OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 9 December 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 9 December 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

34th 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:

Laura Boyce (Healthcare Improvement Scotland)
Brett Collins (Save Face)
Jacqueline Cooney (Scottish Medical Aesthetics Safety Group)
Stefan Czerniawski (General Dental Council)
Amanda Demosthenous (British Association of Medical Aesthetic Nurses)
Eddie Docherty (Healthcare Improvement Scotland)
Remmy Jones (Allied Health Professionals in Aesthetics)
Paula McLaren (Nursing and Midwifery Council)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 9 December 2025

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 34th meeting of the Health, Social Care and Sport Committee in 2025. I have received apologies from Paul Sweeney.

The first item on our agenda is for the committee to agree to take items 6 and 7 in private. Do members agree to do so?

Members *indicated agreement.*

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

09:00

The Convener: The second item on our agenda is to take 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 our scrutiny of the bill is specifically focused on part 1.

The first of this morning's panels comprises witnesses from healthcare representative bodies and professional regulators. I welcome to the committee Jacqueline Cooney, director of the Scottish Medical Aesthetics Safety Group; Stefan Czerniawski, executive director of strategy at the General Dental Council; Amanda Demosthenous, a non-executive director and board member of the British Association of Medical Aesthetic Nurses; and Remmy Jones, who is representing Allied Health Professionals in Aesthetics.

We will move straight to questions, starting with Sandesh Gulhane.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising general practitioner in the national health service.

Good morning, and thank you for coming. I will start with a very basic question. Are the procedures that the bill seeks to regulate completely safe, or do they pose some form of risk to the public?

Amanda Demosthenous (British Association of Medical Aesthetic Nurses): I would say that there are quite a number of risks, the worst being necrosis, sepsis, burns, scars, vascular occlusion and death. There are a range of complications that are pertinent to patients and that we see in our practices quite commonly.

Sandesh Gulhane: One of the simplest things that people think that a GP will see is a cough and a cold. That is normally quite an innocuous thing in examining a patient. Would we let just anybody examine a patient with a cough and a cold—somebody who has no regulations covering them whatsoever? Could we consider even some of the most minor procedures covered in the bill by framing them in a similar way?

Jacqueline Cooney (Scottish Medical Aesthetics Safety Group): I would agree with that, yes. Some of the procedures carry high enough risks that we would not want just anyone doing them—a member of the general public—even if it was someone who had done a day's course on something. In my opinion there is not

enough robust education behind that for people to be able to see things and treat them.

Years of experience on the part of doctors, nurses and other healthcare professionals will see them through, so that they are able to do such treatments and treat any complications that may occur from them. I would agree, however: I do not think that we should allow just anyone to do the majority of the treatments that fall under the groupings in the bill.

Sandesh Gulhane: I spent years as an orthopaedic registrar training how to operate and I would not be allowed to take off even the smallest lesion independently within a hospital setting. It seems a bit fraught.

I will turn to you, Stefan, if I may. In England, the British Dental Association did not want to be part of the regulations or of the group that covers people who could be doing the procedures. Do you have a different take in Scotland? If so, why?

Stefan Czerniawski (General Dental Council): I do not think that we have a different take in Scotland. Dental professionals are, in the terms that we were just discussing, highly trained in a range of procedures. For dentists in particular, that is not just about precise issues around oral health. They are well placed as health professionals to do the job of a health professional.

As with any procedure, the specifics of the procedure and the specific risks around it need to be understood, and it will not be part of a dental professional's normal training to have covered the range of procedures that are the focus of the bill. Therefore, there is a distinction between the question whether dental professionals, as healthcare professionals, are well placed to act in that role, and the question whether all or some of them have the appropriate specific knowledge, skills and experience to act in relation to those procedures.

Sandesh Gulhane: The General Dental Council is one of the organisations on the list of those that act as regulators. Are you happy with that, or do you want to be removed from the list?

Stefan Czerniawski: Generally, we are happy with it. The issue is less about the role of the healthcare professional, particularly in an oversight or supervisory role. Our concerns are much more about the people who might not be healthcare professionals who participate, particularly in level 2 procedures. The relationship does not really exist in other settings of that kind. There is potentially the issue of whether you get sufficient regulatory confidence from the role of the supervising healthcare professional, given that, in a more normal clinical setting, you would expect every member of the team to be a professional registrant in their own appropriate category and with their own appropriate regulator, so that you have a chain of accountability. If we have laypeople, with potentially limited training, conducting those procedures, on the basis of the current approach for level 2 procedures in dental settings, the non-dental professional would be under very limited requirements to meet any particular standards. In an odd way, those individuals would be potentially less regulated than the people conducting level 1 procedures under the civic Government powers. The issue is how much weight it is sensible to put on the professional role of the supervising healthcare professional and the regulatory system that they are part of to be confident in the specific activities that happen under their supervision.

Sandesh Gulhane: Did anyone else want to come in on that?

Jacqueline Cooney: We were just nodding.

Sandesh Gulhane: Remmy Jones, you represent allied health professionals. It is very important that we say that these are not laypeople; they are allied health professionals. What is your opinion of the bill, especially with regard to patient safety and clinical oversight?

Remmy Jones (Allied Health Professionals in Aesthetics): I concur with the comments from my colleagues on the witness panel about ensuring patient safety. I have to agree that professional registration would be the most appropriate grounding for clinical oversight. Furthermore, I think that it would be beneficial to have more than just a simple professional registration. I am a paramedic who has taken the postgraduate diploma in aesthetic medicine, so I have undertaken the extended education, and I feel that that is the most sufficient level of education that I could attain in that regard. It is about having more than just a professional registration, because we are talking about specificity of clinical oversight and, based on my experiences, that means that we need the specifics of aesthetic medicine, rather than a generalist medical registration.

Sandesh Gulhane: Obviously, no individual actually offers everything, but, given your extensive training, do you feel that you would be in a position to offer, potentially, everything that is in the scope of the bill?

Remmy Jones: Yes, based on my training to date. It was extensive training, and I also undertook an extensive period of mentorship as part of that, to ensure that I was clinically competent in all aspects of consultation and assessment, and history taking, specific to aesthetics and the medicines that we are going to use but also in relation to the psychology behind it and the law and ethics around it. For me, that

completed the package. Rather than a generalist approach, it was very specific to the job in hand.

Sandesh Gulhane: Last week, we spoke a lot about Healthcare Improvement Scotland-registered premises. In the case of dentists, dental rooms and the places that are used are regulated quite tightly. Given that, as we have said, there is a risk associated with all procedures and we need to ensure that there is the utmost patient safety, what are your views on whether the premises that are used to perform these procedures should be HIS registered?

Stefan Czerniawski: In respect of dental premises, your summary is generally true, but it is not wholly true. The vast majority of dental practices are not inspected and regulated by HIS, because any dental practice that carries out even a small proportion of NHS work has that work overseen by their NHS board. As a result, only a very small minority of dental practices have the HIS oversight that you referred to. I think that that is a gap, and it is one that has been around for a long time. In the other three nations, the systems regulators generally do not distinguish between premises on which NHS work is carried out and premises on which independent practice is carried out, but the role of HIS is more limited.

The bill's provisions risk emphasising that regulatory gap, because we would be faced with a situation where the majority of dental practices, which would be appropriate premises for the activities to be governed by the bill, would have their NHS work overseen by the boards, but the boards' interest would not extend beyond the NHS dental work. There would be no premises or systems oversight of activities conducted on the premises that were not NHS dentistry.

Amanda Demosthenous: I did a bit of data capture to look at how many complications there are, because it is quite difficult to quantify the number of complications that present via NHS trusts and so on. I managed to get some data from Save Face and the Joint Council for Cosmetic Practitioners, and there are roughly 2,800 complications a year across the UK. We can work out from that that there will be roughly 700 complications a year across Scotland.

Having HIS-registered premises protects against that a lot, because it means that there is oversight and regulation of premises. In addition, the practitioners will have some regulation anyway. From a nursing standpoint, I completely agree that HIS registration is a good standard to set across the board. If there is no standard, no one will check premises and see what clinical settings are being used. People could operate from a garden shed, and it would become very tricky. I think that Jacqui Cooney would agree with that from a nursing standpoint.

Jacqueline Cooney: I have some data from Glasgow Caledonian University. It submitted some freedom of information requests to the Scottish Ambulance Service, and the responses showed that over 1,000 ambulances were called to premises with the words "aesthetics" or "clinic" in their titles. When the university looked more closely at that and dug into the data, it realised that all but two of the premises that the ambulances were called to were non-medical establishments.

The calling of those ambulances carries not just a financial cost but a wider cost to the general public, because other people will be waiting for ambulances that are called when they are not particularly needed. The things that they were called for included people having palpitations after having lip fillers, and people fainting. I go back to your question about HIS-regulated clinics. If things such as that happened in an HIS-registered clinic that I was in, which had the oversight of a medical professional, no ambulances would be called. I and Amanda Demosthenous and the rest of my colleagues on the panel have the ability to deal with a faint, a palpitation or a panic attack after a needle has been inserted into someone's face, and those wider implications would not be risk factors.

As much as HIS can sometimes be the bane of our lives with the overzealous regulation that it does, HIS regulation is robust and we welcome it. I would not have it any other way. I think that it is a safe way forward.

09:15

Remmy Jones: I agree. I have come from England today, so I am used to the Care Quality Commission rather than HIS. I have come here at the last minute, so I apologise if there are differences that I might not be completely aware of.

In the same way that Scotland has HIS, in the rest of the UK we have CQC regulations. Currently, in England, we do not have to necessarily be CQC registered for certain types of treatments in order to undertake them—I believe that those are the level 2 treatments. It is only for the more complex and higher-risk treatments that CQC registration would be required.

In my opinion, the emphasis should be placed on the practitioner and their skill set. The premises licence would be important as part of the licensing. The Joint Council for Cosmetic Practitioners, which I am a member of, offers fantastic support and guidance on the licence for premises. When you register with the JCCP, there is a practitioner licence and a premises licence that are combined. I would imagine that the expectations for those are

fairly similar to HIS's expectations around the health and safety aspects of a premises.

My point is that perhaps there are other options than just having an HIS registration. If you were to use the JCCP as an example of a stance or a governance point, it also covers premises within its registration.

Jacqueline Cooney: I would like to add, though, that because of where HIS sits in the regulatory framework, the clinics are registered as independent medical services. That means that nurses in Scotland have access to a stock of medicines because of the way that the clinics under HIS are regulated. I do not see that any other regulator would be able to do that; HIS can do it because of its position in the regulatory framework. That allows us ease of access to a clinic's stock of medicines. Nurse-prescribers in a clinic who are carrying out the duties of the clinic can gain access to those emergency stocks or to any stock of medicine that is required in that clinical setting. That is not the case in the other three nations, because of the regulations; it is our HIS regulation in Scotland that allows that to happen. I feel that that allows safer access to medicines for the people who are using the services in the clinical setting.

Amanda Demosthenous: It protects the patient well—[*Inaudible*.]

Remmy Jones: Sorry, I will come back on that, because I am not sure whether you are aware of the initiative by ACE Group World to implement postgraduate diplomas for healthcare professionals that will enable them to hold and use emergency stock of medicines to treat patients immediately. That PGD is for healthcare professionals who are non-prescribers, so that they will be able to provide emergency treatment should it be required.

Amanda Demosthenous: I do not know whether that is in place yet.

Remmy Jones: It is not in place yet. I sat on the board as a paramedic expert to support the PGD in April this year. I believe that ACE Group World is just waiting for its registration with the CQC, specifically so that that initiative can come through. It has gone through a robust legal investigation, and that was fine. It is just waiting for the registration to come through so that it can start to implement that for its members.

Jacqueline Cooney: It is fantastic that that is happening for the other three nations; however, the difficulty is that it is for emergency medicines only and not for all medicines. In Scotland, we can hold a stock in the clinic of all of the medicines that we need, such as antibiotics, or steroids for swelling. These things are more—

The Convener: I am sorry to interrupt but we have limited time. Could you please direct your answers to the questions from the committee?

Jacqueline Cooney: Okay; sorry.

Emma Harper (South Scotland) (SNP): Does the bill provide enough clarity on who can perform the procedures that are listed in schedule 1, which includes things such as threading, microablation and injectable Botox, for example? Is there enough clarity around who can perform the procedures that are listed there?

Jacqueline Cooney: No.

Remmy Jones: No.

Amanda Demosthenous: No, and the level of training for them comes into question. What we see out there are people going on a two-day course that is mainly comprised of business skills, not the clinical side. Jacqueline Cooney can give more stats on that. Those people then decide that they are competent and able to do those injectable treatments when, in reality, it takes years of practice to be good at those procedures and to get good results, as well as to know how to deal with many of the complications that can come off the back of them.

Obviously, a background as a medical professional, whether it be in nursing, dental, pharmacy or whatever, prepares us to deal with a lot of the side effects that we see in practice. If someone who is doing the injectable treatments has just done a two-day course and has had no prior training, it is not clear that they will have the level of clinical competence to deal with reactions, complications or undesirable results. That issue comes up a lot. Patients can be quite scarred and will come in very upset. Side effects go all the way up to major things such as permanent scarring, vascular occlusions and necrosis; all those things can present off the back of those treatments. The issue of who can do those treatments under supervision is broadly where the grey area lies.

Emma Harper: Is there a grey area between supervision and management? Does supervision mean that someone is watching the practitioner over their shoulder rather than saying, "I will be in the next room; give me a shout if you need me"?

Amanda Demosthenous: My worry is that we will end up in a situation in which one person is supervising 100 clinics. Who is checking that? In reality, a person cannot be in 100 practices at once. For me, supervision is a foggy term and it needs to be clarified.

Jacqueline Cooney: We need to drill down into oversight of the numbers. If every single one of you in this room was injecting and I was responsible for giving prescriptions to all your patients, how could I possibly have eyes on every

one of you while you were injecting? All it would take is for one of your patients to have a complication and I would be caught up with that as the overseeing medical person. Everyone else would have to down tools because I could not possibly be with every single person.

In Covid vaccination centres, there is a ratio for trained members of staff to NHS band 2s or band 3s when injecting the vaccines. The ratio is 1:3 if people are using pre-drawn-up syringes, but it is 1:2 if they are drawing up the vaccine from a vial. I do not know how well that works in practice, but it is certainly the ratio that it is written down. Those vaccines do not carry the same risks as some of the injectable treatments or of laser therapy burns and whatnot that can happen with those treatments. The level of oversight therefore needs to be robust and appropriate.

Your colleague asked whether we would feel competent to deal with all the treatments that are on the list, and I personally would not. For example, if someone was using a CryoPen to take a lesion off someone's face, even with medical supervision, we would have to ask whether they had a background in dermatology and whether they knew how to recognise a cancerous lesion or whether the supervisor would tell them to go ahead and zap it off? The person providing oversight must also have appropriate qualifications.

Remmy Jones: It is important that the processes do not just become a transactional meeting between the patient and the prescriber or the clinical oversight person. It is important for the patient that they have continuity of care from the point of consultation and assessment right through to treatment, and there would be a risk in having a clinical oversight person who was trying to look after a large number of people; there would potentially not be continuity of care for the patient through their treatment.

Emma Harper: A lot of people who seek to have dermal fillers, hyaluronic acid treatment or Botox do not consider themselves to be patients. That point has come up in our papers. Are we creating a medicalised approach? I am being careful in what I say because I am a registered nurse. I worked in operating theatres; my job was in anaesthesia, looking after people having liver transplants and other such very invasive surgery.

I am thinking about the people who are practising already and are experienced, have gone through lots of training and are quite effective. They would consider themselves competent. How do we match up the requirements for training, supervision and competency? When I gave Covid vaccinations, as a nurse, I was seen as competent to draw up my own meds—even the pre-filled syringes were fine. Once I was supervised and competent, it was a case of "Get on with it, Emma". That is how it worked.

Amanda Demosthenous: I totally see your point. I agree that people do not see themselves as a patient until there is a problem; they then present in practice and definitely see themselves as a patient. When they present off the back of treatment, we hear that they have not gone through consent processes or had aftercare. I have even heard of practitioners blocking their patient when they are dealing with permanent scars; the patient then comes in to be picked up by a medical professional because they do not know where to go. They are extremely distraught at that point; they have often had weeks off work, and there is a lot of psychological distress, because they went in for something that they did not see as a procedure when it is a procedure, if that makes sense.

There is a misconception in that these procedures are pitched to patients as beauty treatments. I would absolutely argue that they are medical procedures that, in some cases, carry quite a high level of risk. There are varying degrees of risk depending on what we are looking at, but there can be high levels of risk.

People definitely feel that they are a patient when they are at the point of coming in and saying that they are seeking legal advice because they have necrosis, scars or something else off the back of a treatment. They are vulnerable, and, when it comes to patient safety, all that is happening now is that we are giving them a level of protection that has not been there as much as it could have been in the past. In other countries' models, these procedures are very much seen as medical procedures. There has perhaps been a slight misconception about their being beauty treatments.

Jacqueline Cooney: Over the years, we have demedicalised what we believe to be medical treatments. However, it is fair to say that, in HIS-regulated clinics at the moment, even a non-prescribing nurse has to have a level of oversight and have a prescriber present. It is not just about suggesting that HIS should register people who are non-medical; HIS also registers people who are medical—it has done that since 2016. We have been regulated since that time, and non-prescribing nurses are already under the same level of oversight as the bill is suggesting for others.

We risk demedicalising what is known as a medical treatment. We must respect the fact that these are medicines, so what else can the treatments involving them be?

09:30

Stefan Czerniawski: On Emma Harper's point that many of the people undertaking these treatments do not conceive of themselves as patients, there are other aspects of the professional healthcare relationship that might be missing.

My colleagues have talked about the clinical skills that are involved. The other thing that healthcare professionals bring is an understanding of the ethics and the importance of appropriate consenting. If you do not understand the risks—if you do not know the consequences of what you are going into—your consent for the treatment that you receive is not properly informed. That is really important precisely because there are complications and a potential transition in the mind of the service user from being a client to becoming a patient. To go through a consent procedure, you cannot wait for a client to become a patient. That is too late. There is, therefore, real value in bringing in some of the skill and the wider behavioural and ethical dimensions of healthcare professionalism earlier than is sometimes the case at present.

Emma Harper: What about a knowledge of prescribing and its role in providing safe and effective delivery? Hyaluronic acid is considered to be a medical device. It is not even considered to be a medication in the same way as Botox is a medication. In addition, there is a move to reclassify it from being a medical device. Do we need to think about what are medications versus what are considered to be devices, such as dermal fillers?

Jacqueline Cooney: We absolutely do, because a lot of the risks of necrosis, vascular occlusion, stroke and death come from hyaluronic acid. When HIS clarified regulation 12, whereby there has to be an appropriately trained professional in the building at all times, which it clarified with us a few years back, it said that that person needed to be there because of the immediate risk from the hyaluronic acid being injected.

If you inject Botox, for example, it takes two weeks to take full effect, so, unless there was an allergic reaction, you would not necessarily have an immediate emergency. However, with the medical device hyaluronic acid you have about four hours to dissolve any occlusion, so there has to be a prescriber there to give access to the medicine to do that. You cannot phone your prescriber who has gone to Blackpool for the day. Your prescriber has to be present, because the situation would become a medical emergency.

It is not appropriate to send the person to the accident and emergency department, because, as you said, people are not all educated to the same level. Just because someone is a doctor in A and E does not mean that they have knowledge of how hyaluronic acid works. The person would be best placed in one of our clinics, because we deal with that substance every day. We deal with any complication. We know how to use the substances. The people who deal with it—not just the prescriber, who provides the oversight—have to have knowledge and experience of the medicines and of the hyaluronic acid, so that they have that oversight. That is my belief.

Patrick Harvie (Glasgow) (Green): Good morning. I am curious. I was already thinking about this because of the term "medical aesthetics", which has come up several times. There has been a discussion about the idea that some procedures have been demedicalised, or that the term "medical" is in contention. I have a basic question. What determines whether a procedure is medical? What defines medical aesthetics as opposed to non-medical procedures that people might have for aesthetic reasons? Is it the qualifications of the person who is conducting the procedures, the setting in which they are conducted, how they are regulated or whether they are done for medical reasons—in other words, to treat a medically diagnosed condition?

Jacqueline Cooney: That is a very good question. In a way, the answer depends on the lens through which you look.

Botox is a prescription-only medicine, so, obviously, it carries some risks. By law, you have to be seen face to face by a prescriber before you have any treatment done. In a way, that carries some influence, as well as the risks and so on that are involved. The indication for your treatment is a big factor. We spend a lot of time on that. When we make our medical notes—we follow a very medical model in the practice that I work in—we speak to the patient about the psychological impact of treatment, we look at their indication and we make a full assessment, which is documented prior to the treatment.

What makes it "medical" is probably trickier, because you could look at it—

Patrick Harvie: There is not an objective definition, then. We are using the term, "medical aesthetics", but is there a clearly accepted definition of what that refers to and what it does not?

Amanda Demosthenous: It depends.

Jacqueline Cooney: It depends on what you look at. Botox, for example, can be used for cosmetic purposes, but it is a medicine. If someone was going to inject a medicine into you, would you prefer it if they did a medical consultation and took the history of medications

that you are already taking in case there would be an interaction between them and the Botox?

I know what you are getting at; you are asking why a non-medical person cannot do one procedure, but they can do another. To respond to that, I ask why a non-medical person could not give an enema. That is what it comes down to.

We have to respect that these things are medicines and medical devices, so what we are prescribing is already clear in the name. There has to be a person present to prescribe it, and they have to be medical.

Patrick Harvie: Even in that answer, you said, "these things", but is there a clear definition of which things we are referring to as medical procedures?

Amanda Demosthenous: There is from a VAT perspective. That is why I said that it depends on what lens you look at it through. From a VAT perspective, it is very clear that if there is no cosmetic indication whatsoever or if there is a medical diagnosis the treatment is considered to be medical. It is either purely medical or purely cosmetic; there is no grey area where it comes to VAT.

I can understand the way that you phrased your question, and why you asked how we clarify the difference. As Jacqueline Cooney said, it comes down to clinical history taking and assessment of the patient, which is not done in a lot of practices. In a lot of places, the process is transactional; a person goes in and says, "I want two areas of Botox", and the practitioner says, "Lie down on the bed."

If someone walked into their GP practice and said, "I want some antibiotics," the GP would take a full clinical history before prescribing the antibiotics. It becomes transactional when the patient comes in and demands what they want, the practitioner says yes and then—

Patrick Harvie: I appreciate that there are different perspectives. From a policy perspective, I am not sure if I am more confused or less confused, but thank you for the answers.

The Convener: We have a lot to get through. Therefore, can we keep our answers concise, so that we can actually get the information that we are looking for?

Brian Whittle (South Scotland) (Con): Good morning. To start, I will ask a fairly straightforward question: do you think that minimum qualifications required to carry out procedures should be in the bill, or would you prefer those to be specified in secondary regulation?

Stefan Czerniawski: As a general point, it would be unwise to get too specific in the bill by including that level of technical detail. Situations change and new treatments and procedures arrive, and getting things too locked into primary legislation could unhelpfully distort practice. Therefore, in a very practical sense, it would be better to have some of the information in secondary legislation.

Brian Whittle: I see that everyone agrees with that—good.

As we have discussed, there is quite a mix of regulated professionals, well-qualified but unregulated practitioners and those practitioners with minimal training. How should the bill approach regulation in a way that recognises industry training? How do we pull that together in the bill?

Jacqueline Cooney: There needs to be a minimum specified level of training and an academic pathway should be offered. That is important.

There is a course in development. It will be available by September next year. At the moment, it will only be for healthcare professionals, and it will involve an element of theory and a practical element, where people go on placements. It will be much like nurse, doctor or dentist training in that participants do a certain amount of theory and a certain amount of practical training.

I am aware of the level 7 qualification that people talk about. However, there is no transferable credit pointage. By that I mean that there are no transferable credits from Scottish vocational qualifications or other university qualifications towards that level 7 qualification. That needs to be standardised and the bill needs to make provision for it. I do not know whether that should be through secondary legislation, but I agree that it needs to be addressed and that there needs to be a set standard.

At the moment, people will go on a one or two-day course and there will be an element of the Dunning-Kruger effect whereby they will be told that they are qualified and so they will believe that, and they will not think that they are doing any harm. However, to those of us who have qualifications at university level and master's level, those people do not seem qualified. Those people get confused; they think that they are qualified, because that is what they have been told.

There is no academic set standard whereby people are taught to a level. For example, a doctor will be trained in a specific way and to a set standard, and it will not matter which university they went to. It is the same with a dentist or a nurse. That standard is not there yet when it comes to aesthetic medicine, and it is something that needs to be considered in the bill.

Remmy Jones: That is what the JCCP is trying to align its educational pathways to. The consensus is that aesthetic medicine should be a form of advanced practice and that it should therefore meet and attain certain set standards that the JCCP has, as far as I am aware, set out. It has several approved educators, and there is a university in south Wales that now offers a full master's level course in aesthetic medicine. Other universities are also looking into introducing that, because there is a call for it. An academic pathway in a specialty would align to an appropriate level of education for somebody who is moving into aesthetics.

Brian Whittle: How is competence currently monitored, and how should it be monitored? How could it be monitored through the bill?

Amanda Demosthenous: BAMAN is working on competency frameworks at the moment, and it is working closely with the RCN on that. For example, someone who has done a one-day training course will not be competent; they will be trained, but they will need to have some supervision to get to an appropriate level of safety. BAMAN has worked closely with other bodies to come up with a specific competency framework for aesthetics.

There would need to be some supervised practice after the training day. As Jacqui Cooney said earlier, there are some two-day training courses for non-medics, after which it is decided that they are competent. I am not sure whether those non-medics have any one-to-one supervision after that; it is not clear, because there are no frameworks in place.

What qualifies as competency following on from that? Some competency frameworks that are specifically checked off and some supervised practice off the back of whatever training courses have been done must be the level that any medical professional, or anyone that is having training, should meet. There needs to be some supervised practice after the training course has been done.

My background is as a nurse and, after 10 years of working as a nurse, I went into aesthetics. I did the aesthetic medicine postgraduate diploma and, after being in business for 10 years, I then did an MBA so that I could understand the business side a bit more. However, those training courses for non-medics tend to cover more of the business side and people lose out on the clinical side, which is more important to understand before getting an understanding of marketing, business and so on. The clinical side is being skipped a bit, and the training courses are more focused on selling to the patient. That is not appropriate when someone first starts out in training, because they are losing some of the clinical competence that needs to come first.

Jacqueline Cooney: Glasgow Caledonian University is developing a postgraduate diploma course in aesthetic medicine at master's level. It will launch next September, and it will include practical and academic elements. Following on from what Amanda Demosthenous said, it is essential to have both elements, because you cannot just get the theory of something and have it be written on paper that you can do it academically; you must be able to do it—we are speaking about hands-on treatments.

For example, if I were going to do a catheterisation in the NHS, I would be shown how to do it by the nurse specialist and then I would be supervised for, say, 10 treatments. A standard would be written down for each individual treatment that I would be offering. That needs to be addressed in respect of aesthetic medicine.

The bill, or secondary legislation, needs to specify the nuts and bolts of it and who can and cannot provide these treatments, otherwise people who have done just a one-day course, or even an online course, and got a continuing professional development certificate will continue to treat patients. That would defeat the purpose of the bill.

09:45

Amanda Demosthenous: There needs to be a clampdown on the training academies as well, because they are a large part of the issue. There needs to be a real standard for training premises and academies, and for the practitioners who are teaching people how to do these treatments. Someone could train by doing a two-day course, and then they could set up their own training academy a week later and be training others. That is a real risk, because there is a business element involved. The training academies need strict and thorough regulation, because that will ensure that the people who are providing the training have a high standard, which will be passed down to whoever is receiving the training.

Jacqueline Cooney: HIS has a role as well.

Amanda Demosthenous: Definitely.

Brian Whittle: I am hearing that there is no on-going monitoring of competence, and that we cannot even define what a medical procedure is—wow.

Patrick Harvie: I will move on to questions regarding fairness and equality. We have heard, both at our previous meeting and in some of the written evidence, a range of views about equalities impacts as a result of the bill. There are those who make the argument that many of the available services and procedures are being provided by a

workforce that is predominantly made up of women who are working independently. Many working-class communities see this area of work as something that is rooted in their community.

On the other side, there is a concern that the equalities impacts will extend to reduced availability and increased cost for these procedures, and that many marginalised groups, or groups affected by equalities issues, will be more at risk if safety standards are not high. Those groups may be targeted more by the industry and may be more likely to access these services.

Can you give us an overview of your attitude to the equalities impacts? It may be that they cut in both directions.

Jacqueline Cooney: At present, there is inequality anyway, because, since 2016, nurses, doctors and healthcare professionals have been under regulation from HIS in Scotland—that is a legal requirement on them—but no one else is.

We are subject to high fees and high standards, and we do not complain about that because we think that it is necessary for public safety. However, if we are looking at equality for people who are now complaining that the situation is not equal or fair and that they are not on a fair business footing as they offer lower-value treatments to the consumer, why did we not look at that when healthcare professionals were affected by the regulation in 2016?

For almost 10 years, we have been under the regulation that the bill is proposing. The bill proposes oversight and HIS regulation and fees. We have paid those fees since 2016, so there has been a level of inequality all the way along, until now. I welcome the bill and I think that it needs to come into force; I do not want it not to be passed—

Patrick Harvie: So, from a providers' point of view, you would say that the bill creates more of a level playing field.

Jacqueline Cooney: It creates more of a level playing field. Some providers are now saying that they would not be able to provide treatments at the low cost at which they are currently providing them. I have sometimes been shocked at some of the costs, because you cannot even buy the medicine at a price that is lower than the cost at which some providers are offering a treatment of three areas with a toxin. I suppose that they are buying unlicensed machines that they are using on consumers. That all needs to be brought into check and put on a level playing field, through HIS and the bill.

I also think—I can talk a lot, as you are hearing—that, although we have had the discussion about whether or not these are medical treatments, without a doubt, most of these treatments are elective. You are not going to die if you do not get them. It is not like getting an asthma inhaler because, otherwise, you will have an asthma attack and die. You are not going to die if you do not get these treatments. If they are elective treatments, why are we looking at the cost? You would get the treatment only if you could afford it, if that makes sense.

Stefan Czerniawski: It is inherent in regulation that you are cutting some things out, because, if you were not restricting the field of what is provided, you would not need regulation. In a sense, what regulation does is draw a boundary and say that some things are outside the boundary. It is the premise of the bill that adding procedures to regulation in the way that we have been discussing will mean that some providers will struggle to meet its requirements, or, if they are able to meet them, it might be at greater cost to them and to the people they treat. There is no approach to this that does not, in some sense, affect the inequalities, in both directions, that were in your question. As always, it is a question of a trade-off between the costs and benefits for the different parties. These provisions will not bring about an absolute line.

Amanda Demosthenous: I just want to go back to your previous question about medical procedures, because there is a European Court of Justice ruling on what qualifies as a medical procedure—it only came into my head after we discussed that point. It is about the assessment, and the diagnosis part is a really big aspect of what comes into a medical procedure. So it is about the diagnosis and the justification for treatment and then the psychological impact on the patient. Hence a lot of bodies that represent nurses, doctors and dentists are looking at the psychological impact and patient wellbeing—what is improved as a result of the treatment. However, as Jacqui Cooney said in response to your point, these are elective procedures. They are more luxury procedures that people do not need in a drastic way—they are not life altering. However, it must go back to safety, so, with regard to equality of access, in whatever we do, patient safety must come first and foremost.

Patrick Harvie: Remmy Jones, do you have anything to add?

Remmy Jones: I concur with the rest of the witnesses.

Patrick Harvie: On the balance between patient safety, and accessibility or affordability, I get the sense that the whole panel is saying that patient safety must be the priority. Is there any merit in the counter argument that, if we reduce the accessibility of procedures for which there is

commercial demand or we increase the cost by regulation, that will drive some people to access the same procedures completely outside the scope of regulation in a much more unsafe setting where they are not at all professionally delivered? Is there any argument that the impact could be negative in that way?

Jacqueline Cooney: That is already happening, so the bill will not make it worse. It can only make it better. The bill will not force anyone to do anything illegal; that is already going on. We have seen videos on social media of people being injected or given treatments in the backs of taxis and in sheds. As a healthcare professional, it is horrific to watch these things being done. Although that will continue, the bill will further enhance safety because there will be a law that states that you cannot do that. At the moment, there is no law to say that that cannot happen, so I think that the bill will have the opposite effect to what you have asked about—it would stop a lot of that activity happening, and people would be more afraid of that.

You might be covering this later, but one aspect of the bill that we have not covered is the summary charge and conviction. The offence carries a fine and a summary conviction, but it is not a recordable summary conviction—

Patrick Harvie: I think that other members will come on to enforcement and compliance later.

Jacqueline Cooney: Sorry.

Patrick Harvie: I do not want to step on their toes.

Jacqueline Cooney: To answer your question—

Patrick Harvie: I am getting a fairly clear sense—

Jacqueline Cooney: I would say that the bill will not make it worse.

Patrick Harvie: Thank you.

Emma Harper: You have kind of already answered this question, Jacqueline. We have heard about fizz and filler parties, and I have seen videos on YouTube. People drink alcohol at them, although you shouldnae really consume alcohol during any procedure. Will the bill help to address that and reduce the ability to have fizz and filler parties?

Jacqueline Cooney: I totally agree. There is no law in place at the moment to stop any of that from happening. When people realise that they are breaking a law, if there is a law in place, the bill will absolutely reduce the extent of that.

Amanda Demosthenous: As Jacqui Cooney has said, it depends on what happens to the practitioner afterwards. There have been discussions about fines, but the law needs to be enforceable enough that people feel a consequence. Otherwise, if there is just a little slap on the wrist or a £200 fine for fizz and filler parties, they may continue.

Remmy Jones: It is the accountability factor.

Amanda Demosthenous: It has to be enough to be off-putting to whoever is looking to organise such events.

Jacqueline Cooney: If someone is earning more than £100,000, say, in a clinical setting—I use that term loosely, as some of the places are not really defined as clinical settings—what would a maximum fine of £1,000 do if it did not carry any other kind of penalty with it? I know that there is a summary charge, but it is not recordable, so what is to stop the person treating it like an expensive parking fine? Some people will flout the law and continue.

Some clinics have got into trouble with the Advertising Standards Authority.

The Convener: We are going to come on to that.

Jacqueline Cooney: Sorry.

The Convener: I would ask you to stick to the specific question.

Jacqueline Cooney: So, the answer is yes, and that is what I think about it.

Emma Harper: Okay—thanks.

The Convener: We have touched on the subject of gathering data and reporting mechanisms throughout the morning, and we certainly touched on it with the panels who were before us last week. I am keen to hear your views on a centralised adverse event reporting system, a national register and standardised training requirements. We have already touched on that a bit, too. There is also the matter of data on complications. Are those systems needed? Who should administer them?

Amanda Demosthenous: They are definitely needed. I spent a lot of time gathering data ahead of this meeting, as it is always good to have some numbers—to have something quantifiable. Save Face and JCCP gather some stats, but there is not really a centralised reporting mechanism for gathering facts and data. Looking at those sources, I could see that there have been about 3,000 complications across the United Kingdom. There was not anything specific for Scotland, but I could work out, based on the Scottish population, roughly how many complications were quantifiable here. I could do a rough analysis, noting that about 700 complications would equate to Scotland. We could then work out the cost to the NHS.

At the moment there is nowhere that people would go to, specifically. Practitioners have spent a lot of time trying to gather data from A and E but, because there is not an ICD code—under the international classification of diseases—A and E does not know how to categorise an aesthetic complication. Therefore, when we look at the audits or anything else, we cannot find what we need. The problem is probably bigger than what I am describing, because it is not written down anywhere. I would absolutely support a national, Scotland-based reporting system, so that we could see the numbers.

The Convener: Who should gather that data?

Amanda Demosthenous: I think—

Jacqueline Cooney: I think there is a mechanism via HIS—

Amanda Demosthenous: Yes, I think there is.

The Convener: Sorry, but it is really difficult for—

Amanda Demosthenous: It is Healthcare Improvement Scotland.

The Convener: It is difficult for the official reporters to record the meeting accurately—

Jacqueline Cooney: It is both.

The Convener: —if you speak over each other.

Amanda Demosthenous: Healthcare Improvement Scotland would be a good place to go to. If all clinics are to be registered with HIS, reports could go back to it.

10:00

There could be a range of complications from an injectable medicine, or from an injectable device—fillers fall under that category, as do Hyalase and CO_2 lasers. That data could be all in one place, but it is not currently being reported. Obviously, you would report back to the manufacturer if there were any issues with whatever you were using, but that data is not going anywhere centrally. There are about 10 different brands of Botox, filler and so on. The data is potentially going back to the yellow-card system and to the manufacturer, but it is not collated anywhere, if that makes sense.

The Convener: Would all practitioners use the yellow-card system and report back to manufacturers if there were complications with a treatment?

Amanda Demosthenous: They should.

Remmy Jones: I think that there is a reliance on practitioners to do that.

The Convener: We have spoken about some practitioners who have perhaps not had the same level of training in these treatments that you have had. Are you assured that they would report that information back?

Amanda Demosthenous: I think that a non-medical professional would not even know what the yellow-card system is, because you learn about it as part of your training. They would not necessarily think to use that system; I think that they would be unaware that it is in place.

The yellow-card system is good for reporting back, but—as you said—a more centralised way would be better. I think that Jacqui has another point to make on that.

Jacqueline Cooney: I am thinking about the situation if the bill is passed and everyone is in an HIS-regulated clinic. At present, if we have a complication, we have a duty to go on to the notification portal and report that to HIS. That would be a way of recording such issues.

The Convener: I appreciate that. I suppose that I am looking at how things currently are. We do not necessarily have a complete picture—

Jacqueline Cooney: No, we do not. We have anecdotal evidence at present.

Although we have the World Health Organization codes, such as the ICD-11 codes, and incidents being recorded in accident and emergency departments, we are unable to extract that data.

In addition, other developed countries do not have non-medical injectors—it is all done by medical people. As medical people, we have a duty of candour, so, as a profession, we have to acknowledge if we have done something wrong, admit to that and apologise to the patient. There is a lot of that in there. I absolutely agree that there needs to be centralisation of data.

The Convener: With regard to public awareness of the proposed changes should the bill become law, should mandatory information be given to consumers to ensure that the bill works and so that the public understand what they are consenting to when they go to a clinic for Botox, filler, a chemical peel or whatever?

Jacqueline Cooney: Absolutely.

Amanda Demosthenous: I really think that Scotland is leading the way here—I think that the public would very much support the bill. We have quite a large practice, and I know, just from speaking to patients, that a lot of them value safety and come to our practice in particular for that reason. All that the Scottish Government is doing in introducing the bill is supporting public safety. We need more information for consumers

who might not have been in for treatment before. There is always a benefit in educating the public as much as we can—that is always in their best interests.

The Convener: They may not currently be aware of a risk when they are engaging in a treatment.

Amanda Demosthenous: Exactly.

Jacqueline Cooney: If they do not—

The Convener: Sorry—can we have just one person speaking at a time? As I said, it is difficult for the official report to record the meeting accurately if several people are speaking. Remmy Jones, did you want to come in?

Remmy Jones: Those people who are not aware of the risks do not see themselves as patients either. It is about public education and raising awareness of the risks that come with the process and the treatment. Much more needs to be done on public education and awareness around associated risks, who they are going to see, what the procedures might involve, what the consent process will look like and cooling-off periods—which I suspect do not occur—in which people are able to obtain all the information that they need to weigh up the risks and make a reasoned judgment as to whether they want to proceed. I expect that, in many practices, that does not occur unless they have a healthcare professional there to enforce it. Likewise, in relation to the subsequent reporting of any complication, we are reliant on the practitioner to provide that information to a centralised Government, or through a yellow-card system; that is, we are reliant on the honesty and duty of candour of the practitioner to do that in order for us to ascertain that data.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. I will spend some time speaking about enforcement and compliance, which we have already touched on a little bit.

To kick off, thinking about things such as providing procedures outwith permitted premises or to under-18s, or obstructing HIS investigations, to what extent are the offences as set out in the bill clear and appropriate? Are the proposed penalties—which we have discussed—of fines of up to £5,000 sufficient to deter unsafe practice? Is there anything else that we should be considering? Should there be sanctions for repeat offenders?

Jacqueline Cooney: There should definitely be sanctions for repeat offenders.

I welcome the bill; I am so happy that it is here. I am happy to be here even discussing it and I feel privileged to do so on behalf of the group that I represent. However, the bill needs to go slightly further so that people cannot continue to flout it through repeat offences. I do not want repeat offences to be treated as if they are simply expensive parking fines, with people being fined again and again.

We have seen the Advertising Standards Authority impose fines on certain clinics that nonetheless continue to advertise cheap deals or a prescription-only medicine. We have seen several times that a certain clinic group has been fined and fined again. However, paying the fine costs it less than the money it makes from the advertising campaign. Therefore, there have to be sanctions. They need to be like the Covid fines—as I likened them to in my head—where there was one fine, and then a little bit more of a fine, and then it became a more serious offence. There needs to be something recordable, because harms, such as burns, can be caused to people because of those treatments.

If a person has not fully and properly consented and does not know the risks—as Remmy Jones said—is the practitioner not doing grievous bodily harm to the person, even if the practitioner does not understand the full implications? The bill needs to be made more robust from that point of view.

Elena Whitham: Does the rest of the panel agree with the need for some type of ladder of escalation, with the level of severity depending on the level of the breach?

Stefan Czerniawski: I point out that we can talk about sanctions only in relation to somebody that we have detected. Therefore, investigation and detection can be more troubling issues.

In the world of dental regulation, for example, tooth whitening is already a protected activity. However, it is widespread knowledge that it is done illegally by some of the same people and in some of the same settings that we are discussing. That is not within the scope of the bill, but I mention it solely to make the point that tracking cases down and taking them through is not straightforward. It is worth considering how cases surface and what routes bring them into the scope of whatever form of sanction is, ultimately, decided on.

Elena Whitham: That is helpful, because one of my questions is about the resourcing of the inspection regime that would need to be carried out. Do you foresee that as being an issue? How would we ensure that HIS was adequately resourced and empowered to deliver on the intentions of the bill?

Stefan Czerniawski: We have to distinguish between premises that, in this scenario, HIS would be inspecting and others. By definition, those being inspected by HIS are likely to be doing legal things in legal ways. Under the bill, the people

outside the system would be subject to the HIS power of entry, but they would not otherwise be directly inspected.

Fundamentally, there is a choice. We either wait for cases to arise and people to report concerns, or we have some form of investigation and go out looking for cases. Both models can work. A lot of local authority work happens on the go-and-look basis.

In this kind of area, however, it depends much more on reporting. If you want to be confident that a very high probability of what will become illegal practice is being detected, you will probably need somebody to have the resources and the remit to look for it—some of that might work at local authority level, or it might be the remit of HIS. If you are willing to be responsive and address cases as they arise, that is a cheaper system to operate.

Elena Whitham: Do you foresee unintended consequences from the bill? Last week, in one of his questions, Patrick Harvie touched on equality of access and fairness, and the fact that some practices might be driven underground and people will be able to access services outwith licensed premises, which will obviously prove to be the trickiest part of the system to detect. How can we ensure that that is thought about in the bill?

Stefan Czerniawski: In the end, it is a question of balancing risk. Some people do not want to comply but, on the whole, most people want to be compliant. People do not want to break the law if they have a system to comply with, and the bill will introduce that system. The benefit from bringing most of this activity into regulation is very large.

As you have said, the cost is that it might drive some people further away from good practice. However, as has already been mentioned, in the absence of any statutory control at present, anybody could be doing anything anyway. In that sense, people will not be driven to do things differently from what they are doing now. Therefore, the risk is no greater; it is just that what people are doing will become illegal, having not been illegal in the past.

Elena Whitham: Are the provisions and offences in the bill suitably clear to enable compliance? We have started to uncover already that how people would comply with the measures set out under the bill is perhaps not really clear.

Amanda, you look as though you want to say something.

Amanda Demosthenous: If you are practising in this area, you must be familiar with whatever standards are set out as part of regulatory compliance. The accountability really is on the professional who delivers the service—they must have a good understanding. Anyone can turn around and say that they did not really understand or appreciate what the changes were but, if the information is clear and easy to access, the accountability needs to be on the individuals who offer those services, who must be familiar with where the line is drawn between what they can and cannot do and fully understand what is within or outwith the law.

As Stefan said, for a lot of people, nothing will change. Scotland really is leading the way with regulation. For me, regulation only means better standards. All that can come off the back of more regulation is a better standard across the board and consequences for those people who do not follow those good standards. I see only positive things coming from regulatory changes.

Elena Whitham: Jacqueline, I would like to explore your concerns around the fact that a summary conviction is not recordable. Do you want to speak to whether the top-level conviction that could be applied here is strong enough?

Jacqueline Cooney: The summary charge is not a recordable charge. I understand that there would be legal implications and costs with recordable charges but we cannot have a law that we do not actually enforce or that only delivers fines.

Back in 2016, we were told that if we did not register with HIS, we would get a £3,000 fine, get reported to the procurator fiscal and potentially have a criminal charge. As a nurse or a medical professional, you cannot have that—you would get struck off your register. The fear factor was fed in. However, to date, nothing has happened. No convictions have taken place, yet some healthcare professionals are still flouting that particular law.

10:15

Like Amanda Demosthenous, I think that the bill can only improve patient safety and standards. I can only say that we cannot allow the bill to fail. There has to be a tangible, recordable charge if someone is likely to repeat the offence. Will the procurator fiscal take it seriously? I think that they will take it seriously only if there is a recordable summary conviction. For example, if a drunk person was caught doing the toilet in the street, they would have a recordable offence from a summary charge put on their record, but if someone injects someone, which causes a stroke or, potentially, death, why is that not recorded? Those were my thoughts when I read the bill through and dug into that issue. The harm that someone can do is great enough to carry a proportionate tiered approach, and it would be proportionate for the charge to be recordable for repeat offenders.

Elena Whitham: Does anybody else on the panel want to say anything before I hand back to the convener?

Remmy Jones: It is important not to undermine the professionalism that we are striving for here, and by not having any enforceable convictions for those repeat offenders, we undermine that process. We need to have a fair but structured escalation for those repeat offenders, so that if we accidentally miss somebody who has perhaps not understood or has misinterpreted the legislation, they have an opportunity to learn and improve. Anything subsequent to that, we need to think about the patient being the primary focus and that potential for patient harm.

Elena Whitham: I will come back to you, Stefan, because I have just thought about this. You spoke about the local authority level and the licensing that is going to go around this. Do you feel that there is a role for the local authority to work in partnership with Healthcare Improvement Scotland to ensure that we have licensed individuals and licensed premises complying with the system as set out in the bill?

Stefan Czerniawski: I am probably not close enough to the detail of how it operates to have a strong view on that. It is precisely because local authorities will be involved in the level 2 licensing that that is where the blurs and the overlaps are most likely to occur, so it seems likely that local authorities will be better placed than HIS to be the first line of detection.

Elena Whitham: That is very helpful.

Amanda Demosthenous: Lasers come under environmental health at the moment—a different category—and some practices have quite advanced lasers, such as CO_2 lasers, which can cause significant harm. Sometimes with lasers there is the potential for quite permanent damage, which might prove quite tricky for the councils to manage, but at the moment, if something goes wrong with a laser, it is reported to environmental health. That should be okay, but whether that approach changes or stays in place, there needs to be a clear reporting process.

Joe FitzPatrick (Dundee City West) (SNP): We received some very powerful evidence from Advice Direct Scotland. It was powerful because of the case studies, including those about teenagers as young as 15 being on the end of botched procedures, which got a bit of coverage in the media yesterday, as you will no doubt have seen. That brings us back to a discussion that Sandesh Gulhane led last week on whether 18 is the correct age limit. I am keen to hear your thoughts on that and on whether you have the tools to enforce that—that is, if 18 is the correct age limit. Eighteen is the age that young people can start buying alcohol, but a number of supermarkets, because it is difficult in many cases to identify whether someone is 15 or 18, use the challenge 25 strategy. Do you think that 18 is the right age limit to set, and how would you make sure that it is enforced?

Jacqueline Cooney: At the moment, if you take someone to a tattoo place or a piercing establishment, they check the person's passport. There is a place near to where I live. I watched them turn a young boy away. He had taken his brother in who had told them, "My dad said it's okay," and they were like, "No, we need evidence of your age and you need a parent with you."

If you are going through the medical process of taking the person's name, their address, their basic information and all their medical history, there is less chance of not knowing the person's age. You can also ask for a passport. When you take the appointment you can say, "Can you bring a passport or some form of identification?" so that you know.

That said, most of my patients are aged 25 years and older. I do not know whether I am speaking for just my particular clinic, but I rarely see anyone from the younger age group. Would I do some of these procedures to someone under that age? Probably not. As a healthcare professional, I would be more likely to say no to someone who is younger anyway.

There are mechanisms by which you can check the person's age. There will always be fake identity documents and all that. However, I agree that, if you want to be seen as being proactive in trying to establish what the person's age group is, the requirement needs to be set at 18 years and older. As I said, we have been under the regulations since 2016.

Amanda Demosthenous: I agree with Jacqui Cooney. That age group is not typically represented in the patients we see, given that a lot of the treatments that we offer are more to do with anti-ageing. I would struggle to justify giving an 18-year-old a treatment for something like that when I do not feel that it is a clinically justifiable treatment for them. There would be an element of saying no. My worry is that some people might not take that viewpoint and that they would just think, "Right, there's some money on the table here. This young person's come in and they want this doing. I'm just going to give it to them."

I would question the justification for treating 18-year-olds on the whole, although I understand that a level has to be set somewhere. I can absolutely see that, from a consent perspective, at the age of 18, people are likely to have an understanding of treatment procedures. However, in our sector, it is questionable whether giving the treatment would

be clinically justified. There are other things, such as skin care, microneedling and treatments that give skin health benefits, which might be appropriate for that patient. However, we do not tend to see many patients of that age coming into the practice that I work in anyway.

Joe FitzPatrick: Should the age be 21 rather than 18?

Amanda Demosthenous: Yes, that would be my personal preference, because I cannot see how treatment could be clinically justified for someone younger than that. We certainly do not have 18-year-olds who present.

Joe FitzPatrick: Stefan Czerniawski or Remmy Jones, would you like to come in?

Stefan Czerniawski: We have to be careful in distinguishing between what might be clinically appropriate for somebody and the level at which they are capable of offering informed consent and understanding the risks and benefits. I think that 18 feels like the right place for informed consent. It might well be that there are treatments that are wholly inappropriate for 18-year-olds—that is a different issue. It is also important to note that, in a very small number of cases, there might be a medical justification for treating somebody who is under 18, so it is important that age is not an absolute bar. However, there would need to be specific medically prescribed reasons for treating somebody younger than 18.

Remmy Jones: I tend to see two avenues in assessing patients when they come in. One avenue involves beautification treatment—which I think is what we are talking about and where we might see the younger age group, who are influenced by social media. Like my colleagues here, I see very few of those people. I think that that is just because of the message that I portray in relation to my ethics. The second avenue involves rejuvenative or age-defying treatments.

The approach very much depends on what the younger patient is coming in for. If they are looking for a microneedling treatment or a skin treatment for something like acne, there is absolutely scope to manage that patient. It comes down to your clinical assessment and your ability to assess the driver behind them seeking those medical treatments. We would want to screen for things like body dysmorphia and whether their seeking treatment is part of a potential mental health condition. That is where the clinical assessment becomes really pertinent, alongside the ability to deep dive and to form trust with the patient who is coming in, so that they are able to be honest and open about their drivers for seeking that treatment in the first place. That is important.

Joe FitzPatrick: Some of the concerns are with things like fillers in cases where people are using social media to say, for instance, “This is what my lips should look like.” In those cases, that is the driving force, rather than a health issue—it is absolutely based on what social media is telling them their face should look like.

Remmy Jones: To me, that would indicate that they are seeking a beautification treatment. They have seen something on a social media post—a celebrity with a certain look and style—and they want to emulate that. Is that because they have low self-esteem, low self-worth or low self-confidence? Do they fully understand the potential consequences of embarking on medical treatment, including that something could go wrong? There is also the risk, every time they have a treatment, that their acknowledgement of what they see in the mirror being representative of how they look will fade—that can escalate quite quickly with things like body dysmorphia, and patients might seek more and more treatment because they are trying to emulate something. That, to me, is potentially a mental health condition. That is where we need to be scrutinising the drivers behind the patients seeking treatment.

Amanda Demosthenous: Going back to whether the age should be 21—

The Convener: Please be very brief.

Amanda Demosthenous: Making the age 21 might become quite tricky for those who are coming in for other things that fall under the treatment umbrella, such as acne treatment. I completely agree with what my colleagues are saying when it comes to treatments such as dermal fillers. The issue is that patients who are coming in for beautification could fall into the trap of having treatment where it is not necessarily needed.

Joe FitzPatrick: Okay. Thank you very much.

The Convener: I thank the witnesses for their evidence this morning. I am going to briefly suspend the meeting so that the witnesses can change over.

10:26

Meeting suspended.

10:36

On resuming—

The Convener: We continue item 2 by taking evidence from a panel of witnesses on the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill. Our second panel comprises representatives of regulators, enforcers and inspectors. I welcome Laura Boyce, chief inspector of regulation, and Eddie Docherty, director of quality assurance and regulation, from

Healthcare Improvement Scotland; Brett Collins, director of Save Face, who joins us online; and Paula McLaren, who is the senior advanced practice adviser at the Nursing and Midwifery Council.

We will go straight to questions and I will kick off. To what extent do you think the bill provides suitably clear definitions of procedures and practitioner roles to enable consistent enforcement and, if you think it does not, what specific areas need clarification?

Laura Boyce (Healthcare Improvement Scotland): Good morning and thank you for having us today. From our perspective, most of the bill is clear in principle. It would be useful to have clarity about some of the definitions that were in the original consultation, particularly on the training, supervision and delegation criteria, because that would help to enable us to regulate with consistency and specify terms around training, delegation, supervision and the expected standards.

I understand that the United Kingdom Internal Market Act 2020 has been the rationale for not putting those definitions in the bill and potentially putting them into secondary legislation, but we would support their being clarified. Definitions could create challenges for us with the operational implementation.

Also, from the definition of "permitted premises", it appears that the intention is for services to be run from fixed premises to control the healthcare environment and the standards pertaining to that. Healthcare Improvement Scotland regulates independent medical agencies as well as independent clinics and there are some examples of where an independent medical agency could be providing non-surgical procedures. If it is expected that services are run only from the permitted premises of an independent clinic, we would seek to clarify the role of an independent medical agency. I can give an example of that, if it is helpful.

The Convener: I am a wee bit confused, Laura, because you started off by saying that you think that the bill is clear and that there is lots of clarification in it, but you have just cited a lot of areas where you would like to see more clarification.

Laura Boyce: I think that we fundamentally agree with what is provided for; there are just some small points to note for consistency. Our understanding is that the training delegation is one of the powers for ministers to outline in phase 2. I am saying that we would like to see that drawn out in the secondary legislation for the bill. We would support that approach because we think that we need it. The point about the United Kingdom Internal Market Act 2020 is just conversational. Because this is a newly enforced area from June of this year, it is still quite new for people. For clarity and consistency, we think that it would be worth asking whether it is specifically fixed premises of an independent clinic that are being referred to. That is the rationale for what I said about those two aspects.

The Convener: I am really keen to explore that, because what you have said are small points of clarification are, to me, big issues of law. Who will delegate? Who will supervise? What training is required? I see those as fundamental aspects of the regulation of the procedures that we are talking about. Eddie Docherty, do you want to address those?

Eddie Docherty (Healthcare Improvement Scotland): In the broadest sense, the clarity in the bill is exceptionally helpful and it really moves things forward. The areas that Laura Boyce has mentioned are ones that have been of concern for a while, particularly around the competence and capability of an individual. If we had a magic wand, we would like that to be more clearly defined. On the piece about it being registered professionals, in the main, and there being delegated authority, there are clear guidelines. However, for specific technical skills, there is a view that it is always more helpful if the guidelines are clear, concise and can be followed universally. I hope that that is helpful.

The Convener: Kind of. I am still hearing that there are lots of areas of clarification that need to be teased out or established for the bill to fundamentally do what it sets out to do.

Do you see the procedures that the bill covers as being clearly defined?

Laura Boyce: Yes. We are content with what has been proposed for group 1 procedures, which is local authority licensing. On groups 2 and 3 as they are laid out, we are content for the permitted premises to be regulated by HIS.

The Convener: Does anyone else want to come in at this point?

Paula McLaren (Nursing and Midwifery Council): The Nursing and Midwifery Council is the independent statutory regulator for nurses and midwives across the UK. I think that your question was specifically about definitions and clarity. As an independent professional regulator, we do not have a position on the risk groups or criteria, but we broadly support the approach to developing consistency for both professionals and members of the public.

As a clinician and a registrant, I think that anything that adds clarity and reduces inconsistency will help to mitigate some of the

risks that have been identified in relation to the bill. We would like clarity on how the criteria will be developed as well as on how often they will be reviewed and by whom.

The Convener: Is the bill clear enough on what will constitute supervision or management by a healthcare professional? That might be a question for you, Paula, given that you are here as an NMC representative.

Paula McLaren: In relation to supervision and delegation, we are clear through the standards that are set out in our code about the requirements on all professionals, including those who work in non-surgical cosmetic prescribing. There are requirements on supervision and the appropriate knowledge, skills, competence and capability to deliver such procedures. In June, we updated our position on remote prescribing—

The Convener: Sorry, but can I bring you back to the question? I am not asking about the NMC's code or your policies and procedures. I am asking about the bill. Is the bill clear enough on what constitutes supervision or management by a healthcare professional?

Paula McLaren: The bill could be clearer on expectations about supervision. We hope that it will align with our position on that.

The Convener: What else needs to be clarified? What needs to be added to the bill in order to satisfy the NMC's code?

10:45

Paula McLaren: It is about being clear who can supervise in these situations, training and competence and making sure that professionals are able to supervise. Not everyone who is not a medical prescriber will be suitably qualified to work in, or to supervise professionals who work in, this area of practice. There needs to be clarity around prescribing and around who is able to supervise the individuals who are carrying out these procedures.

The Convener: Would you expect there to be additional training for those registrants?

Paula McLaren: Under our code, we would expect individuals and practitioners to undertake additional training in order to be able to carry out those procedures. We need to be clear that it is not only about prescribing; it is about the totality of non-surgical cosmetic procedures. As I said, our code sets out our expectations around additional training. Individuals have to demonstrate that they remain competent and capable in their scope of practice and roles. That includes ensuring that they are having on-going professional development and appropriate education and training.

The Convener: I should put on record that I am registered with the NMC.

Brett Collins (Save Face): We included the issue of clarification in our response to the consultation. In relation to what needs to be clarified, although "supervision", "delegation", "training" and so on might be small words, they involve a massive piece of work. Quite a bit of work needs to be done to provide more clarification, especially in relation to supervision and delegation.

This is an ever-evolving sector, with new treatments and new ways of delivering them. In my understanding, there are currently no mandated qualifications in the HIS set-up for things such as cosmetic surgery—which is, in principle, a much higher-risk set of procedures. There must be more clarification about exactly what supervision looks like. That does not exist in the current pathway.

The Convener: Thank you.

How can the legislation ensure that procedures cannot be misclassified as lower-risk categories as a means of avoiding strict compliance requirements, and what mechanisms would prevent such avoidance?

Eddie Docherty: We believe that in the bill there are clear guidelines and clarity about what the procedures are and how it will work. We are very supportive of that level of clarity.

There is always an ability to have workarounds in systems such as this. However, our response is overwhelmingly that the approach in the bill is a much safer one and that the definitions are exceptionally helpful to move the system forward. Healthcare Improvement Scotland would take a clear view on how we would interpret the bill and how we would enforce it, should there be any issues about that.

The Convener: Laura Boyce, do you want to add anything?

Laura Boyce: No—I am content.

The Convener: My final question is about the verification of minimum training standards. That would fall under HIS's remit, which includes training and qualification standards for practitioners. How feasible would it be under a different approach for there to be enforcement and monitoring of those standards to make sure that they are complied with?

Eddie Docherty: Part of that goes back to the professional registration of the individuals. From a Healthcare Improvement Scotland perspective, we would look for clear indications of competence and capabilities according to the individuals'

professional guidelines and that those map across to the delivery of care.

It would be incredibly helpful to have a standard approach in which we establish a baseline for what competence and capability look like, academically and clinically. The professional standards give us enough to work from just now, but it will be a grey area until we get full clarity or we have been through the full process of the bill.

The Convener: Would that be for healthcare professionals?

Eddie Docherty: Yes.

The Convener: What about practitioners who are working in settings where they are supervised by healthcare professionals, but who are not registered nurses or doctors?

Eddie Docherty: It comes back to how registered professionals exercise their delegation of functions. We would expect that to be clear, concise and available for us whenever we do any form of inspection or if we have any concerns. Laura Boyce might want to add to that.

Laura Boyce: Yes, I am happy to build on that. From an operational perspective, when a service registers the services or procedures that it provides, we would expect it to provide us with its standard operating procedures, tell us how informed consent would be obtained and what standards are expected of the clinician, explain how that will be articulated to the service user and tell us what the record keeping standards are. That would be applicable to anyone working in the service.

At the moment, we are not able to quantify how many providers that are non-healthcare professionals will be able to align with a healthcare professional to meet the definition of a permitted premises under Healthcare Improvement Scotland regulations.

There will be no change for those who are already registered with us, and at the moment, we are working on the premise that the vast majority meet the standards that we expect on ethical information sharing and informed decision making for the service users who engage with them. They are standard processes for the registration of a service.

When we inspect a service, we look at aspects of record keeping, the interactions with the service user on what the most appropriate treatments were and whether the treatments were undertaken or declined following consultation. That is the standard process for us, and we do not foresee any change to that.

The question that is unanswered is how many non-healthcare professionals will be able to align themselves to a healthcare professional for the prescriber aspect of the legislation. It is broader than only the prescribing part of the procedure, however; any adverse events or complications that arise also have to be considered.

As our regulations stand at the moment, we would already require that, for non-surgical procedures, the individual must be over 18 and that the practitioner must have a prescriber on the premises. Therefore, the bill is mostly in keeping with how we currently function operationally.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

We will come to the regulation of the workforce later, so I will keep this question very tight. The GMC regulates the content of a medical degree, so, related to the question that the convener asked, who should set the educational standards, curriculum approval, quality assurance and training oversight for people who train to be aesthetic practitioners and will be regulated as such?

Paula McLaren: As we are an independent regulator, we do not think that it is appropriate for us to set education and training standards for those working in the aesthetics field. We think that that is a role for the Government. We ensure that professionals who are on our register and working in the field uphold the legislation of the country that they are working in.

Sandesh Gulhane: If not you, then who?

Paula McLaren: It is for Government to set the education and training standards. We set education and training standards for certain post-registration qualifications, including independent prescribing, but our code refers to continuing professional development. Ensuring that individuals who undertake non-surgical cosmetic procedures have the relevant education and training, whatever that might look like, would fall in the realms of continuing professional development. If the Government were to set some parameters around education and training and bring in the regulation that is suggested in the bill, that would bring clarity and ensure that professionals were reaching and maintaining a certain standard. In Scotland, we could then ask for those practitioners to demonstrate capability and on-going professional development through our revalidation processes, which occur every three years.

Eddie Docherty: There are currently Scottish Government-accredited programmes for aesthetics. I do not think that there is a definitive answer but, if we look at other competence structures, a cross-professional group that links in with its regulators—that is regulators in the broadest sense—tends to work most effectively.

The skill that is delivered to a patient should be consistent whether the person delivering it is a doctor, nurse or midwife. A cross-professional group has been seen to work pretty effectively, with support from colleagues in the Scottish Government. We would be happy to take a view to support that but could not confirm it.

Elena Whitham: Good morning. I want to speak a bit about offences, the inspection regime and the penalties as they are set out in the bill. The penalties for offences are set in the bill as fines of up to £5,000. Is that sufficient to deter unsafe practice? How could we ensure that we build an effective system that handles persistent non-compliance? Should there be an escalation beyond fines? If so, what would you want to see?

Laura Boyce: At the moment, for us, it seems a proportionate approach to regulation. We already approach any intelligence around unregistered services that meet the definition in a supportive model to seek registration; then we would look to do our systematic processes of enforcement. If a registered service were in breach, we would look at improvement notices and emergency conditions to try to protect the wellbeing of the service users and the broader public. The proposals in the bill are proportionate with where we are.

Your question about repeat offences is important. We have no indication at the moment as to how big a problem that could be. When we have concerns of a public safety or public protection nature, we already work closely and share intelligence with Police Scotland for it to take forward with the Crown Office and Procurator Fiscal Service. If a greater public safety concern existed, we would absolutely seek to continue those relationships with Police Scotland. We are aware that, through the bill's extension of our enforcement powers, we would look to build cases to take directly to COPFS and we think that that is a proportionate element.

The other part that might be beneficial is that we would continue to work to strengthen the memorandums of understanding that we already have with other regulators. Again, it is not only about criminal proceedings. Where there are professional registrants, we have already established reporting structures around fitness-to-practice processes; we would look to strengthen and use those aspects so that the deterrent was almost dual-pronged. I am not sure whether that is helpful.

Elena Whitham: Yes, that is very helpful. Brett Collins, from a Save Face perspective, what are your thoughts about the offences that are set out and the penalty levels that are proposed?

Brett Collins: I do not disagree with what has just been covered. The challenge that we perceive is that there is a lack of centralised data that identifies the barriers to safe practice and the types of complications and issues that exist in this sector. Although we are talking about repeat offenders and so on, it is difficult to understand what the issues are. We raised this concern eight or nine years ago: the current landscape in Scotland is that we are regulating what we describe as low-hanging fruit—healthcare professionals who are operating from fixed premises. What we are not really getting into is the detail of where the problems arise or understanding the real issues that exist in relation to the poor levels of service that the public are exposed to at the moment. It is difficult to quantify how you would address that and whether it is appropriate to do so.

Elena Whitham: That probably speaks to some of the questioning that I have undertaken in the past two weeks. I will perhaps turn to HIS colleagues to ask about that inspection regime that will need to be there in the non-low-hanging fruit premises—so, not the licensed premises but beyond that. Have you started to think about how that would look in practice and how you would perhaps do that with HIS and environmental health officers? What role would Police Scotland and other agencies have? How will that look?

11:00

Laura Boyce: I am sorry; could you clarify whether you are asking about services that are currently unregulated but that would be registered with us under the bill's proposals?

Elena Whitham: I am asking about premises that perhaps should be registered with you but are operating under the radar.

Laura Boyce: Okay, we are talking about unregistered services that should be regulated.

At the moment, we work on an intelligence-based model and use a supportive mechanism. Most people, when we approach them, do not realise that they are supposed to be registered and they engage with us. We have a fairly high success rate with individuals. The registration process has a footprint and we engage people in a support mechanism to help with that.

A large part of the work around the bill—it will require Healthcare Improvement Scotland, the professional regulators and the Scottish Government—will be a public messaging campaign on the proposals and on the timelines for us to be able to get services and providers in a position so that they are adequately able to prepare themselves for registration. We would not be able to regulate everyone overnight, so we would definitely require communication, public messaging and a timeframe in which to engage

with the sector. From what has been submitted by the Scottish Government along with the bill, it is difficult to quantify the exact number of services that we would be expecting to register and meet that definition.

Elena Whitham: Paula McLaren, from the perspective of your professional body and your membership, should enforcement be paired with education to support practitioners and encourage compliance rather than relying solely on punitive measures? How will your organisation support your members?

Paula McLaren: As a professional regulator, we have no views on offences, inspection and enforcement. We believe that those are matters for Government, but we would ensure that when issues are identified, as Laura Boyce highlighted, we have mechanisms in place for sharing information. We have a memorandum of understanding with HIS, for example, and we are part of the sharing health and care intelligence network. When we identify issues with fitness to practice, for example, we would share that intelligence.

I would come back to the point that, whatever final position is outlined in legislation, we would ensure that there was clarity among our professional membership, that they were aware of the bill, and make it clear to professionals working in non-surgical cosmetic prescribing.

Elena Whitham: Finally, is there a role for Police Scotland, and what could or should that be?

Eddie Docherty: There is definitely a role for Police Scotland at the end of the chain. The key message on public safety is that we have a low threshold for criminality. There is competence and capability, but if there is deliberate obstruction, we are starting to breach into serious concerns about probity issues and practitioners' intentions. We already have a low threshold for discussing issues with Police Scotland, and I believe that we take a strong, although relatively distant, approach. We would not want to be heavily engaged with it all the time, but there has to be a strong approach to how we manage the system.

Elena Whitham: On the intelligence-sharing part of the inspection regime, how important will environmental health officers be to our local authorities?

Eddie Docherty: The role and function of the Health and Safety Executive has become significantly clearer during the discussions. I have a discussion the week after next with colleagues in HSE about the secondary and tertiary impact of that, and we are keen to pursue information-sharing protocols with local councils. We take a systematic approach to managing all that, and it does not appear that Healthcare Improvement Scotland, plus or minus the professional regulators, are working in silos. There has to be a consistent approach so that all the appropriate agencies are engaged.

Brett Collins: I know that we are talking about how the bill will operate in the future, but my understanding, through HIS regulation of independent clinics, is that all relevant healthcare professionals who provide face-to-face private services should be operating from an HIS-registered clinic. In Scotland, that means that, where toxin is prescribed for a treatment or where medication is used to treat dermal filler complications, people from one of four professional registered backgrounds—doctors, dentists, nurses and midwives, or pharmacists—are required to do face-to-face consultations. Therefore, any doctor, nurse or dentist providing services in the sector in Scotland should already be operating from an HIS-registered clinic.

The bill's policy memorandum estimates that between 1,000 and 1,500 clinics or service providers are not, but should be registered. Given that you currently cannot or should not be able to get treatment in Scotland without a healthcare practitioner providing a face-to-face prescription, that indicates that there is an existing problem that is not being addressed in the current landscape. Ultimately, that means that there are potentially 500 healthcare professionals that are in breach of the code of conduct that is set out by the likes of the NMC—as we heard, it updated the guidance in June—or that there are potentially 500 clinics that have no prescribers and are using illegally imported, unlicensed or counterfeit medication. That is the current landscape, because there is existing legislation that requires both face-to-face consultations with healthcare providers in the sector and that those providers be registered with HIS.

Elena Whitham: It is very helpful to have that on the record. I think that whoever is asking the next questions will ask about resources for Healthcare Improvement Scotland and operational challenges, so that aspect will be explored in that context.

Brian Whittle: And that will be me. [*Laughter.*] Good morning, and thank you for being here. With regard to the baseline, we have heard a lot of evidence about the wide variety of practitioners involved in the industry, from highly qualified healthcare professionals, right the way down to those who can go out and ply their trade having maybe been on course for a couple of days. How do we ensure that the way that we deliver regulation catches the practitioners who are potentially causing most of the issues? I hesitate to use the term "rogue traders", but we know that they exist. How do we make sure that they are

identified and caught, rather than impacting on businesses that are going to be continually compliant just because they are the easy ones to target?

Eddie Docherty: That is definitely a challenge, and, as Laura Boyce suggested, on the back of the bill, there is a real opportunity for public engagement, so that people understand where things are. We need to engage with people about what their expectations should be. With regard to responsibility, the onus is on individual practitioners. Should they bypass all our standard processes, it is about capturing and sharing intelligence. Could the process be stronger? I believe that it could be. However, the mechanisms for doing so are quite challenging. A lot of advertising happens on social media and it is incredibly difficult to observe and manage that. In Police Scotland, colleagues have shared concerns in other fora about the difficulty of a burgeoning social media presence for certain types of advertisements. We are committed to continuing and expanding this work, but there is no doubt that it is a challenge in Scotland.

Laura Boyce: I will not reiterate what Eddie Docherty said, but we have quite good and established relationships with organisations such as the Medicines and Healthcare products Regulatory Agency and the Advertising Standards Authority, so that we share information, where we have intelligence about something that is not necessarily in our remit but maybe falls within theirs.

Eddie Docherty alluded to what should be reported in public messaging. Within our remit, we can investigate complaints and we look at notifications of adverse events. There is something there for us about establishing a more seamless mechanism to report that information, and doing some thematics around it and about how we utilise that in the future in relation to monitoring the medium to long-term changes in the independent healthcare sector.

Brian Whittle: My next question for HIS is, if we are going to establish protocols for ensuring compliance, how do we practically resource that, and where are we short of the practical resource that will be required to deliver the bill?

Eddie Docherty: Part of the fees associated with the increase in registration should help to support that in the long term. However, to be honest, it is currently quite a long way away from being a self-financing process. The discussions with the Scottish Government about baseline funding will need to continue. We have the view that, as the system expands, we are likely to require more money to meet the requirements.

I have a view that there should be—and we have been working towards—a systematic approach over the next three to seven years to develop a self-funding model. The system is, rightly, based on public safety rather than on a business model, and continuing down that route means that there will be a delay while we work towards that model. We have some processes in play that should help with the financial system, but the fundamental level of baseline funding will probably need to increase. Right now, we are reviewing all our processes in relation to independent healthcare, so we will be better able to assess that once we have understood the landscape and the processes in independent healthcare.

Laura Boyce: Building on what Eddie said, it is intended that the equilibrium point will be reached. There may initially be a necessity for pump-priming. I give assurance to the committee that the fee model is part of our review of our sustainable approach for independent healthcare regulation and that we are currently undergoing that review. The other aspect within that is our tackling of aged debt—or bad debt, as it may be known—which is when services may not have paid their fees for regulation and the costs of those are borne by Healthcare Improvement Scotland for the regulatory function. There has recently been an amendment to the overarching National Health Service (Scotland) Act 1978 that allows us to take action to cancel and deregister services for non-payment of fees. We are actively seeking to pursue and recover aged debt and outstanding debt, which should bring us back to that more viable financial position in the medium term.

Brian Whittle: I just want to check—do Brett Collins or Paula McLaren want to come in on any of those questions? If you do, please indicate.

Paula McLaren: As a professional regulator, we would not have a view on resourcing to deliver the bill. That is not within our remit.

Brian Whittle: Laura Boyce, you have led me to the issue of proactive detection. Again, there is a practical element here—if that is going to be part of what HIS is involved with, it will require resource for HIS to be proactive rather than for HIS to passively wait for reports to come in. Where do you stand on that? Is it something that will have to be properly resourced?

Laura Boyce: There is a balance in relation to that risk-based, service-by-service approach and to how we would deal with it. The legislation places the duty on the services to be registered. As part of the broader lead-in to any enactment of the bill, we would look to engage with the services and individuals that we think would fall within that provision, and support and help them to

understand the registration and inspection processes.

We already have established networks—I know that you have already heard evidence from groups such as BAMAN and the Scottish cosmetic interventions expert group. There are already forums where we engage with them to reach and utilise their networks in order to share information about any changes in our regulatory functions. They are also a great source for sharing back with us intelligence about how we are doing. It is about us building on the existing platforms.

There will obviously be an operational element to that in terms of workforce training and upskilling, both of which we are looking to explore as part of the current review process to see what the workforce looks like and whether we have the right mix of skills and the right people in the workforce.

Fundamentally, the legislation as it stands places responsibility on the service provider to register with us rather than on HIS to proactively detect them. As I said, we would take a risk-based approach to that. Obviously, when there have been public safety issues, we have already utilised our relationships with Police Scotland, the Medicines and Healthcare products Regulatory Agency and so on.

11:15

Brian Whittle: Finally—

The Convener: Brett Collins wants to come in.

Brian Whittle: Sorry—please come in, Brett.

Brett Collins: HIS was originally developed to regulate hospitals that care for seriously ill and vulnerable patients, and the regulation of healthcare professionals within aesthetics is quite a different landscape. I made the point that there are potentially hundreds of healthcare practitioners in Scotland who should be registered with HIS, but there appears to be no clear evidence of a policing, proactive approach to ensuring that the current legislation is followed.

Within the bill, there are unquantified complaint costs, which indicates that there has been no account taken of any increase in the volume of complaints.

As I mentioned, we are currently regulating low-hanging fruit. We are committed to delivering safe services, but this is a completely different landscape, in which, as has been mentioned, there are operators on social media, ghost practitioners and people using products that they should not be using and which come into the UK illegally.

There are unquantified elements of enforcement costs. We have been talking about the fact that the process will not be cost neutral in the foreseeable future, and the amount of cost and resource that would be needed to make it anywhere near effective is particularly challenging. I think that it is disturbing that we are not getting a true feel for what those costs might look like as part of the bill process.

Brian Whittle: That is really useful, Brett, and it takes us where my line of questioning is going. It is about how we can deliver a bill that everybody will be compliant with, but it is also about how we do so practically and effectively.

My final question along those lines is about some of the things that have not been considered, such as issues that are associated with the enforcement provisions. For example, how will we address things such as secure storage and the maintenance of a chain of evidence for seized items, including counterfeit medicines. What is the Scottish Government's role in ensuring that those issues are taken care of and that we have the tools to deliver the bill practically?

Laura Boyce: I am happy to come in on that. There are some key points in there. In our written response, we commented on things such as the power of seizure and covert surveillance. We know that there are potentially some challenges with the Regulation of Investigatory Powers (Scotland) Act 2000, so we would need clarity around any interactions that would impact on our ability to undertake such functions.

From the evidence that has been provided to us, the largest challenge is that we cannot reasonably estimate the number of services that are out there. However, we have established processes whereby, if we have intelligence that there are services that should be registered, for example, we have structures in place, from a supportive mechanism up to looking at imposing emergency conditions and cancellation or making approaches through Police Scotland.

We have also sought clarity around the fact that we are a specialist reporting agency for direct reporting to the Crown Office and Procurator Fiscal Service. We have not operationally implemented that process previously, but we are currently working towards what that would look like. There are tools that we know that we have at our disposal that we need to explore, and areas for us to expand into. As you have alluded to, whether that can be done within a cost-neutral envelope or whether it would require an element of pump priming at the outset is probably unknown.

In relation to Brett Collins's point that there are potentially hundreds of such practitioners out there, through our services, we receive a fairly

regular flurry of inquiries about services that people believe should be registered with us but are not, because of the nature of the current regulations. They might provide, for example, dermal fillers, which do not need a prescription. Under the legislation, that means that there is no need for the involvement of a registered professional.

We think that there is an opportunity for clarity to be provided so that we can regulate with more certainty for individuals who make such inquiries to us. Brett's point about what we do with that information was well made. The bill would provide us with more clarity in relation to making contact with those individuals, starting the registration process, inspecting against a standard and, ultimately, providing assurance on the public safety element.

Emma Harper: Good morning. Before I ask my substantive questions, I want to follow up on the point about dermal fillers not needing a prescription. Is that because—I raised this with the previous panel—hyaluronic acid is a medical device, rather than a medication? Does that need to change?

Laura Boyce: It is deemed to be a medical device, so it falls under the MHRA's remit. That, along with counterfeit or illicit supplies of medication, is one of the largest areas that we engage with the MHRA on. That is why we share information.

On whether the status of hyaluronic acid as a medical device should change, I probably cannot provide a clear answer, because I am not an expert on that aspect. However, it is an area of dubiety, and it represents a challenge with regard to our regulatory position. If we were to say that such procedures were group 2 procedures that need to be carried out on a permitted premises, as the bill proposes, that should, in theory, provide more clarity for us in addressing the gaps in the legislation.

Eddie Docherty: That is a fair point. Colleagues in the MHRA would probably be best placed to make that assessment. If we go back to the fundamental principles of public safety, there is an interdependency, and we would need to seek clarity from our colleagues in the MHRA. Healthcare Improvement Scotland is not acting on its own. We would need to seek further clarity in that regard through our relationship with the MHRA. It may well be that a safer approach would be for hyaluronic acid to be a prescribable medication. It is not currently. However, the people at the MHRA are definitely the experts in the field, so it is difficult for us to give a definitive answer.

Emma Harper: To follow up on Brian Whittle's question, there are a lot of businesses out there that you know are providing treatments for people. As Brett Collins said, they are the low-hanging fruit—the businesses that are easy to detect or find. However, it seems that the number of unregulated businesses that offer non-surgical procedures is greater than the number of regulated businesses that offer such procedures. Paragraph 14 of the financial memorandum provides some numbers. It refers to the fact that not all hair salons will do Botox treatments, for example, but even if only 20 per cent provide such treatments, about 5,000 new businesses will need to be regulated—and those businesses might come forward and apply or they might need to be found.

How much time do you think will be needed to enable a transition? More people will need to look into this area, and people who want to apply will need to have the time to transition, which will involve them turning their place of practice into an HIS clinic area. What are your thoughts on timelines?

Laura Boyce: Again, that is a really good point. We do not want to have a date for implementation without being in a reasonable position to meet public expectations and provide the necessary clarity.

We do not see implementation being achievable prior to the end point of the 2027-28 financial year. We need to get clarity on our relationship with the Crown Office and Procurator Fiscal Service in relation to direct reporting, and we need to clarify the information-sharing agreements with local authorities, especially in relation to the power of seizure, which Brian Whittle mentioned. We need time in order to be able to robustly establish the mechanisms and procedures that we require. We also need the data to be available so that we have much more clarity on the size and scale of the services that we are talking about regulating. It would not be achievable for us to undertake that within the next financial year.

Emma Harper: Does the financial memorandum accurately reflect what you think might be required in terms of investment, including for the delivery of the transition?

Laura Boyce: Yes and no. It is really difficult to say when we have no reasonable means by which to estimate services' level of commitment to and conformity in engaging with that process—for example, whether some 500 services out there will all be able to align themselves to a healthcare professional in order to be defined as registered, or whether some businesses will align themselves only to the local authority licensing scheme. That presents challenges.

The other aspect relates to the reporting mechanisms. We might want to source things

such as information technology infrastructure. The way we get intelligence and information from the public or from other services now is pretty much through a mailbox or an inquiry line. We have not costed the elements of a more robust reporting process or portal approach, because, at this point in time, we do not understand the size and scale of what we would be trying to address. We would see an incremental, phased approach being taken once we got to the point of implementation. Would that be fair to say, Eddie?

Eddie Docherty: A phased approach would be proportionate and reasonable. We have applied such an approach in a variety of areas, including where an individual or a group identifies themselves as requiring to register with us. If they begin the process reasonably, we stop the clock because they are acting reasonably. Then, over a time period, we focus on those who are high risk as part of a risk-based approach.

Emma Harper: Laura Boyce mentioned IT systems. I am a former NHS Dumfries and Galloway nurse. When there was an adverse incident, we entered it in Datix, which has been replaced by InPhase. Would there need to be some kind of tracking mechanism for reports of issues where somebody's safety has been compromised?

Laura Boyce: That is a valid point. At the moment, we have a notifications portal for registered and regulated services. The challenge with it is that some issues are recorded as a complication of dermal filler, some as a duty of candour incident, and some as an adverse outcome for a service user. There is probably a mechanism for us to engage with our stakeholders and the services that we regulate to ensure consistency and to allow us to do that thematic piece.

Eddie will probably come in on the back of my response, but, as you alluded to, there are already models in the NHS that set out the standards that we expect for adverse event reporting and notifications. There is definitely transferable learning in other areas of Healthcare Improvement Scotland.

Eddie Docherty: That is a key point. I am sure that everyone is aware that Healthcare Improvement Scotland is moving from a concordance model to a compliance model for adverse event reporting. There is significant overlap when it comes this type of work, so that we can consistently and routinely collect that information. The onus will always be on the individuals involved—that is how it works for adverse events.

We have already begun conversations with a variety of stakeholders on how we can start to implement that. In public safety, we ask, "What went wrong, what can be learned, and is there anything that can be shared across the entire environment?".

Emma Harper: Given the public advice that has been issued about the proposed new process for the regulation of non-surgical procedures, does the financial memorandum cover what might be required in providing wider information to the public about what is coming down the line?

Eddie Docherty: We have done significant comms pieces in the past. We have not particularly built such an approach into the financial memorandum, but we know that we are likely to draw together funds and approaches from across multiple agencies. That will need to be done at scale, but we have had obvious success with previous changes, which shows that we can engage. There is no doubt that we would like that engagement to be broader and for us to have a greater ability to do it, but we are aware of financial constraints and are trying to work within them.

11:30

Brett Collins: I will bring the discussion back to the requirements for clinics and practitioner providers that are not currently engaged with HIS and perhaps should be, and what that should look like moving forward. We should consider whether there is scope to look specifically at the requirements for non-surgical treatment providers, due to the fact that aesthetic treatment is very different from what would be done in a hospital setting, where seriously ill and vulnerable patients are treated. Aesthetic treatment is minimally invasive and provided electively to a generally fit and healthy population. Certainly, business owners and treatment providers see some of the requirements in the HIS standard as prohibitive, which may have a negative impact on their willingness to engage in the process. If that standard is not reviewed so that it is fit for purpose for this specific sector, there will be barriers, and if the standard has unnecessary barriers, surely it should be reviewed.

For example, HIS guidance sets out premises construction and finish standards. Premises must adhere to the requirements to have "seamless and smooth", "impervious (sealed)" and "gap-free" surfaces, including "coving between the floor edge and wall", which would necessitate extensive and costly structural renovation of existing clinics.

If you have a logical understanding of the treatments and how they are carried out, you can see that the standard goes far beyond practical hygiene requirements for aesthetic settings and aligns more with operating theatre specifications.

We want to understand how many service providers there are out there that, in principle, should all be engaging with some form of healthcare practitioner. We have touched on the fact that dermal fillers are not prescription-only medicines. Any clinic or service provider that is offering dermal fillers should also be capable of managing complications, but, in reality, in order to manage complications from dermal fillers, you need prescription-only medicines. Therefore, our concerns are not only about HIS's capacity, how many more people and departments are involved and how much more IT and artificial intelligence infrastructure we create. We need to ask whether the requirements are too onerous for the sector, and whether going far beyond what is required will have unintended consequences for service providers.

For 11 years, Save Face has been committed to ensuring that the environments that we assess are safe, hygienic and appropriate for the treatments that are provided in those environments, but that does not extend to requiring them to meet hospital standards. There are components of what is done in hospitals, with things such as sharps disposal and medicines management, but the current framework and the standard that needs to be applied and met are particularly onerous. The cost implications will continue to be a barrier for the sector.

Emma Harper: Finally, some vulnerable people might seek procedures such as dermal fillers too often, to the point that their physical appearance might be perceived to have been altered and others may say that it does not look good any more. Would the notification process involve flagging up whether someone attends more frequently?

Eddie Docherty: That would certainly be an ambition. Adverse event reporting in any form is about identifying things that have gone wrong, or could have gone wrong, and the point that you raise would be key in relation to aesthetics.

In the private sector, there is a significant body of evidence on what has happened in other areas, such as heavy industry, in which reporting on adverse events has been truly effective and has changed entire systems. We are supportive of applying the adverse events reporting approach. We understand that the thresholds may look different; however, we have evidence that the private sector will work effectively with the requirements once we get over some initial hurdles.

Sandesh Gulhane: I have a very basic first question: who should regulate aesthetic practitioners?

Laura Boyce: With regard to the independent sector in Scotland, we regulate for the definition of the services and the providers; we do not regulate activity per se. I know that that question has been raised because we have a different model from the CQC with regard to activity. For us, it is about regulating the services and the providers, and the professional groups within that. If non-healthcare professionals were able to align themselves to the model for registered healthcare professionals, which is what provides us with certainty and assurance on public safety, it would fall to us to regulate them. We believe that group 1 treatments are lower risk and suitable for local authority licensing, which is similar to how things are already regulated in the tattooing and piercing industry.

I would link that back to the point that Brett Collins made about the fixed premises guidance and the standards. On the importance of regulating and the approach to independent hospitals and clinics, it is about the consistency of the environmental standard, because it should not really matter what the procedure is. Whether the procedure is carried out for the purpose of wellbeing, for aesthetic reasons or for an identified physical health need, the environment, medicines management and infection control procedures should meet the standards, so we believe that that approach to and regulation of those services and providers is the right way to go. Therefore, those aesthetic clinicians would need to be able to align themselves with that model for our regulation. Does that answer your question?

Sandesh Gulhane: So, the direct answer to my question is that, aside from group 1 treatments, the regulator should be HIS.

Laura Boyce: Yes, it is HIS.

Sandesh Gulhane: Do all aesthetic practitioners have insurance? Is that your general feeling?

Laura Boyce: I could not comment on the general unregulated industry, but, as part of the registration process for Healthcare Improvement Scotland, your indemnities and your liabilities are part of the process that we undertake as part of your registration and inspections.

Sandesh Gulhane: Should we regulate individuals or premises, or both?

Eddie Docherty: The question probably goes to the heart of this work. Different models will approach that differently. The model that we have can definitely be expanded to cover more parts of the industry, but I suggest that there will always be an option for a mixed approach, working with our colleagues in bodies such as the NMC to regulate professionals. That regulation is well established and works extremely well, so a combined

approach will be particularly helpful, especially if we are now going to see non-registered professionals who need that level of supervision. There will always be debates about what the supervision will look like, but, in principle, it is a particularly strong option.

Sandesh Gulhane: Therefore, there should be a mixed approach.

The NMC regulates nurses who perform aesthetic procedures. How many cases have you had in front of you, in the past year or so, that have related specifically to aesthetic malpractice?

Paula McLaren: I cannot comment on that today, but I can find that out for you. We updated our position because we are seeing an increase in fitness-to-practice cases not only in relation to non-surgical cosmetic procedures, but in relation to prescribing, particularly remote prescribing, which is why we addressed that in our updated statement. I can get the figure for you.

Sandesh Gulhane: However, there are cases.

Paula McLaren: Yes, absolutely, and they are rising.

Sandesh Gulhane: How do you ensure that nurses whom you regulate and who do aesthetic procedures are up to date and that they have the appropriate training in the first place? We touched on that in the first question, but can you expand on that?

Paula McLaren: We do not set any specific requirements around education and training for non-surgical cosmetics, but we do have standards around independent prescribing. We know that this work will require a prescription in the majority of cases.

We have standards of education and training for independent prescribing. Our standards of proficiency around that come through the Royal Pharmaceutical Society's competency framework, which sets out the capabilities. The framework applies not just to nurses and midwives, but across allied health professionals who are prescribers—the majority are signed up to it.

We also have the code. From talking to other registrants, we all know that if we are not aligning to and abiding by the code, we could well end up having to justify or defend ourselves through fitness-to-practice processes.

We require individuals on a three-yearly basis to inform us through revalidation that they are appropriately educated and trained. That would include training in aesthetics if they were working in aesthetics. We are clear that individuals must maintain their scope of practice and ensure that they have the knowledge, skills, education and training required to deliver those services.

We have processes in place to ensure that our professionals align to the code. We also have those education and training standards for prescribing, and our updated position on remote prescribing is the expectation of a face-to-face consultation in those situations, both when meeting the individual for the first prescription and for every consultation thereafter.

Sandesh Gulhane: I do not mean to pick on nurses. The GMC deals with doctors, but the GMC is not here for me to ask it questions.

It seems to me that there is not a level playing field here in that, if you happen to be a nurse who is doing aesthetics, you are held to a standard that could see you struck off—quite rightly, in some cases—but if you are not regulated, you can operate with very few consequences.

Paula McLaren: Yes, and that is the challenge, as we have heard this morning. It is the responsibility of the nurses and midwives—who often work with unregulated professionals when prescribing medications and delegating procedures—to make sure that whoever is undertaking the procedure is appropriately trained and understands the risk of complications with those procedures. We are clear about the delegation of responsibilities and the need to ensure that whoever is being delegated to is appropriately trained and competent. We are also clear that, when something is delegated, the responsibility remains with the individual who has delegated, whether that is through prescribing or otherwise. We have very clear position statements and standards around delegation.

We are undertaking a review of our code at the moment. The current code has been in place since 2016. As part of that, through talking to—

Sandesh Gulhane: Forgive me, but, as you are updating your code, would it be helpful if, through this bill, there were standards for you to reference?

Paula McLaren: Yes, absolutely. They would add clarity.

There have been calls for us to look at delegation. We issue guidance and position statements, but if we included everything in the code, it would be 5 million pages long. There is an opportunity to update, but we also have additional guidance around delegation. There are requests for us to have the ability to do that.

Our updated position brings us into alignment with the other health and care professional regulators. We have co-produced high-level principles on remote prescribing, so we are all in alignment in the cosmetic procedures space.

11:45

Sandesh Gulhane: This is my final question. Do the witnesses consider that the bill as drafted will provide the regulation that is required in this field? If you do not, what changes should we make?

Eddie Docherty: The bill is a significant step forward. The bill is clear and its impact on public safety will be clear. One challenge in this type of environment is that it is constantly changing, as it reflects, for example, changes in social and cultural beliefs. We will always struggle to be ahead of that. The bill is structured in such a way as to give you the powers to respond to that and make things much more effective.

Some really strong messages are coming through the bill. I do not think that it is perfect, but I do not think anything can be perfect, given the nature of the systems that we are working in.

Sandesh Gulhane: Are there any changes that you would make?

Eddie Docherty: The clear identification of competence would be massively helpful. However, competencies change as the methodologies change, and it might be difficult to imbibe that. It may be a case of having a reference point or a requirement that multiple agencies work together to do that.

Laura Boyce: I will make two points that build on that. First, I absolutely support the bill and believe that, in the current landscape, it is completely proportionate. We must be mindful that the inherent risk of any procedure will not change as a result of the bill—it is simply about the controls and the mitigations that we put around such procedures in trying to improve public safety. We need to be really consistent about that in the public health messaging.

Secondly, we are very supportive of the proposal to not allow procedures to be undertaken in hospitality and exhibition venues. I would clarify the point—this is a change that I would really seek to enforce—that non-surgical procedures should be undertaken within an independent clinic rather than within an independent medical agency. For example, you might have a training academy where a botulinum toxin is injected into a live model as part of demonstration procedures within exhibition and hospitality venues. We would want to strengthen the section that deals with that.

Sandesh Gulhane: Would you write to us on that?

Laura Boyce: Yes, of course.

The Convener: Mr Collins wants to come in.

Brett Collins: On the bill being fit for purpose, my concerns are more about how realistic it is to bring all of this into a meaningful and effective landscape. There is no doubt that the NMC, the GMC, the General Pharmaceutical Council and the GDC have aligned approaches in relation to things such as remote prescribing. However, we can generally say that that is an issue within the industry. Again, the issue is how that would be policed and enforced, and, importantly, how the public in Scotland would be educated about to what to expect when walking into a treatment provider and that those expectations would be ingrained.

What do we need to make that happen, and what volume of resource do we need to make it effective? I am sorry for bringing it back to this, but there are potentially hundreds of healthcare practitioners operating in Scotland and the mandated regulations are not being adhered to—they are not being policed and they are not being put in place effectively. I guess that my disconnect is with what will change and with how the bill will extend a process that will ensure public safety.

Also, when we get into delegation and supervision, that changes the landscape significantly. I think what is important—

Sandesh Gulhane: Sorry to interrupt—it is difficult to interact in an online setting. What change would you make?

Brett Collins: There needs to be a review of the roles that practitioners have in non-surgical treatments, whether they be medical or healthcare professionals or non-medics, and—if you are going to cover this—of what competency looks like. Ninety-nine per cent of those who operate, whether they are healthcare or non-healthcare professionals, attend one or two-day courses, and they may attend many courses throughout their career in aesthetics. However, we have data to support the point that many healthcare professionals move into aesthetics and get trained on a one or two-day course but then invest in additional training, because the training that they initially received was not comprehensive enough to make them feel confident and competent. That issue exists among healthcare professionals, but it also exists among non-healthcare professionals. There is not currently a solution to the issues of education and training that I would consider to be fit for purpose.

There is also the question of how, retrospectively, we can bring the training up to date and how we can safeguard that moving forward. Can we put something in place that will enable future generations to access resources and training that are fit for purpose and that are future proofed as the industry evolves and changes shape as new treatments evolve?

We can develop a fit-for-purpose bill in principle, but, if the realities regarding the landscape, enforcement, policing and public awareness are not also in place, the bill will not dramatically improve the landscape and address the issues that most ethical treatment providers, whether they are healthcare or non-healthcare professionals, want to be addressed.

Sandesh Gulhane: Thank you.

Patrick Harvie: My question is about the consistency of regulation. On the question of consistency between different parts of the UK, one view is that we should generally err on the side of consistency and regulatory alignment, because that is simpler to communicate, it is easier for everyone to understand and it avoids unintended consequences in relation to the movement of people between different jurisdictions for one reason or another. Another view is that it is not good to prioritise alignment for its own sake, and that we should align with something only if we think that it is the right regulatory position. According to that view, we should not adopt a lower regulatory position just for the sake of alignment.

On where such regulatory decisions should sit, there is again a view that, in relation to devolved matters, the devolved Government and Parliament should decide whether divergence is justified to achieve a public policy objective such as patient safety. Another view, which is embodied in the United Kingdom Internal Market Act 2020, is that the UK Government should decide, in the interests of market alignment and fairness for market operators, to impose a common approach.

What are your general views on, first, whether alignment between the different jurisdictions in the UK is important? Does it matter? Are there any unintended consequences of such alignment? Secondly, to what extent is the level of divergence or difference that is proposed in this legislation workable and manageable?

Eddie Docherty: You make some incredibly strong points. The mixed-model approach of managing registration and regulation is workable and can be improved. We would always want learning to be sought from other parts of the UK and across the world, while being proportionate and reasonable. There is not a perfect answer to that question, but we should remain proportionate, fleet of foot and prepared to seek more information—for example, on whether the CQC is doing something that is particularly helpful or definitive—and then be able to map that across. We already have strong relationships with senior teams in CQC, and we regularly seek that type of information. One size may not fit all, but both models are workable. However, there is not a perfect answer.

Patrick Harvie: You do not, in principle, see problems arising from divergence between the two jurisdictions.

Eddie Docherty: Everyone works towards the same principle of public safety. As long as that remains enshrined in and at the core of what we are doing, every group will work proportionately. The actual scale or volume and indeed activity within Scotland and England, for example, are not identical. Therefore, it is potentially extremely helpful to have the ability to respond locally.

Patrick Harvie: Are there any other views?

Paula McLaren: Our updated statement has brought us into alignment with the other professional regulators, and that has been helpful. We constantly review the legislation across the four countries, and we understand that there are different systems in place. We work to ensure that our professionals are working within that legislation.

Scotland has different legislation, and that has started conversations on holding prescription-only medicines, particularly emergency supplies in establishments where non-surgical cosmetic procedures are carried out. That has been a real positive; it has started conversations and debate in England. Where we can align, that helps to mitigate public protection risks and provides assurance to members of the public. Consistency, oversight and, where possible, alignment, are important.

Patrick Harvie: Is that four-nations dialogue purely among your professional colleagues, or are you aware of that happening between Governments, too?

Paula McLaren: Both. It takes place in all the areas where you would imagine it happening, including with Government and with chief nursing and chief midwifery officers. We have an employer liaison service, which works across a regional footprint and involves regular conversations with senior professionals within organisations.

Laura Boyce: Building on what Paula McLaren has said, I note that there would need to be a slight shift in our overarching legislation for us to bring unity, but we are all working collaboratively according to a principles-based approach. The cross-regulator platform and the cross-regulator forums are exceptionally helpful and are well established. We perceive the bill as a levelling up of the public safety aspect, and we would almost justify that as the rationale for the divergence.

Patrick Harvie: It is inevitable that the closest comparisons that we make on a regulatory issue such as this are with other UK nations, but should we also be looking at the wider, global picture? If we raise standards to a regulatory level that we

are happy with here, there will be people who get encouraged to go on holiday and get procedures done unsafely somewhere else. Is there anything that we can or should do under the bill that would address the issues of information, awareness or promoting access to services in other jurisdictions and other countries? Is there anything that we can do in that regard to address safety?

Laura Boyce: I am not sure how feasible it is to include that within the bill, but health tourism is certainly becoming much more common, and we hear about the complications from that. Any shared learning in relation to health tourism from Scotland or the advertising of it in Scotland would be a strength. It would be good to try and limit that through the bill. We are aware of advertising for some aspects of health tourism at exhibitions and conferences and in professional magazines, so anything that could be done to prevent that would be a strength—although I am not sure whether that is possible or achievable.

Paula McLaren: I do not know how feasible it is to cover that in the bill.

We undertake a lot of international mapping in all our work. I am aware that there are the same challenges in Australia, and we regularly have conversations around some of the challenges with our counterparts in Australia and in European countries. It is a matter of having an open dialogue.

It is a complex challenge—it is hard enough across the four nations of the UK—but there is certainly something worth exploring there.

Patrick Harvie: The only other point relating to consistency that I—

The Convener: Very briefly, please, Mr Harvie: we are due to finish at 12 o'clock.

Patrick Harvie: In that case I will stop there.

The Convener: Thank you.

I know that Mr Collins wanted in again, but perhaps he could submit what he wanted to say to the committee in writing: that would be greatly appreciated.

I am sorry to have to rush on, but the committee has more work to do this morning. I thank the witnesses for their attendance.

11:59

Meeting suspended.

12:04

On resuming—

Subordinate Legislation

The Food Safety Act 1990 Amendment (Scotland) Regulations 2026 [Draft]

The Convener: The third item on our agenda is consideration of an affirmative instrument. The purpose of the draft Food Safety Act 1990 Amendment (Scotland) Regulations 2026 is to amend provisions of the 1990 act by restating secondary assimilated law within the meaning of section 12(2)(b) of the Retained EU Law (Revocation and Reform) Act 2023. Regulation 2 amends section 17 of the 1990 act to replace references to "EU" obligations and provisions with "assimilated" obligations and provisions, and it replaces a reference to "directly applicable EU provision" with

"provisions of assimilated direct legislation".

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 18 November 2025 and made no recommendations in relation to it.

We will now have an evidence session on the instrument with the Minister for Public Health and Women's Health and her supporting officials. Once any questions that we have are answered, we will proceed to a formal debate on the motion. I welcome Jenni Minto, the minister; Emma Luton, a Scottish Government lawyer; Greig Walker, project lead in the Scottish Government's constitutional policy unit; and Jennifer Howie, UK and international relations team lead at Food Standards Scotland.

I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): I am pleased to join the committee to consider the draft Food Safety Act 1990 Amendment (Scotland) Regulations 2026. As the committee will be aware, I am advised on food safety standards and labelling by Food Standards Scotland. The proposed minor technical amendments arise as a consequence of the UK Government's decision to leave the European Union and the need to ensure that the statute book in Scotland remains operable. Food Standards Scotland worked diligently with the Food Standards Agency and the Scottish Government to update "EU law" references to "retained EU law" references where they were found.

The instrument relates to a deficiency in the 1990 act, which provides the legal foundation for food safety standards in Great Britain. The

amendments to the 1990 act were originally going to be made by a GB statutory instrument. However, once it became apparent that the Food Standards Agency and the UK Government were pausing the GB SI, Food Standards Scotland and the Scottish Government agreed that the responsible approach would be to introduce a Scottish statutory instrument instead. The approach serves to enhance the clarity and accessibility of the devolved statute book and give the Parliament reassurance that orderly preparations are being made in Scotland for an EU reset. I stress that the amendments are technical in nature and do not amount to any change in policy. They are necessary to ensure that the statute book is brought up to date. There will be no impact on businesses or any other stakeholder group. I ask the committee to agree to the proposed instrument, and I am happy to take any questions.

Sandesh Gulhane: Thank you for coming to the committee, minister. The changes are technical, but will there be any implications for industry?

Jenni Minto: In what respect?

Sandesh Gulhane: In any respect. Will there be any implications for industry as a consequence of the way in which the regulations are written?

Jenni Minto: The reason for introducing the SSI is to return the statute book to how it should be. The statute book has not been updated, so it still refers to “EU law”, which is no longer factually correct, because we now have “assimilated law”. That is the change that will be made.

The UK Government is currently working to improve relationships with the EU. Of course, the Scottish Government believes that Scotland’s best interests would be served by rejoining the EU as an independent member state, but, until we get to that point, it is important that we rebuild a close relationship. When the work on an EU reset is done, we will have a statute book in which that work can be integrated quickly and efficiently.

The Convener: I have had no indication that any other member wishes to ask a question, so we will move to agenda item 4, which is the formal debate on the instrument on which we have just taken evidence. I remind the committee that officials may not speak in the debate. I ask the minister to move motion S6M-19531.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Food Safety Act 1990 Amendment (Scotland) Regulations 2026 [draft] be approved.—[*Jenni Minto*]

Motion agreed to.

The Convener: That concludes our consideration of the instrument.

The National Health Service (General Ophthalmic Services) (Scotland) Amendment Regulations 2025 (SSI 2025/337)

The Convener: The fifth item on our agenda is consideration of a negative instrument. The purpose of the National Health Service (General Ophthalmic Services) (Scotland) Amendment Regulations 2025 is to deliver the full implementation phase of a policy to support independent prescribing optometrists and ophthalmic medical practitioners to manage patients with 10 complex acute anterior eye conditions through general ophthalmic services, thereby reducing the number of patients who need to be referred to hospital eye services.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 18 November and made no recommendations in relation to it. No motion to annul the instrument has been lodged.

Do members have any comments on the instrument?

As members have no comments, I propose that the committee does not make any recommendations in relation to the negative instrument. Does any member disagree with that?

Members: No.

The Convener: At our next meeting, on Tuesday 16 December, the committee will conclude its stage 1 scrutiny of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill by taking evidence from a panel of witnesses on part 2 of the bill, followed by a concluding evidence session with the Minister for Public Health and Women’s Health.

That concludes the public part of our meeting.

12:11

Meeting continued in private until 12:31.

Official Report
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Scottish Parliament
Edinburgh
EH99 1SP

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Telephone: 0131 348 5447
Fax: 0131 348 5423

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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