused by dermal fillers. That sort of thing does not always present there and then, at the time of treatment, but can develop a few hours later or even the next day. Therefore, having a medical professional on site during the delivery of the treatment might not always be useful, because there could be a need to access a practitioner or prescriber when the complication itself arises.

There is also 0.63 per cent risk of developing anaphylaxis through the use of hyaluronidase. As non-medical professionals, we do not claim to have the same knowledge or experience of healthcare, but we do have level 3 first aid and anaphylaxis training, so we have the ability to recognise anaphylaxis and to know when an EpiPen would be needed. That is a prescription-only medicine, but, if we are looking at public safety, we need to develop ways of ensuring that qualified practitioners keep collaborating with medical professionals so that we can deliver safe, timely treatments on those rare occasions when adverse events happen.

The available data shows that complications that can arise are caused by what we call "rogue injectors", not by qualified practitioners. As Louise Caithness has said, we must stop putting those two groups of people into the same category. In most industries, including in healthcare, stories of malpractice pop up when there are complications, but we do not put all healthcare providers into the same bracket. Qualified aesthetics injectors should be seen in the same way.

Joe FitzPatrick (Dundee City West) (SNP): This is a United Kingdom-wide issue, but it is being dealt with differently in Scotland and England, and the approach to regulation proposed in this bill is not the same as the approach being taken in England. Lynsey, what are your thoughts on the two approaches? Have we got it right here,

or could we learn more from what is happening in England?

Lynsey Wilson: We absolutely support regulation, but it should be proportionate. When the Keogh report came out in 2013, the Scottish Government was made aware of the potential risks if regulation were not brought in, but, for more than a decade, it has allowed practitioners to take qualifications, create businesses and develop careers and livelihoods. This legislation might now have a major impact on those professionals.

The licensing model proposed in Scotland would allow healthcare and non-healthcare practitioners to work from the same premises without major restrictions. We have HIS here, which means that a non-healthcare professional cannot register their business without having a prescriber. The consensus with regard to most practitioners in Scotland is that they are concerned about finding a prescriber available to cover the aesthetics clinics that need a medical professional.

As I have already said, the Scottish Government does not have any data on how many prescribers are qualified in aesthetics and can therefore oversee that process. There might be a risk of prescribers leaving NHS services and moving into private clinics, or of clinics being forced to close if we cannot find enough prescribers to facilitate them, which will mean consumers not having the safe access to treatment that they previously had. That is a concern, because where will they go then? I believe that a different model could be put in place.

In addition, the National Health Service (Scotland) Act 1978 could be amended to allow for the recognition of non-healthcare providers who are qualified in aesthetics to a minimum of level 7 and bring them within the scope of professionals who can register. There could be collaborations with prescribers who are available within a short radius, so that, in the rare event that they are needed, they can be contacted in a timely manner—

The Convener: I am sorry, Ms Wilson—I will have to get you to wind up.

Lynsey Wilson: Okay—sorry.

The Convener: We have 50 minutes left of the session and we still have an awful lot of questions to get through, so it would be helpful if we could keep questions short and answers concise.

Joe FitzPatrick: That answer was helpful, Ms Wilson, because you have laid out the differences between the models in England and Scotland. We can discuss later whether the Scottish model is safer.

Moving on to Tina McCaffery, I note that you said that you represented practitioners across Scotland and the UK. Perhaps you can explain who exactly you represent, and then go on to talk about the impact of having different regulations in Scotland and in the rest of the UK.

Tina McCaffery: Yes, of course. I set up the non-medics aesthetics committee, which represents the non-medical practitioners across Scotland and England and has sought their views overall on the different systems in Scotland and England.

Joe FitzPatrick: That was useful, because you might be able to speak from the point of view of practitioners in both England and Scotland. Two different regimes are being proposed, and it would be good to hear your thoughts from an industry perspective.

Tina McCaffery: We all desperately want regulation across the devolved nations. However, the two formats in Scotland and in England are incredibly different. As we know, England is looking at going down the licensing route with local authorities, whereas in Scotland, we are looking to bring in HIS and have prescribers on premises.

All of our members say that they would prefer the licensing route, as it would mean the industry being governed in a very similar way to the licensing that is already available for various things such as microblading, tattooing and so on, in comparison with what is going on in Scotland. There is also a lot of concern about how the Scottish approach to regulation and the licensing approach in England will work together, given that the two models are so different in style.

In Scotland, HIS will be involved, along with the prescribers, as Lynsey Wilson has described. However, when we look at practitioners—the non-healthcare professionals—being put into HIS-registered premises, I come back to another concern that I have about having prescribers on premises at all times. It is a heavy burden; it is not financially practical across the board, nor is it practical for non-healthcare providers who are trying to run their businesses correctly.

Joe FitzPatrick: Thank you, Tina—

Tina McCaffery: I am sorry—I cannot hear you.

Joe FitzPatrick: I am sorry—the convener has just reminded me that I need to move on, unless Louise Caithness has something specific to add from an industry perspective.

Louise Caithness: On the practical element of HIS registration in Scotland, I would note that our industry is very diverse and predominantly female led, and many of our specialists work in very flexible locations. For example, they might rent rooms on a relatively ad hoc basis, and many of them work from home in order to balance their work with the burden of childcare. HIS regulation

would inhibit them from being able to continue practising in those locations because, both practically and financially, they will not be able to make the adjustments needed to meet the standard.

Joe FitzPatrick: That was helpful. The ad hoc aspect of the work is of huge concern in that respect.

I want to turn, very quickly, to Douglas White. Can you tell us whether, from your perspective, you have any concerns about there being different regimes in Scotland and in England?

Douglas White: From a consumer perspective, I would say, as we said at the outset, that there is a hierarchy of concerns, at the top of which is improving safety. That means that, in Scotland, we have to regulate in the way that we think is appropriate in order to improve safety. That would come first, and then there is the question of proportionality and ensuring that we have the right level of regulation in place for different procedures, both to maximise safety, but equally—in fact, this should not be an equal consideration—to improve consumer access, where that can be done safely. Clearly, where we can get as close as possible to the UK in that respect, it will be good for consumers, as it is better not to have differences in regime. However, it all depends on whether that can be squared with those other priorities.

10:15

In addition, I would note briefly that the licensing scheme proposals for England talk about supervision by regulated healthcare professionals, but we do not have a lot of detail yet about what that would mean in practice. Equally, the Scottish bill, in referring to what happens when regulated healthcare practitioners are on site, includes language about procedures being undertaken under their management or "in accordance with" their direction. It would be helpful to have some more clarity on that so that consumers know what exactly it means in practice, given that a parallel debate is going on in England about what the term "supervision" means.

It would be helpful to consumers if those two aspects played out in a way that achieved as consistent an approach as possible. Nevertheless, safety is the top goal.

Brian Whittle: What is driving demand for non-surgical procedures? How does advertising and body-image pressures influence that? Are the pressures more acute for the younger generation—those who are under 18? Would potentially limiting such procedures to those aged 18-plus mitigate that? When it comes to advertising cosmetic procedures, how do you manage unrealistic expectations?

Louise Caithness, do you want to come in?

Louise Caithness: Me? I was waiting for somebody else to speak. [*Laughter*.]

I totally agree that there should be an age restriction. I do not think that it is good practice to deliver the treatments to those who are under 18 years old. We certainly do not do that in my business. We provide wart and verruca removal treatment. We have had requests from parents to provide that treatment for under-18s, but we do not deliver those treatments to that age group—that is not part of our business model.

For treatments that are purely about aesthetics and appearance, again, I do not think that it is good practice to deliver those to under-18s, and I agree that that restriction should definitely be covered in the bill.

With regard to how we advertise the treatments and what consumers are looking for, I think that that is very cost driven in certain areas but not in others. We have a wide range of consumers; in my business, most of our clientele are around my age, which I will not disclose. We do not have a younger audience. I think that most people will be attracted to a similar business model, whether that is somebody who is working on the high street or from home, or those who are working in a more clinical environment. We will attract a very diverse audience. The diversity of our industry also applies to our consumers, too.

On advertising, I agree with Douglas White that what is regulated must be advertised in a way that ensures that consumers know what to look for.

Brian Whittle: I will layer my next question on top of that, because I know that we are a bit short of time. It is about unrealistic expectations as result of certain unscrupulous types of advertising, shall we say. How do we prevent that, because it is a mental health issue?

Douglas White: The Advertising Standards Authority has issued updated guidance, "Cosmetic interventions", which requires adverts to be "responsible". It also says that marketers should "hold evidence" for claims of their efficacy, that they should ensure that they do not exploit insecurities or portray offensive stereotypes and that they "should not trivialise" procedures. That is a really helpful framing.

In its written submission, the Advertising Standards Authority said that it would be keen to explore with the Scottish Government the

"practicalities of enforcing advertising restrictions"

—particularly if the advertiser is not a registered provider. It also seeks clarification on who it

"should engage with and possibly refer non-compliant advertisers to",

and the effect of the guidance that it provides to advertisers.

We very much agree with those points. Engagement with the ASA to make sure that its guidance is being applied by all practitioners will be important.

It is also important that practitioners are aware and have an understanding of the issues and are able to signpost people, ideally, to proper, trusted mental health support organisations. That provision of information to consumers, and what would be appropriate information for practitioners to be required to give, could be looked at. Some consideration should be given to whether signposting to appropriate mental health support could be taken forward as part of that.

Louise Caithness: In response to what Douglas White has said, it is already built into the regulatory framework for training that we ensure that clients can give proper, informed consent before their treatment is carried out. Part of that process involves making them aware of the risks, complications, benefits of treatment and alternative treatments. It also requires the practitioner to recognise whether it is safe to proceed with the treatment—not only physically but mentally and emotionally.

Lynsey Wilson: We absolutely support the point that the treatments should not be carried out on anyone under 18. When it comes to advertising and social media, there are content creators, and advertisements of prescription medicines—from both healthcare providers and non-healthcare providers—happen all the time. Although the ASA has set out its rules, those are not always followed. Unfortunately, from my position, I am unsure what the ASA can put in place to ensure that social media content aimed at encouraging young viewers is not posted.

When it comes to unrealistic expectations of results, ethics is part of the qualifications and training. No ethical practitioner would carry out a treatment just for the sake of it. Every treatment must be suitable for the client.

The vast majority of people who have had extreme non-surgical procedures have probably had those carried out by someone who is either not entirely qualified or not ethical in determining what is suitable for the client.

Tina McCaffery: To respond to that from the mental health perspective, we know that there are physical risks, but the psychological risks are very high. There is no real requirement in the bill to look at the various aspects of body dysmorphia. As has rightly been pointed out, within the qualifications—especially at level 7—we train practitioners to identify all the flags for body dysmorphia.

However, you need to look at this from a training perspective. All practitioners must be required to have proper training in identifying clients who walk through the doors who are psychologically vulnerable to body dysmorphia. Although that is covered in the qualifications, nothing is really set out in the bill to ensure that such training happens.

Paul Sweeney (Glasgow) (Lab): I would like to ask a bit more about the impact that the bill will have on small, independent or home-based businesses, and how regulation could be designed in a way that improves safety while not creating barriers that would drive people to use unregulated providers.

Louise Caithness: Post Covid, we saw a huge change in the beauty and skin industry. Many salons closed because it was not financially viable for them to continue, and there was a drive in people working from home more.

City centres have changed, as has the dynamic of people's movements throughout the day. We have seen a huge increase in practitioners working from home or in, say, cabins in their gardens—that sort of arrangement—and that approach has been working extremely well, allowing predominantly women and mothers to carry the burden of childcare and work in a safe environment at home and in an environment that is accessible to their clients, too. Under the HIS framework, it would be virtually impossible for such practitioners to convert their place of work and meet the necessary arrangements, just because of the practicalities of where they are working from, and because of financial considerations, too.

Therefore, I think that it would be really beneficial if the bill, perhaps, took a tiered approach with regard to HIS to ensure that those delivering non-invasive treatments could continue to do so with some basis of regulation, instead of being brought under the greater HIS umbrella, which covers surgical procedures. There is no balance in that respect, and it is important to recognise that a lot of people work in very diverse environments.

I talked earlier about ad hoc arrangements; by that, I mean people renting clinical spaces or rooms to work in, and not on a full-time basis. That does not mean that their delivery is by any means ad hoc or substandard; they are simply not committing to business premises full-time, as doing so is just cost prohibitive. It is important that the bill looks at that diversity in our industry, which we value and which we should not be inhibiting the growth of.

Paul Sweeney: Thank you. Are there any other views?

Lynsey Wilson: The implementation of the bill in respect of HIS-regulated clinics will have a massive impact on non-healthcare professionals. We would not be able to register our business without a prescriber and, as previously discussed, prescriber availability is extremely limited at the minute. We are talking about small businesses that are being run in a predominantly female-led industry; even if we wanted to comply, we would have no means to do so without a prescriber.

Something must be put in place that would allow qualified aesthetics practitioners to register their business in their own right, and that should be workable for both healthcare and non-healthcare providers across the sector. At the minute, if no prescriber is available to attend your clinic during your working hours, you cannot work. If you have a prescriber, but they are off sick or on holiday, you cannot work. The situation would be even more difficult if the prescriber had to be employed by the person because, if they were off sick, they would still be entitled to money from the company, even though the owner could not work.

That might sound fine for larger clinics, which have other means to support that, but the vast majority of practitioners in the industry are independent, female-led small businesses that work on their own and collaborate with prescribers.

As Louise Caithness said, models of working changed through Covid. I believe that regulation can be introduced that is effective and proportionate, providing safety for members of the public while protecting the large number of small businesses and economic growth. I do not believe that the bill is fair just now. Even just requiring a prescriber in order to register will completely push out qualified non-healthcare aesthetics practitioners.

If Scotland were to adopt a model similar to that in England, amendments would still have to be made to the 1978 act to allow prescribers to access local authority registered clinics. Indeed, as I have said, the 1978 act must, at a minimum, be amended to allow qualified non-healthcare practitioners to come under a regulatory system, with perhaps a separate category for aesthetics.

In its response to the call for views, Save Face outlined that HIS was set up to regulate hospitals, operating theatres, surgeries and so on, and that level of clinical standard is not exactly necessary for some aesthetics treatments. There needs to be a more tiered approach, or a separate category created that is inclusive of all practitioners within the industry.

10:30

Douglas White: I will come in briefly from a slightly different perspective, from the consumer side. We empathise with the challenges that colleagues are sharing about the journey to regulation and the desire to find solutions that enable practitioners to operate safely under different types of regulation.

The greater the number of differing levels in a system—whether in premises, practitioner qualifications or standards—the more we would have some concerns about the risks to clarity, consistency and certainty for consumers. Where is it that they should go for what type of procedure, and what are the standards or qualifications that different people are adhering to? That principle about consumer certainty and clarity—and safety, obviously—is key to decision making around that.

Paul Sweeney: Is your key issue the need to have a level playing field?

Douglas White: Yes, and it is essential that we look at the steps and actions that can be put in place to help existing businesses on that journey to regulation, whatever that ends up looking like—whether that is to do with funding support to make the changes to premises that might be required, or whether that is about looking at the models through which regulated healthcare professionals or prescribers will be available to people. It is really important that we consider that business development and business support angle, while seeking to achieve that certainty, consistency and clarity for consumers.

Paul Sweeney: There are points about the proportionality of the regulations, the idea of the level playing field and the need to have a pathway for reaching compliance.

What support would be helpful in enabling people to reach compliance? It was mentioned earlier that prescribing was a practical challenge, but practitioners work in collaboration with prescribers, so maybe that is one example of where things could be more tailored or more nuanced.

Lynsey Wilson: The limitations right now are that prescribers cannot work outwith HIS clinics. Therefore, at present, a non-healthcare professional who is not in a HIS clinic cannot have a prescriber present for a face-to-face consultation or to assist for anything else. We need to find an inclusive way to bring the industry together. It cannot just be that you have to be a healthcare provider to register your business. There are many non-healthcare practitioners who want to be regulated and want to comply, but they physically cannot do that without a prescriber. A model must be put in place that allows practitioners to be

registered and regulated but without that bottleneck.

I am unsure how it would even be possible to estimate how many prescribers we have. There are more than 500 HIS clinics. Most of the prescribers that we know of and collaborate with work, perhaps part-time, within the NHS. Some of them work in their own clinics. Therefore, finding prescriber availability for your clinic at all times is extremely difficult. Also, you cannot rent space in another HIS clinic if you are not a healthcare provider. For us, the proposed legislation is very disproportionate. I believe that we need to find a way to include qualified practitioners in the same regulatory system so that we can all be on a level playing field, committing to the same levels of clinical standards.

Paul Sweeney: Thank you. I think that Tina McCaffery also wanted to comment.

Tina McCaffery: No, it has all been covered, actually.

Paul Sweeney: Okay. On the point about prescribing, what would an ideal structure look like for you?

Lynsey Wilson: If we look at Scotland and England, at the minute, prescribers can work from any location in England. When their licensing scheme comes in, prescribers will be able to attend local licensed clinics, provide consultations and oversight and attend for adverse events. In Scotland, under this legislation, they would not be able to do that. If we want to create a system that is equal across all the UK nations, having the same system everywhere would stop confusion for consumers who are looking to get these treatments carried out.

Ideally, if the English model was adopted in Scotland, there would be more compliance, and more clinics would be able to offer a safe clinical space, with prescribers available to attend. Also, that would allow us to have links with potentially more prescribers, rather than having just one on site at all times. Therefore, if one was not available, you could source others who were able to attend. When it is regulated that you have only one prescriber in your clinic who is there at all times, it is difficult to find others when the usual prescriber is not available. The English system would allow healthcare professionals who offer or assist in aesthetics treatments to access local licensed clinics. At the very minimum, we should adopt a model through HIS that allows tied practitioners to be registered in their own right.

Patrick Harvie (Glasgow) (Green): Good morning. As the Scottish Government does with all legislation, it has carried out an equalities impact assessment. Several witnesses have mentioned that a great many of the businesses that would be affected by the bill are female led. Unless I missed something, that might be the only equalities impact that has come up in the discussion so far.

Aside from that issue about providers of services or the people running businesses, can you reflect on the range of equalities impacts in relation to people who access or buy services, whether those relate to gender, socioeconomic inequalities, disability or the impact on rural areas? In doing so, could you consider not only access to the services but safety and whether the attempt to drive out what some witnesses have described as rogue operators and to ensure a high standard of safety has a positive equalities impact for the particular groups that might have specific reasons for accessing the services that these businesses provide?

As I am not in the room, I will not point to anyone, so whichever witness wants to jump in will be very welcome.

Lynsey Wilson: As you mentioned, the industry is predominantly female led. There are businesses in semi-rural and rural locations, where people have limited access to prescribers or other means. Lots of people—consumers and practitioners alike—will be affected in relation to a range of equalities issues. Having a fair system to regulate the competence and qualifications of practice standards helps to support clinics in rural areas.

On the number of females in the industry, the bill would potentially see businesses close—the Scottish Government estimates that there are 1,500 clinics, which is potentially just the businesses with a high street front, but practitioners who are not recognised in those figures will also have to close—so I believe that the bill will have disproportionate equalities impacts.

Louise Caithness: We are pushed for time, so I will give bullet points. To go back to female-led businesses and those who carry the burden of childcare, that is a huge part of our industry.

There has to be a look at equality in the training that is insisted on under the bill. On regulated training and one-day courses, there absolutely is no comparison between those, but regulated qualifications are lengthy and costly, and excellent accredited courses exist, the cost of which is far more achievable for people to gain accredited qualifications. We also need to look at the insurance companies that are accrediting shorter courses and insist that they meet a minimum standard, so that everybody can access training fairly.

The cost of treatment has to be considered as well. If this becomes a hugely costly exercise for businesses, the burden of cost will be passed on to the consumer. We will not be accessible for

those who are priced out of our reach, so it is an economic issue.

Moreover, we have an audience of clients who do not want to go to a medical space for treatments and who take great comfort in visiting a non-healthcare or non-medical environment. We need to support those clients, whether from an emotional perspective or for any other reason. There must be diversity in the industry, so that we can ensure that there is an equal playing field for everybody.

The Convener: I believe that Tina McCaffery wants to come in.

Patrick Harvie: Sorry, convener, but I would like to come back in, as neither of the witnesses who has spoken so far has touched on the second aspect that I raised.

The Government asserts that the equalities impact of raising standards and addressing the safety issues that particular groups who are perhaps more likely to access those services are currently exposed to will be positive. This touches a bit on the points that Brian Whittle raised about advertising. Advertising in its broadest sense and cultural pressures impact on marginalised groups, whether that is around gender norms or the way that gender norms can be racialised. Those issues might push people toward accessing services in different ways.

I encourage the two witnesses who have not spoken to touch on that aspect. Will the raising of standards have a positive impact, as the Government suggests, for disadvantaged, marginalised or other equalities groups?

The Convener: Tina, do you want to come in at this point?

You are on mute, Tina.

No, we still cannot hear you. I will go to Douglas White while we try to sort that out.

Douglas White: It is really important that all consumers benefit from the same safety protections and have clarity around expectations. Legislation that aims to raise the bar for everyone with regard to the safety that it delivers should be beneficial for all consumers and take account of different equalities considerations.

I will touch on a couple of points in relation to different groups. First, I refer back to the Advertising Standards Authority's guidance on the advertisement of non-surgical procedures and its desire for further engagement about how it should deliver that in accordance with the bill. That is a good place to advance those more detailed considerations about actions that might be required in that advertising landscape to ensure that particular groups in the population are being promoted to, if you like, in ways that are safe and appropriate for them. There is a route through that set of advertising considerations to look at that issue.

10:45

Secondly, I made a point earlier about the opportunity to strengthen the bill around the provision of information that practitioners might be required to offer to consumers at the outset of a procedure. That might offer an opportunity to think about whether particular dimensions of that information need to be tailored to meet the needs of different groups in the population. Detailed work would be required to think through what that would look like in practice, but that could be a mechanism by which that type of work might be undertaken.

The Convener: Mr Harvie, if it is all right to go to Tina McCaffery now, we will do so; I think that we have sound.

Unfortunately, we do not have sound. Back to you, Mr Harvie.

Patrick Harvie: I am sorry that we cannot hear from one witness. Every witness is free to send us a written note after the meeting if there was something that you wanted to put on the record.

The Government asserts that mitigations to the potential negative impacts could be put in place. The Government's view is that there is a positive balance between the positive and negative equalities impacts, but that there can be mitigations for the negative impacts. Will the witnesses comment on what mitigations they believe will be in place or ought to be in place to ensure that we get the maximum positive equalities impacts and the minimum negative equalities impacts?

Louise Caithness: I will refer to training again. One of the biggest risks in terms of equality from a practitioner's perspective is that it would be a big leap for them to achieve, as Lynsey Wilson mentioned, the HIS regulation. We need to consider how that risk is mitigated by looking at what the pathway might be and at alternatives such as levelling within HIS regulation, so that the treatments that are less invasive require a different licensing structure to those that are deemed as surgical procedures. That is something to consider, and training also needs to be looked at.

There is a lot of discussion about regulated training, which is very important, but there is also excellent accredited training available. To mitigate the risk of practitioners not doing any of it, not following any regulation pathway and working under the radar, we need to make sure that

training pathways are accessible and affordable. That needs to be looked at in detail.

Lynsey Wilson: I believe that the current proposals will disproportionately harm women in the industry, small independent businesses and practitioners from rural areas. I believe that there is potential for harm in those areas. If a regulatory system is brought in that includes everyone in the sector, and all practitioners who have qualifications can meet a regulatory pathway, those equality risks would be reduced. That would obviously support businesses, women and the growth of the economy. I believe that consumers who are seeking treatments would have the confidence that their practitioner has relevant qualifications and they are in a licensed or regulated premises. I believe that there is potential for disproportionate harm, and it needs to be looked at.

Patrick Harvie: Finally, is Consumer Scotland confident that the approach that the bill proposes will reduce the disproportionate risk for people with, for example, low levels of literacy or other barriers to understanding what services are being offered, what they are being sold and what the risks are? Will the bill reduce that potential inequality of harm or risk that is being run by certain groups in accessing services?

Douglas White: That is an area where more can be done in the bill. For example, it could require providers to give that information to consumers as they go to undertake a procedure. It could provide a clear specification of what information should be provided, and—I did not say this earlier, but your question rightly prompts it—clear guidance about how the information should be provided, in terms of the accessibility of its content and the language that is used to describe risks, aftercare and where people might go if they wish to make a complaint or seek redress. There is an opportunity to strengthen the bill by including a requirement not only that such information is provided but that it is provided in the way that you describe.

Patrick Harvie: Thanks very much. That is all from me, convener. Do you want to check one last time if Tina McCaffery's audio has been sorted out?

The Convener: I will move to questions from Elena Whitham, because we have only nine minutes left of our meeting. If Tina is able to speak in response to the questions, she can perhaps address those other issues.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. I want to spend some of the time that we have left speaking about enforcement and compliance, which have been touched on a lot this morning.

I had wanted to start with Tina McCaffery—Tina, I do not know whether your audio is sorted. Do you support the offences and penalties that are proposed in the bill and, if not, what changes you would suggest? Your submission to our call for views stated:

> "Improvement notices and education should come before criminal sanctions, reserving offences for deliberate or reckless malpractice."

Tina, is your sound back?

As Tina's sound is, unfortunately, not back yet, I will put that question to all the witnesses. How do you feel about the offences and penalties that are proposed in the bill? What changes would you suggest to them, if any?

Lynsey Wilson: I believe that effective enforcement targets unqualified practitioners and illegal or rogue injectors who are offering unlicensed treatment. They are the people who are causing harm in the industry, not qualified aesthetics practitioners. Although all our treatments have risks, those risks are extremely reduced when the practitioner has a regulated qualification. It is evident that, across the sector, people are offering treatment in non-clinical spaces and using unlicensed products—they are the people we have to target.

The sanctions that are in place are essential to limit how such people offer treatments. My concern is how you find those people and what is in place to seek them out. We know that they sometimes operate from their homes or other premises. I would like to know what measures will be in place to enforce the bill and ensure that rogue injectors are found and sanctioned.

Elena Whitham: Is your concern not so much about how the inspection process for licensed premises might take place as about the wider issue of rogue practitioners who might not get caught under the bill? They will be covered by the bill in terms of the offences that they would be undertaking, but is your concern about what the mechanism is for finding them out?

Lynsey Wilson: Yes.

Elena Whitham: I can see that Louise Caithness is also nodding. Would you like to come in, Louise?

Louise Caithness: I worry that any regulation can begin to regulate those who do not need to be regulated, if that makes any sense at all, and that there are those who would just fall completely outwith the regulation—they are the ones we are talking about who are delivering poor and dangerous treatments. I would like resources to be applied to limiting those practitioners' ability to deliver treatments, whether that is done through the local authority, with a licensing scheme, or is

built into the regulation. I would like to know how that sort of thing can be targeted, because it is those practitioners who are giving trained non-medical or non-healthcare practitioners a bad reputation, and it is really unfair.

Elena Whitham: Is there also concern about some form of safety paradox arising? In other words, in seeking to increase safety and raise standards, we might see that part of the system grow a little, but some people might be priced out of the market as a result and turn to other areas that are not regulated as effectively.

Louise Caithness: Most definitely.

Elena Whitham: In that case, how can we ensure that that part of the market—the off market, the black market or whatever you want to call it—is effectively regulated under the bill?

Louise Caithness: Resources need to be allocated to that. We also need to make the consumer aware of good and bad practice in the hope that they, ultimately, will regulate the market by not choosing, or by reporting, such practitioners.

Elena Whitham: Douglas, do you want to bring a consumer perspective to this?

Douglas White: I come back to the three-pronged approach that I talked about earlier. It is vital that we raise public awareness and provide information to consumers to ensure that they know what regulation looks like, what they should be looking for or what to spot, and when that sort of thing is not there. We have also been having discussions about the pathway to compliance and support for businesses that want to comply with the new regulations to ensure that they are brought on that journey.

The third and final element is enforcement. We need to ensure that we have sufficient resources for enforcement mechanisms to find the operators who choose to stay outwith the new regulatory system and to apply the appropriate penalties.

Elena Whitham: Finally, should we, as some believe, have a system in which improvement notices are issued first, with a path to compliance thereafter, instead of moving directly to sanctions and criminal charges? Should a legal route for appeal be set out in statute, too?

Lynsey Wilson: I believe that, if a clinic is inspected for any reason and is found not to be complying in certain ways, a notification will be appropriate. I think that that is what happens just now in regulated clinics. However, it would depend on what they were doing that was wrong.

It is very difficult to put that sort of thing into words, given that, yet again, we are focusing on bad practices. In the industry just now, there are members of the public who are quite happy to go and receive botulinum toxin from unlicensed sources; because they have had no complications and are happy, they will continue to do that. With this regulation, we are ensuring that consumers across Scotland get access to safe treatments, but I believe that people will continue to go down the black market route. We need to develop some kind of resource to figure that out and put in place a plan to get rid of the people who are creating the most harm within the industry.

Elena Whitham: The final comment goes to Douglas White.

Douglas White: This is not a detailed view of the kind of pathway that you were specifically setting out, but, as you will know, there are lots— [*Interruption*.]

Elena Whitham: I am sorry, Douglas, but your mic was not on there.

Douglas White: Apologies.

I will not give a detailed view of the particular options that you were setting out, but I just want to say that there are, of course, lots of models of good practice and examples of less successful practice in a range of other sectors and industries, and I am sure that it would be useful to look at how a high level of compliance can be achieved and to do further work on the transferability of some of that learning to this context.

Elena Whitham: That was very helpful. Thank you.

The Convener: I thank the witnesses for their evidence. I briefly suspend the meeting for a changeover of witnesses.

10:59

Meeting suspended.

11:10

On resuming—

The Convener: We will continue agenda item 2 by taking evidence from a second panel of witnesses on the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill. Our second panel comprises representatives of the cosmetic procedures industry. I welcome to the committee Lesley Blair, who is the chief executive of the British Association of Beauty Therapy and Cosmetology and Confederation of Beauty Therapy and Cosmetology, and Victoria Brownlie, who is chief policy and sustainability officer at the British Beauty Council. We will move straight to questions.

Emma Harper: Good morning to youse. You might have heard some of the first panel's

responses to our questions. This is our first evidence session, so I will open it right up. What are your views on the proposed model of regulating non-surgical procedures, as set out in the bill?

Lesley Blair MBE (British Association of Beauty Therapy and Cosmetology and Confederation of International Beauty Therapy and Cosmetology): I welcome the bill as a starting point, but it obviously needs a bit more bones about it to be successful. If we are going to do it, we need to do it right at this stage to get some sort of oversight in our industry.

As a starting point, the bill is welcomed and needed in our industry, which is ever-evolving. Things change so quickly that it is difficult to keep up, and they have gone quite askew over the past number of years, so it is welcome that we should have some sort of oversight in place, especially from governing and regulatory bodies.

I will go deeper if you would like me to, but I will let Victoria talk now.

Victoria Brownlie MBE (British Beauty Council): I pretty much second that. Lesley has been working on the matter for many more years than I have—probably since the Keogh review in 2013. Since we were started about six or seven years ago, we as the council have been working really closely with the UK Government on regulation in this area. We absolutely welcome regulation in aesthetic, non-surgical cosmetic procedures as I feel that it is essential for professionalising and raising the standards and reputation of the industry.

Emma Harper: What role do you think that Healthcare Improvement Scotland or other industry bodies have in setting up safety standards for practitioners who need to be trained, regulated and supported?

Lesley Blair: As I said previously, we need the oversight for us all to adhere to. Health Improvement Scotland is predominantly for healthcare professionals; we need some sort of licensing model for non-healthcare professionals, who offer a lot of the treatments and modalities that are being performed daily. It is very important to set up that model so that we get some parity.

Although I believe that everyone should stay in their own lane and work to their own capabilities and qualifications, we need oversight. A lot of that is about consumer awareness because many consumers do not know what they are asking or looking for. We need something that will educate the consumer and everyone out there and give people something that they know will be followed—for the consumer to know where to go and for the practitioner to know what they should or should not be doing.

11:15

Victoria Brownlie: The accessibility of the treatments that we have now has made procedures seem somewhat more frivolous than they perhaps were seen maybe a decade ago. Regulation and oversight from, say, Healthcare Improvement Scotland will be vital in hitting home the fact that these are procedures with a risk of complication and of things going wrong. You need mandatory standards in place, first, to check that the practitioner is actually fit when it comes to standards, training and competency and, secondly, to ensure that the premises themselves are safe and hygienic so that the person having the treatment knows that they have been inspected and that there is recourse, should something go wrong. In the system that we have at the moment, that reassurance and recourse is just not there for the vast proportion of non-healthcare practitioners who offer such treatments.

Lesley Blair: There is no accountability for non-healthcare professionals and no recourse if something goes wrong. Healthcare professionals are accountable if something goes wrong—they can be struck off from their association and so on—but that is not the case for non-healthcare professionals. We would like to see regulation, because it will raise standards within the industry.

Emma Harper: I know that there is a hierarchy of procedures ranging from non-invasive to more invasive. Over the weekend, I read about an incident involving eyebrow wax that was so hot, it should not have been applied to the skin, and it burned the person's eyelids. I know, as a former operating room nurse, that we would check the temperature of the water that we were going to use, the saline for irrigating an open abdomen and so on. We had processes in place.

I am interested in the consent process with regard to risks, benefits and alternatives and the documenting of all that. I might be touching on other people's questions, but I was wondering about the tracking of those conversations to ensure that consumers are aware of the treatments that they are accessing.

Lesley Blair: I am really glad that you have brought that up, Emma. I was a practising beauty therapist for over 30 years, but I stopped just before Covid, simply because other work got in the way, unfortunately.

However, this is a very important issue, and it is all about having the proper qualifications and, indeed, regulated qualifications. We were talking earlier about the question of accredited training versus regulated qualifications; I am very much for regulated qualifications, because I think that there is a benchmark in that respect with regard to national occupational standards. As a result, we

can be assured of the quality of the qualification that is given, because, in the end, there is an examination to ensure that we reach that national standard.

Anyone who has done waxing—to use that example—should know what to do. If somebody came to me, I would have a thorough consultation with them to ensure that they were not using any retinols or Roaccutane, because all those things cause skin thinness, blah, blah, blah. I would document everything on the consultation; I would test the wax on myself and then on the client; and I would have the client sign the consultation to say that I had done all that. It is very important to have all that in place.

As an insurance company—which we are, too—we say in our code of practice and good practice guide that that must be done prior to treating the client and on every single visit. Let us be honest, though: how many times have you had that sort of thing when you go for treatments? When I go to places, it does not happen, and I have to ask for it to be done.

As I have said, this is very important. This is where the likes of ourselves and other bodies such as the British Beauty Council could be out there, educating our members and the industry. We show what good practice is, and it is what we try to do every single day.

Emma Harper: I have a final question, convener.

The Convener: Please be brief.

Emma Harper: What effect will the bill have on the reputation of the aesthetics industry?

Lesley Blair: I hope that it raises it—I really do. It needs to be raised. We have talked about the wild west and the charlatans who are out there. This is happening all over the place, and it is just because the industry is moving so quickly. It has been allowed to happen, but that is no reason for us to leave the industry there and to allow this sort of thing to continue.

We have to step in and ensure that the standards are there. There are lots of questions that we are going to have to ask, and lots of different research that we are all going to have to do, but this is such an important issue, and I think that the majority of professional, regulated, qualified people are absolutely welcoming the bill with open arms.

Victoria Brownlie: I agree. It is absolutely welcomed. However, the bill is quite thin. It would be good if there was much more on training, education, supervision and oversight and a little bit more tightness around the type of healthcare practitioners that can supervise and oversee people having treatments in their premises. In UK legislation, for example, only members of the NMC and GMC, and pharmacists and dentists can supervise. The bill includes a substantially longer list of regulating organisations, which is probably too broad for what we are talking about. Ultimately, we want the person supervising or overseeing a treatment to be trained in the modality and have deeper knowledge and understanding of the modalities that they will be supervising.

Sandesh Gulhane: I declare an interest as a practising NHS GP. Thank you very much for appearing today. Earlier, in private, the committee was asking exactly the same question about why the list of regulators is as it is in the bill. Victoria, given what you have just said, I will ask you to respond.

However, I am also very interested to speak a bit further about what consumers do not know. When people go to a doctor in a GP practice or in hospital, they know the standard of care that they are going to receive, but when they go to someone in the beauty industry, they do not. For example, botulinum toxin needs to be in the fridge and stored between 2°C and 8°C, and vaccines are the same. Medical practitioners have to prove that there is a medical-grade fridge and that substances are stored at that temperature, but that does not necessarily happen everywhere, does it?

Victoria Brownlie: Absolutely not. The council has been very clear from the outset that we think that only healthcare practitioners should be offering injectable procedures. I am completely with you on your concerns. There are perfectly competent non-healthcare practitioners, but we have no guarantee that there is that competence across the board. Also, if there is an instance of an adverse reaction to injectables, I do not feel that non-healthcare practitioners have the competency, knowledge and availability of prescription-only medication to deal with such complications swiftly and as necessary. If we say that the primary focus of the bill is to address the risk to the public, we cannot have non-healthcare practitioners touching injectables.

Sandesh Gulhane: Going back to the point about consumers' confidence and knowing that they get a basic standard, will having the bill in place ensure that reputable businesses will follow the code, get inspected and ensure that their products are kept in the appropriate environment? Will it ensure that the people providing treatment have a basic level of competence?

Victoria Brownlie: It will come down to enforcement, which is always the concern about such things. We can have the most robust regulation, but if adequate resource and funding are not given to robust enforcement, then who is to say? We hope that the inspection process and a

public education campaign—which, as Lesley Blair rightly said, we would absolutely support being involved in—would educate the public on what they should be looking for when they go to a premises. However, the proof of the pudding will be in the enactment of the bill and in its enforcement once it has come into effect.

Sandesh Gulhane: We heard from the previous panel about people performing procedures at home and in their garden pods, for example, and that such businesses would be put at risk. In my opinion, if someone is providing a procedure, they need to do that in a clean environment where there is the ability to wash their hands and have certain levels of hygiene. That is what a HIS premises would provide and it could still be made a comfortable, homely environment.

Victoria Brownlie: I had some concerns with the previous evidence about removal of livelihood. There are still hundreds of procedures that are not listed in schedule 1 that could be offered to consumers—Lesley is more knowledgeable about this—by practitioners from levels 1 up to 4 or 5. [*Interruption*.] It is up to level 7.

Yes, there will be some limitations on the procedures that non-healthcare practitioners can offer, and no-one is arguing about that. Our view is that public safety is the number 1 priority and that treatments should not be being offered just anywhere. There should be strict oversight on certain treatments in the schedule—not necessarily all treatments. The idea of treatments being done remotely, in mobile units or in pods in people's back gardens is completely against what we are trying to do here.

Lesley Blair: We are asking for parity and an even playing field from the beauty therapy side, but also from the medic side. If medics and healthcare professionals have to jump through hoops and have proper ventilation and cleanliness standards—all of the things that are involved in being an HIS clinic—it remains very unfair that non-medics do not have to do that. That is the situation that we have just now. I totally agree with the point about working in cabins and so on. There are some absolutely amazing businesses, but certain procedures need to take place in certain premises so that they are overseen and regulated.

Sandesh Gulhane: My final question is about what we heard from the first panel about there being no mechanism for recourse. Will the bill provide people with a mechanism for recourse if something were to happen? If not, what would you do?

Lesley Blair: I would say that the bill would not do that at the moment. It needs some meat on the bones. It is about requiring accountability from non-healthcare professionals. The previous panel would agree with that. We want there to be a level playing field across the board. Having that accountability will make a massive difference. However, we need to work on what is in the bill. It is fantastic and a great start but we need to ensure that everything is in place: the training, the education, the premises standards, the observing, the supervision and so on. That all needs to be very much in sync and part of this as well.

Sandesh Gulhane: If you could write to us with your suggestions, that would be great.

Lesley Blair: We absolutely can. You will be sorry that you said that. [*Laughter*.]

Brian Whittle: Good morning. I have a question off the back of the previous panel. Having listened to them, it seems that there is a concern around the lack of collection of data, especially around any complications that may have arisen from any kind of procedure.

If, as part of the bill, we developed a system through which we collected and deployed that data properly, would that in itself help to develop a system where those individuals who are operating a really good business would be highlighted? Would we also be able to start to weed out those operators who are giving the industry such a bad reputation at the moment? It seems that there is a real lack of collection of data.

Lesley Blair: There absolutely is a lack of data at the moment. It is not being collected because there is no requirement to do so from a legal perspective, but it should be collected as a matter of good practice. However, we do not have a lot of that in the industry at the moment. If that were to be a mandatory requirement, it could only help us over the years. Building up data would allow us to assess who should be doing what, and where it should be being done, and also to look at patterns to see what is going wrong.

We do similar in relation to insurance for the lower-level modalities, such as what Emma Harper said about waxing. We notice that there is a correlation between people who do not have regulated qualifications and claims; claims are higher for people who do not have regulated training. We do not insure them now, so we do not get to see that data as much. Our claims are down because we only insure people who are properly qualified.

Victoria Brownlie: We know that the NHS has to scoop up and deal with a lot of the complications and problems that arise from things going wrong, but there is no single reporting system to ensure that they are all recorded in the same way. If people attend accident and emergency, three or four different reasons could be presented for why they have come in, and the reason recorded would not necessarily state that it

was definitely to do with aesthetics or non-surgical cosmetic procedures. That in itself is an issue and some kind of universal system for recording would be useful.

We know that, in relation to the vast majority of complications, people either go back to the practitioner or, if they do not want to go back to them, they go to another practitioner and, in essence, ask them to fix the problem. However, there is a real reticence in the industry around fixing somebody else's work, which is probably also the case in the private sector in the health profession.

We definitely need a universal system for how we track and deal with those complications when they arise. It is also important to say—although I am not trying to defend bad practice—that some of the complications do not come about as a result of negligence or fault on behalf of the practitioner. Sometimes the person has an allergic reaction or they have not disclosed certain information. There can be various factors; it does not necessarily reflect incompetence on the part of the practitioner.

11:30

Brian Whittle: But you would be able to record that.

Victoria Brownlie: Yes, absolutely. Do not get me wrong—the more data we have, the better. The fact that we have not had the data has meant that we have been able to kick the can down the road for many years on this issue. We recognise that. We have been pushing for regulation for many years and the fact that we have not had the data has made it increasingly difficult.

Joe FitzPatrick: You mentioned that there was a difference between the regulations that are going through in England and the proposed model in Scotland. I am certainly sympathetic to your suggestions for how we could make the proposals for Scotland more robust. There are obviously other differences, so I wonder whether you could give us some thoughts about where we are getting it right and where there are things in the UK system that we should be looking at.

Victoria Brownlie: I think that where Scotland is now is kind of where the UK was with the Health and Care Act 2022, which gave the secretary of state powers to bring in future licensing and so on through secondary legislation. That is kind of where Scotland is going with the bill, with a few slight changes.

However, what is currently missing from the Scottish bill is the annex on grouping procedures. The proposals that went out for consultation at the end of last year included an annex that listed procedures under group 1, group 2 or group 3, which was really clear. However, the current bill has basically blown that out of the water. Groups 1, 2 and 3 do not exist now, and, as a result, the bill proposes no regulation of the lower-level procedures, which are much more common and widespread.

We have been fighting for a licensing scheme for years. The enforcers—the people who work in environmental health, trading standards and so on—are crying out for regulation because they know that dodgy practices are going on in their local authority areas, and they currently do not have the teeth or the powers to be able to close those people down.

The enforcers have been coming to us saying, "Please help us", and we have been saying to the Government, "Please bring in something that gives these people better enforcement and prohibiting powers." At the moment, they do not have those powers.

That is my worry with the bill. We absolutely welcome regulation of the higher-risk treatments—we need immediate action on those, and it is good that we are moving in that space. However, if we have not dealt with the secondary level, where there are significant volumes of procedures—some people have them every single day—and things that are going wrong in that space, that element will be able to continue. That is my concern.

Joe FitzPatrick: Are you able to tell us what types of procedures you are concerned about that will not be regulated by the bill?

Lesley Blair: Those are the peels, skin needling, radio frequency non-ablative laser treatment—

Victoria Brownlie: Heat and cold treatment, too. I could send you a list after the meeting.

Joe FitzPatrick: That would be useful. I think that the committee thought that some of those procedures were covered by the bill, so it would be useful to know what you think is not covered.

Victoria Brownlie: In England, the system will be different—a red, amber and green system is proposed. There are procedures in the green category for which people still have to have a licence but there is no supervision element. There is currently no such provision in the Scottish bill. In addition, certain lower-level amber treatments are proposed for the scheme in England that are not covered in the Scottish bill.

We talked earlier about supervision. In our opinion, you cannot have a one-size-fits-all approach to supervision. Some procedures will require a person to be physically in the room to oversee a procedure when it takes place, whereas

other, much lower-risk procedures will still require some level of supervision—for example, by a listed person who can be on the other end of a phone should something go wrong.

Joe FitzPatrick: It would be really helpful if you were able to write to us to highlight that information, as it would probably be easier for us to digest.

Victoria Brownlie: Of course—I am happy to do that.

Joe FitzPatrick: Lesley, would you like to add anything else about the differences between the two systems?

Lesley Blair: No. Victoria is the policy person—she is very good at deciphering all that.

Victoria Brownlie: I did miss one thing out, which Lesley would probably have highlighted anyway. There is no stipulation in the bill as to what education and training there should be. We can say until we are blue in the face that a Health Improvement Scotland premises can offer only certain types of treatments, but ultimately there will still be non-healthcare practitioners potentially offering those treatments with supervision, and there is nothing in the bill to say that those people have to have a regulated or accredited qualification. There is nothing on the supervision and training requirements for the person who is undertaking the supervision and oversight. Just because a person has been an optician or chiropractor, or—what was the other example?

Lesley Blair: An osteopath.

Victoria Brownlie: That does not necessarily mean that they should be able to oversee botulinum toxin injection. They have to have the correct level of training for the modality.

Joe FitzPatrick: It is helpful that you have put that on the record. We were talking to the bill team about that earlier.

Lesley Blair: It is very important. Although we want everyone to be able to access training for the different modalities and treatments, they have to have the prior knowledge as a stepping stone to do so. As I mentioned, an osteopath's path to doing that should not be the same as another medic's path, nor the same as it would be for a beauty therapist. We would need to do more training on anatomy in order to get us to a place where we were able to perform those modalities. That is important.

Conversely, from a medical point of view, we do not agree that just because somebody is a doctor, they should be able to do skin peels after half a morning of training when we are asking for a regulated qualification to be put in place in order for beauty professionals to do the same thing.

Joe FitzPatrick: I suppose that some of the detail for which you are asking could come in secondary legislation or in guidance, but it is useful that you have put that on the record—thank you.

Victoria Brownlie: If you are going to do that, we need a clear timeline for when it will happen. Otherwise, the regulation will be flawed. We need at least an understanding that those things are going to come in by X date, and some kind of commitment in that space, otherwise the proposals are pointless.

Brian Whittle: I want to ask about how we regulate advertising, what is driving the demand for non-surgical procedures and whether people, especially those in the younger generation, are being realistic about potential outcomes.

There are potentially mental health issues in that regard. The previous witnesses made an interesting point when they said that that would be taken into account as part of training—

Lesley Blair: As part of proper training.

Brian Whittle: They said that there are operators out there who are operating exactly in the way that they should be. The ethics issue is not black and white.

Lesley Blair: No—that is very important. When I did my training more than 30 years ago—when I was in primary school, obviously—we were very much indoctrinated in body dysmorphia and in ethics and standards. That was important.

Now, with the inception of one-day and two-day courses, the training can be very quick. The courses are about getting in, learning how to do the treatment and getting back out again, because people want to make money very quickly. We are, therefore, not seeing as much training on ethics in a lot of the non-regulated training that takes place.

To come back to your original question, which was about advertising, with the growth of social media, TikTok and everything else that is out there on all the different channels, we are seeing unrealistic expectations. That is especially the case with young girls. It really worries me when I see their ideal of what beauty should look like—it is all filtered and it is not how people look, but they think that they have to look like that. That is giving rise to mental health issues. People go to get treatments done and unscrupulous practitioners give them treatments that they do not need. A lot of the blame lies with the practitioner. They should be able to say no, and should not perform a treatment that they do not think is right for the client or patient—whoever is in front of them.

However, social media has a lot to answer for. I know that the Advertising Standards Authority says that people are not allowed to advertise

wrinkle relaxation injections with botulinum toxin because it is a prescription medication. However, because fillers are a medical device, they can advertise them. There needs to be some oversight in that regard, but I do not know how we do that—

Brian Whittle: That was my next question.

Lesley Blair: Sorry.

Victoria Brownlie: I think that the ASA would argue that it is already trying to regulate the advertising, but we know that, at present, its approach is essentially reactionary rather than proactive. When people advertise things in a way that they are not allowed to do, there is very little recourse. There is some—although very little—low-level banning, for maybe a couple of weeks. They are asked to take the post down and given several warnings first.

We need a much more robust system, with penalties for misusing advertising and putting up unsuitable advertising. We also need greater penalties for the social media companies. I do not know whether you have been through your social media feeds recently, or whether you are an avid Instagram user, but every other post now is an advertisement. The accessibility and visibility of advertising now mean that it is much more prolific than it was even a couple of years ago—people are unconsciously ingesting all that information, all the time. As Lesley said, whether you realise it or not, the advertising is going in and you are being influenced by it.

Also, there is a lot more reality TV out there than there was previously, and these unrealistic body images are being projected by the people who generally go on those shows. They are subsequently selling or promoting products across their social media channels with, again, very few checks that they are saying the right things or doing things correctly. That is technically advertising as well, but because someone famous is doing it, it is not necessarily seen as that.

Brian Whittle: That is why it is so important that the practitioners are held to a high standard, because they are ultimately the ones who can say yea or nay to a procedure.

Lesley Blair: Yes.

Victoria Brownlie: Yes.

Brian Whittle: I suppose that it then becomes a resource issue. It is all very well saying, “Here are the standards we want you to stick to”, but how do we enforce that?

Lesley Blair: I was going to say that this can be self-funding as well, because if we have a licensing scheme in place and there is a charge for that, that will raise revenue. I would hope that some of that could be pigeonholed for the advertising side of things, because there are a lot of false claims out there.

Also, there needs to be more communication to people out there so that there is more awareness of what can go wrong. I do not think that people understand what can go wrong—that you can go blind if a filler goes wrong, or you can lose your lip. I have some fantastic photographs that I show to friends when they are going get things done—they are of somebody with half a lip; it has all kind of melted away.

If you show such photographs to somebody before they get a procedure, they will think twice about who they go to to get it done, instead of going somewhere just because they have seen somebody advertising it for £50 on TikTok or whatever. It is really important to educate people on what can go wrong.

Brian Whittle: What you have said would certainly make me think twice before I got my lips done.

Carol Mochan (South Scotland) (Lab): I think that the witnesses have already answered some of my questions, which are around training and competency. Just to be clear, there are voluntary standards, which we have been told will support regulation and improve safety, and I wonder whether you think that they will do that. Alternatively, do you think that we need to have mandatory training qualifications?

Lesley Blair: One hundred per cent. We are self-regulating as an industry body. We have now taken a massive commercial decision that we will not insure someone unless they have a regulated qualification.

Unfortunately, just because we have made that decision does not mean that everyone else has. Most insurance companies are commercial. Also, someone does not need to be insured to carry out a lot of these modalities. The requirement that they need to be insured should be set in stone. That is very important.

Another point is that someone does not need a qualification to be insured. They can just go and do one day’s training and then be out practising—they could be working as a bank nurse one day, and the next day they could be doing some quite high-level treatments. I would like that to go away.

One-day courses and accredited training are so important for our industry because it is ever-evolving and we need to continually develop. However, as I always say, you cannot build a house on sand foundations. You need the regulated qualification there and then you can build on that. That is where accredited training, add-ons and so on come in.

Just because someone has a sparkly certificate does not mean they are actually qualified and able to do a modality. Everyone laughs when I say, “All that glitters is not gold”. People walk into salons, see certificates up on the wall and think, “Oh, they must be good because they’ve got a nice, shiny certificate.” That is why we need regulated training—through Ofqual and the SQA—so that there is a benchmark. With national occupational standards, it is all set in stone. At least we have then got that benchmark, which people have to adhere to.

Some of the accredited training is really fantastic. However, there is not the same oversight there, and we cannot monitor it to the same level. It is very important as an add-on, but it should not be done as a stand-alone.

Victoria Brownlie: Building on that, the regulated qualification is important but so are regulated or approved providers. You can have as many voluntary registers as you want, but if there is no legitimacy or competency in terms of the provider, the qualification is not worth the paper that it is written on.

We have seen a proliferation of all kinds of training providers putting themselves out there and essentially preying on people who, as has been mentioned, have limited incomes and are in good faith taking a qualification that they think will then make them fully competent in injectables after two days. However, that is absolutely not the case.

There is a reason why the course takes four-plus years. It is because practitioners need that time, experience and level of competency, along with the discussions around safety, risk and anatomy and all the other things that the course encompasses. That is why it takes that long. However, people are being sold a product for £5,000, or however much, and saying, “If somebody with these letters after their name is saying that that’s okay, that means that it’s okay.” We need something from the Scottish Government that says, “No, these are the only providers that can provide this training”, or “Only people who offer this particular type of regulated qualification can be a training provider”. Unless we have that, we will, unfortunately, continue to see a situation in which there are hundreds and hundreds of different training providers.

11:45

Lesley Blair: It is also about the use of certain kinds of terminology. The word “level” is used a lot just now. As an insurance company, we constantly get people sending in their certificates so that we will insure them at level 2, level 3, level 4 or level 5. However, when we check the certificate, we see that it is just a play on words. I would like that terminology to be protected in education.

My biggest bugbear is the use of the word “qualification”. There is the idea that a qualification is regulated training and so on, but I would say that accredited training is not a qualification. When people in our discussions say, “Oh, I am qualified in this,” I always say to them, “No, you have attended a training course on it. You do not hold a qualification in it.”

Getting the right terminology out there is really important, including for the consumer. We had an event at the Parliament at the beginning of the year on consumer awareness—Brian Whittle was there—and we need to educate the consumer on what they have to look for. I can send the committee details on that.

Carol Mochan: All my questions have been answered.

Paul Sweeney: I thank the panel members for coming today. I want to touch on a topic that was discussed in our earlier evidence session. We discussed the tension between a level playing field, so that consumers have confidence that the services are of a certain standard, and managing the barriers to entry for smaller, independent, home-based businesses. What is your view on that balance, and how could regulation be implemented without disproportionately affecting smaller players in the market?

Victoria Brownlie: It goes back to what I said previously around there being certain premises that are suitable for treatment levels that we are talking about. The higher the level of risk, the more likely it is that the treatment needs to take place in more of a clinical environment. Unfortunately, although I completely welcome people having the ability to diversify and to offer treatments and services in their homes and in mobile units—if they do so while fully qualified in what they are providing—certain treatments, in our opinion, should not be given by those people. As I said, there is still a plethora of other treatments that they could offer that fall within the scope of their qualifications.

Paul Sweeney: Will you go into a bit more detail about where that split should be and what the treatment hierarchy is for a certain setting?

Lesley Blair: One thing that we are continually trying to advocate for is that anyone who is performing a treatment should either be able to manage any complication themselves or have a person who can do so in the same building or with them in the room. People say that prescribers can be a phone call away and so on, but you cannot account for traffic, an accident, a puncture in their car on the way to a clinic or whatever.

For us, it is fine for a practitioner to do higher-level modalities in a more clinical setting if they have the correct qualification and the correct oversight. I do not know whether that can be done when someone is working from home or a mobile unit, and, at the moment, I would say that it probably cannot. As I said, it is important for everyone to stay in their lane and to do what they are able to do—and not necessarily what is comfortable. Having the correct clinical setting is very important.

To go back to the point that I made at the very beginning of the evidence session, if we are asking healthcare professionals to pay a large licence fee and to tick all the boxes and so on in order to be covered by Health Improvement Scotland, other people doing the same modalities need to face the same levels of enforcement and have the same levels of oversight.

Paul Sweeney: That is helpful. Could mitigations be designed, such as support for training, so that individuals could develop their skills to meet the regulatory requirements that are to be introduced? There is also the issue around facilities and logistics, which we have discussed. Could there be access to common clinical space and a common user facility? How might that be developed? What is your view on how that could happen? It might be a nice idea, but would you create—

Lesley Blair: Please correct me if I am wrong, but there is no reason why a cabin in somebody's garden could not be an HIS clinic as well. There is no barrier there. It is about having the correct standards for everyone. We are asking for parity, but there must be parity across everything. We cannot have it all ways.

Everyone should have access to the training. We are working with a number of colleges just now on some sort of shorter training for skin needling, skin peels, laser treatment and so on. The idea is that you would go to a centre where your competency—and what is missing from it in order for you to gain a regulated qualification—would be assessed. The person would only have to do that so that they would not have to retrain. Many very good operators out there have been doing modalities for 10, 15 or 20 years, so it would probably be quite onerous for them to retrain to get a certificate. However, we must be assured that they are meeting that national standard.

There are ways of doing that. We are working with centres to make that transition much easier for people, both financially and from a time perspective, given that a lot of people work full time. This is a predominantly female industry—the survey that Victoria Brownlie did a few years ago showed that, in the beauty industry in the UK, 88 per cent of the workforce and 80 per cent of business owners are female—and it is important that we support it. However, safety must be paramount—we must ensure that safety is there.

Victoria Brownlie: I have sympathy for the view that a route should exist for people who are not practitioners to get the professional level of standard qualification—to be something like a prescriber, for example—without having to accumulate, in essence, tens of thousands of pounds-worth of debt to go through a university healthcare practitioner route. However, I know that the situation is slightly different in Scotland.

I would really like to work with regulators, Government and so on to look at ways of finding a more accessible route. As it stands, a level 7 qualification is meant to be a master's level qualification. Additional mitigations need to be in place to ensure that there is more of that clinical level of safety, which, ultimately, we do not necessarily experience every day in the beauty professional environment.

Lesley Blair: It is really important to look at how we could get everyone to that level. We do not want to encourage people to do a nursing degree only for them to leave and go into aesthetics—there would then be the burden on the NHS of paying for that but not getting the benefit of it. If we could work together and get some sort of aesthetic nursing training, people would not need to go through the full medical nursing degree. They would, however, need to go through all the very important parts in order to manage complications for all the different modalities that they would be doing as an aesthetic nurse.

Paul Sweeney: If there is a difference between Scotland and England, do you think that our legislation could have potential unintended consequences, particularly around driving behaviour underground, into an unregulated space, or to different jurisdictions or even overseas?

Lesley Blair: That is why we need parity between Scotland and England. The differences were very apparent during Covid, when we had what we called "maskgate". In Scotland, we were wearing masks a lot longer than in England, and people were crossing the border for treatments. It would be really good if we could avoid that and have as much parity as possible.

We will never avoid driving behaviour underground. However, I think that we would get a lot of buy-in as long as we made things as robust as possible, with fair but firm enforcement—that is very important. People would train, because most people fundamentally want to do the right thing—I hope so, anyway.

Paul Sweeney: Ms Brownlie, you mentioned that certain treatments are not appropriate in

certain settings. Could you give us a couple of examples of what you are talking about, for clarity?

Victoria Brownlie: Sorry—could you repeat the question?

Paul Sweeney: You mentioned in your initial response to my question that it is not appropriate to carry out certain treatments in, say, a home setting. Could you give me some examples of what you are talking about?

Victoria Brownlie: Injectables—anything where we are intravenously injecting—would definitely be included in that. There has been a massive surge in vitamin injections. If you are hungover, you can go and get a vitamin injection, and there are weight-loss injections, which are administered by a clinical practitioner as opposed to the individual. I do not think that anything injectable should be done in anything other than a clinical setting.

Patrick Harvie: Good morning. I want to talk about the equalities impacts, which I asked the previous panel about. A moment ago, Lesley Blair talked about the number of women-led businesses in the industry and followed that by saying very firmly that safety is paramount. I would like to explore that balance a bit.

The previous panel was quite clear about the positive opportunities for people who provide such services and about wanting to ensure that there is still access to the services. It was a bit more difficult to draw out the disproportionate risks and harms that particular groups in our society might face at the moment. Do you agree in principle that a completely deregulated, free-market approach to the issue would reduce inequalities in business opportunities and might reduce inequalities in access to treatment but would massively exacerbate inequalities in relation to harm and risk? Do you agree with the Government's position that the bill strikes the right balance in mitigating some of the negative equalities impacts? The Government's view is that the positive equalities impacts from the bill would outweigh the negative ones.

Lesley Blair: It goes back to the point that safety must always come first—it must be our first consideration in anything that we do. Victoria Brownlie very eloquently explained that, if you have trained throughout the different levels, you are able to do many different things.

We are not at all advocating that no-one should be allowed to do anything; we are saying that we should make sure that everyone is trained and qualified to an appropriate level. That might mean that, if you want to train in injectables but do not want to go down the medical or the healthcare route, you will have to work with a prescriber, and if you do not want to work with a prescriber, you will have to go down the medical route to become a prescriber, and so on. There are absolutely no barriers there that would restrict any training for anyone.

To go back to the beginning, we need a level playing field—we need everyone to be qualified in the modalities that they are offering and to be proficient. That means that it must be open to everyone to go down that route. Especially in relation to people upskilling from what they are doing just now, if they do not hold regulated qualifications, there must be pathways in place. We are working on that just now, and people are doing that already in order to gain qualifications.

I am probably talking more about level 4 qualifications in treatments such as skin needling, skin peels, laser treatment and so on. We really hope that there will be a regulated training requirement that operators will need to hold when conducting those treatments.

Victoria Brownlie: The accessibility and availability of those treatments has absolutely exploded over the last decade or two, and, as a result, the regulation—or lack of it, as it currently stands—has not kept pace with the proliferation and availability of treatments, which change every year. Some of the procedures that we talked about a couple of years ago, when the work first started here on the types of treatments that should be considered within scope, have moved on greatly, and I imagine that they will do so again in the years to come. There is a responsibility there for us. There are issues around whether what is in the bill is proportionate and whether it will affect some people more than others, in a positive or negative way.

12:00

In relation to the accessibility and availability issues, we found that there has been a huge influx of people offering these treatments, because they have seen an easy and accessible way to make good money and careers out of them. I should say, and I have said previously, that a lot of people who are doing that are doing so with great levels of training and competence and are having very few things go wrong. However, there are others who are taking part in what is essentially a race to the bottom—a race to cheap prices—and they are in competition with each other because becoming a provider is so much more accessible than it was five or 10 years ago.

That puts at risk vulnerable adults—especially young adults, who are impressionable—who are being sold services without the correct oversight or the checks and balances to ensure that they should be having the treatments; that they understand the risks and the alternatives; and that

they look at whether they even need these things in the first place and at the deeper reasons behind why they want them. Another issue is whether they can afford the treatment. There are situations in which people take out credit cards and loans and take on debt in order to fund these treatments. For me, the risks far outweigh the potential negative effects that could come as a result of restricting the ability to offer such treatments to certain groups of people.

Patrick Harvie: I do not want to put words in everybody's mouths, but it sounds as though both of the witnesses are saying that the equalities impacts of the bill lean more towards positive than negative.

One witness on the previous panel made the suggestion that, in addition, some people are having language accessibility issues in relation to the provision of available information, and one witness suggested that there could be improvements to mitigate any disproportionate risk of harm to people in that category. What are the present witnesses' reactions to that? I will come on to the issue of age in a moment.

Victoria Brownlie: Lesley Blair's organisation, BABTAC, has a great campaign that tries to educate people and to simplify the messaging in that way. The bill is beneficial to the groups of people that you discussed, Patrick, because it will hugely simplify the provision of information to members of the public about what is safe and what is not a safe route, in a way that does not currently exist.

We have discussed the "wild west"—it sounds dramatic but, when people go to have these treatments or inquire about them, it is Russian roulette as to whether they will get a safe procedure. The bill—which, as I have mentioned, needs some work—goes some way towards improving the public's level of understanding of what the safe avenue to go down is if they want to have any of the treatments.

Lesley Blair: I agree with what Victoria Brownlie has said.

Patrick Harvie: Finally, let us turn to the issue of age. There seems to be a broad welcome for having an age limit of 18. I do not hear any dissent about that. However, judging from one or two of the comments that I have heard, there is a question mark over whether any additional safeguards are needed for younger adults—that is, people who are over 18, who are adults, but who may for one reason or another be particularly vulnerable to social media influence, coercion or the social pressures that drive people to access these services for the wrong reasons.

If we were talking about healthcare, I would say that I am a strong advocate of Gillick competence. The principle that young people—including those who are not yet adults—have the competence to understand decisions about their own lives needs to be respected on an individual basis. However, we are not talking about healthcare; we are talking about buying services. I am resistant to using the term "treatment", which implies that it is treatment for a condition, as these services are on sale on a commercial basis. Is there a need for any additional safeguards for younger adults or for other groups that may be particularly vulnerable to those pressures and social influences?

Lesley Blair: We would lean towards the operator or practitioner being able to govern that. There is a definite need for an age restriction, so that someone should be at least 18 to get any of these treatments—unless they are doing so for medical reasons; there are many non-aesthetic reasons to have treatments. However, we must allow the practitioner to assess the need for additional safeguards when they have the client—or the patient, if they are a medical provider—in front of them.

They have to be given the oversight to do that. It would be very difficult to manage that need otherwise, and I do not know how we could quantify or manage it. There is probably already something on that issue—including in relation to body dysmorphia—in the standard of training that we insure, to make sure that consideration of additional safeguards is part of good practice.

Victoria Brownlie: I will add to that by going over what Lesley Blair mentioned earlier about the difference between a regulated, accredited qualification and short courses. Technically, somebody who has a regulated qualification—and Lesley Blair with her 30 years' experience—will know what things should be mandatory within any consultation period for someone who wants a service. That would include, as Lesley mentioned, a cooling-off period and discussion of risks, potential effects and things that might not go the way that the person wants them to go. All those things should be discussed with the client or patient before they have the treatment. There should then be a period of at least 24 hours in which the person is encouraged to go away and speak to others, to talk it through and to look up the treatment and do their own research before going back and having it. They should not be able to just come in and have the treatment straight away.

The process that I have described should be par for the course for people who are operating reputably.

Lesley Blair: Yes, that should be the case, for sure, with the higher-level modalities.

Patrick Harvie: Thank you, both.

Elena Whitham: Good afternoon. We have only a couple of minutes left, so I will quickly run through a few questions around enforcement and compliance.

Do you foresee any practical challenges that the aesthetic industry might face in meeting the bill's requirements on inspections and compliance?

Lesley Blair: At the moment, yes. For example, environmental health is very low in resource, but I hope that, if we had a paid licensing scheme, we could raise the finance to fund it and make it self-funding. Industry bodies such as ours and the British Beauty Council would be happy to work with environmental health on that, as we do just now with its governing body, to give advice and to help to support it. It must be given the correct enforcement powers—as I said, the powers need to be quite strong in order to make people stick to the scheme and to make sure that environmental health knows what it is looking for. That is very important, because we hear all the time from environmental health, "I don't know what I'm looking for. What is the qualification? What is the certificate?" We can definitely work with it on that.

Victoria Brownlie: Healthcare Improvement Scotland also has a responsibility to be part of a successful enforcement process and the roll-out of the scheme in the same way that the Care Quality Commission has a responsibility for the regulatory oversight of higher-risk procedures in England. If we are saying that Healthcare Improvement Scotland premises are deemed to be safe premises because of the practitioner qualifications, the fact that they are inspected and so on, Healthcare Improvement Scotland should bear some responsibility for the oversight and supervision, which would then feed into this work.

Elena Whitham: That is very helpful. Do you support the offences and penalties that are proposed in the bill as drafted? Is there anything within those proposals that you would seek to change?

Victoria Brownlie: I support what is in the bill currently, but I go back to what I said about the need to license other kinds of treatments that are lower risk but that still require some level of licensing and oversight. At the moment, the complete lack of provision in the bill for such a licence means that, ultimately, people will be able to continue offering those treatments with little to no recourse for the consumer should something go wrong and—I am sorry, but I have completely lost the word; Lesley Blair and I talked about it yesterday—without any degree of the client knowing whether the person has the correct level of qualification, whether their premises have been inspected or whether they are ticking all the boxes.

Elena Whitham: Do you feel that, when we see breaches under the legislation, there need to be improvement notices, education and work towards compliance? Obviously, if breaches are so serious that they need to be dealt with immediately—

Lesley Blair: It has to be proportionate. It goes back to what Victoria Brownlie said about the licensing side of things, which is so important for the many modalities that have different levels—for example, skin needling, skin peeling and laser treatment. It is absolutely fine for a beauty professional to do certain levels of skin needling, skin peeling and laser treatment. If they have a level 4 qualification, they are more than able to perform those treatments safely and to manage any after-effects. However, it needs to be proportionate, because skin needling and peels can go deeper, and laser treatment can be made more ablative and take away a lot more layers of skin. That is where we need the approach of the licensing leading into the HIS oversight, so that we can all work together.

As Victoria Brownlie rightly said, at the moment, we are not able to home in on the levels that we should and could be doing safely as non-medics, because there is no oversight of that. Non-medics can do deeper peels, skin needling and laser treatment, so we need to work on that.

Elena Whitham: Should there be an even playing field for the licensing of a tattoo artist or a tattoo studio and the licensing of somebody who is operating a laser to remove the tattoo?

The Convener: Ms Whitham, a licensing scheme will come in, in parallel with this bill.

Elena Whitham: Okay. Thank you. That answers my question.

The Convener: Sorry—I said that in case we were going to go off on a tangent. Was there anything else you wanted to ask?

Elena Whitham: No. I know that we are out of time.

The Convener: We will have a final question from Sandesh Gulhane.

Sandesh Gulhane: We talked to the previous panel about young people, and Louise Caithness said that her business would not do anything for anyone aged under 18. A few other witnesses also spoke about the age of 18. What do you think is the correct age, and why? People can vote at 16 in Scotland, and the law talks about different sentencing for those aged under 25. What age do you think is appropriate?

Victoria Brownlie: Lesley Blair may feel differently about this, but I think that the age of 18 is proportionate, because we are also looking at the way that our bodies are developing as we

move into adulthood, and I think that 16 is still too young to see how your body is developing and changing. You could say that it will continue to change until the age of 21, and so on. However, back in 2021, we were instrumental in pushing through the legislation that restricted injectables so that no one under the age of 18 could get them, and we would want parity with the UK in that respect, too.

Lesley Blair: I agree, 100 per cent, that the age limit should be 18, for all the same reasons, as well as for enforcement and for people sticking to it. We would get an awful lot more buy-in for that age restriction. Given that people can be married, buy a house or whatever at that age or below, it would be overkill for us to say that someone cannot get a treatment until they are 21 without parental consent or that they cannot have it at all until then.

Sandesh Gulhane: Thank you.

The Convener: I thank the witnesses for their evidence. At our next meeting, on Tuesday 9 December, the committee will continue its scrutiny of the Non-Surgical Procedures and Functions of Medical Reviewers (Scotland) Bill, taking oral evidence from two further panels of witnesses. That concludes the public part of our meeting.

12:13

Meeting continued in private until 12:32.

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