

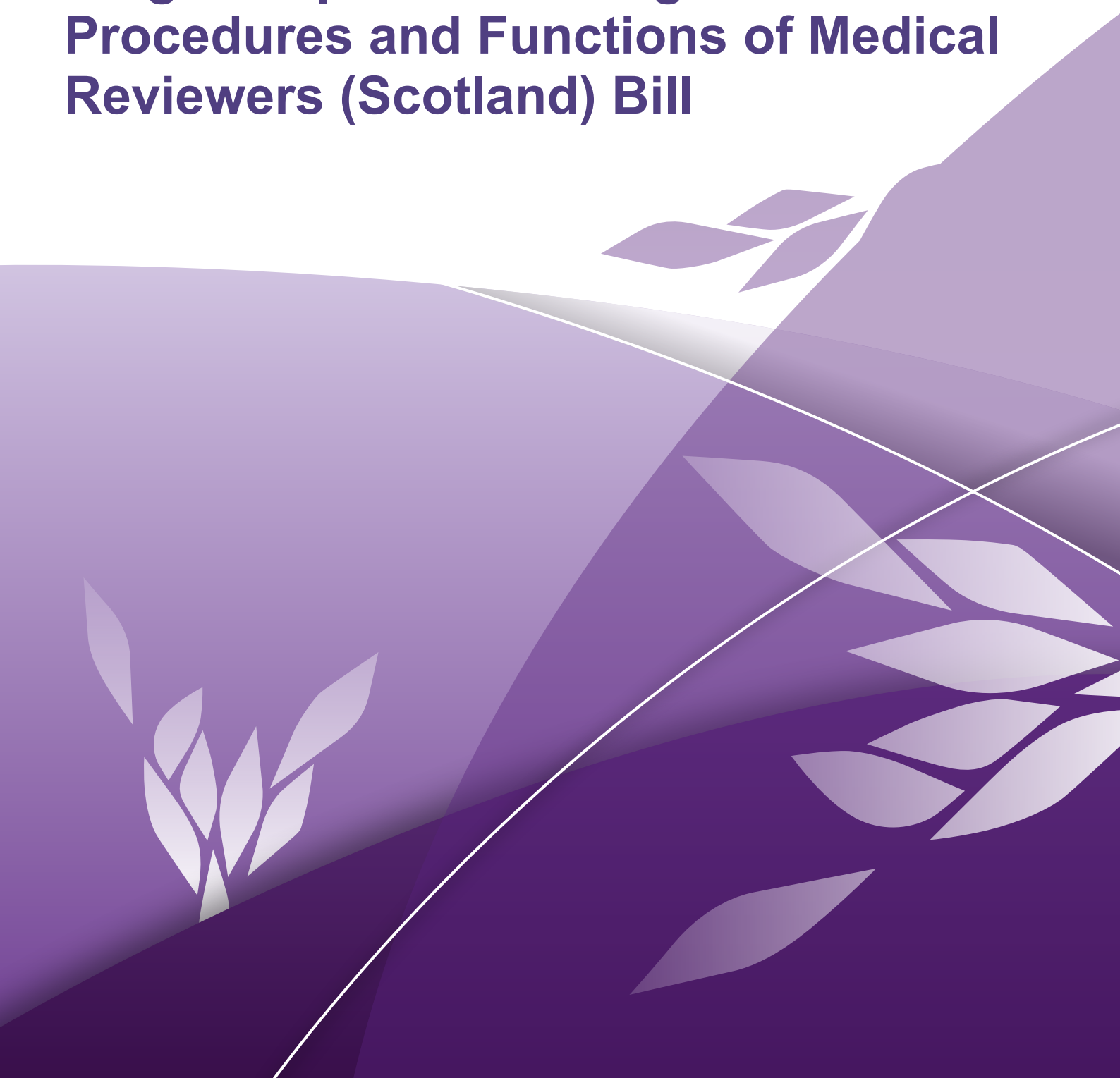


The Scottish Parliament
Pàrlamaid na h-Alba

Published 27 January 2026
SP paper 976
2nd Report, 2026 (Session 6)

Health, Social Care and Sport Committee

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



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Health, Social Care and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Social Care.

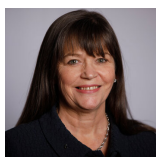


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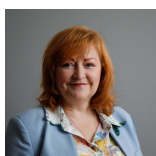
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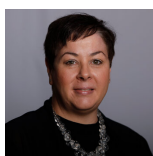
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Membership changes

1. The following changes to Committee membership occurred during the course of this inquiry:
 - On 17 December 2025, Gillian Mackay MSP replaced Patrick Harvie MSP as a member of the Committee.
2. The following declarations of interest were made during the Committee's scrutiny:
 - Dr Sandesh Gulhane MSP declared an interest as a practising NHS GP.
 - Emma Harper MSP declared an interest as a former NHS Scotland and NHS England employee and as a registered nurse.

Summary of recommendations

3. This report sets out the findings of the Health, Social Care and Sport Committee's scrutiny of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill at Stage 1.

Part 1: Non-surgical procedures

Non-surgical procedures - definitions and exemptions

4. Under the exemption from the Bill's provisions for procedures provided by health care providers for the prevention, diagnosis or treatment of an illness, the Committee notes that regulated healthcare professionals (who qualify as health care providers in this context) are defined as persons regulated by any of the eight councils listed in section 1(3). The Committee acknowledges that section 4(3) of the Bill goes on to define a shorter list of healthcare professionals who can provide or manage non-surgical procedures in an independent clinic registered with HIS – one of the categories of 'permitted premises' defined by the Bill. However, the Committee is concerned that listing these eight councils could create the impression that any of the healthcare professionals regulated by these eight councils could deliver these procedures in an independent clinic. Therefore, the Committee would recommend making clear in guidance accompanying the Act that, in order for an independent clinic to qualify as "permitted premises", there must be a healthcare professional who meets the narrower definition in section 4(3) either providing the services or managing them.

Permitted premises

5. The Committee acknowledges concerns expressed by some of those businesses currently providing non-surgical procedures about the Scottish Government's proposed approach to regulation of these procedures.
6. To alleviate these concerns, the Committee asks the Scottish Government to provide appropriate support and guidance to help responsible providers of non-surgical procedures to make the transition successfully to the new regulatory framework.
7. At the same time, the Committee recognises that patient safety must be the overriding priority. It supports the two-tiered approach being taken by the Scottish Government where higher risk procedures will only be permitted to be undertaken in permitted premises under supervision from authorised medical practitioners, and lower risk procedures will be subject to a licensing scheme to be introduced via secondary legislation.

Clinical oversight

8. The Committee highlights significant evidence from its Stage 1 scrutiny that the

Bill lacks detail on the question of clinical supervision including minimum requirements for supervision, clinical as well as managerial aspects of supervision, and minimum qualification requirements for those providing supervision. While acknowledging that a lot of this detail will need to be addressed in secondary legislation, the Committee calls on the Scottish Government, in responding to this report, to set out its proposed approach, including what precisely that secondary legislation will cover and provide the Committee with an update on discussions with the UK Government regarding UKIMA.

9. The Committee has gathered extensive evidence of a huge variability in the quality of training and qualifications available to and held or undergone by those currently providing non-surgical procedures. The Committee is firmly of the view that establishing clear and appropriate standards in this area will be critical to the Bill's successful implementation and enforcement. In this context, the Committee seeks assurance from the Scottish Government that secondary legislation related to the Bill (including Scottish and UK legislation) governing training, qualifications and standards will address the following:
 - UK-wide alignment of education and training standards;
 - ensuring all providers are suitably trained and qualified in health protection and infection control;
 - ensuring all providers are similarly suitably trained and qualified to be able to undertake patient mental health screening and to ensure properly informed consent;
 - ensuring all providers have a suitable level of training and qualification to be able to manage complications safely and effectively should they arise;
 - ensuring that people are unable to act as providers if the training they have received falls short of recognised standards.
10. As highlighted earlier in this report, the Committee has also heard evidence that having the status of a regulated health care professional does not, of itself, demonstrate any prior experience of the non-surgical procedures covered by the Bill that would be necessary to fulfil the supervisory responsibilities envisaged by the Bill to a suitably high standard. The Committee therefore reiterates its call for the Scottish Government, in responding to this report, to set out what minimum training and qualification standards within the discipline of non-surgical procedures covered by the Bill supervising clinicians will additionally be required to demonstrate.

Age restriction

11. In accordance with the evidence it has received during its scrutiny, the Committee strongly supports the provisions of the Bill that would make it an offence to provide any non-surgical procedure covered by the Bill to someone under the age of 18.

Enforcement, offences and penalties

12. The Committee has heard strong evidence to suggest that, as currently set out, the level of sanctions against those committing offences under the Bill will be an insufficient deterrent to those bad actors willing to commit repeat offences who may consider repeat fines to be an acceptable cost of continuing to operate outside the law. The Committee, therefore, calls on the Scottish Government to set stronger penalties for offences committed under the terms of the Bill.
13. The Committee also recognises that it may take time for responsible operators that want to comply with the law to take the steps necessary to achieve full compliance – and that there will also be a need for additional information and support to be provided to accompany the Bill’s implementation to help providers to take the steps necessary to comply with the law. The Committee calls on the Scottish Government to set out its plans in this area, including whether it plans to provide any financial support to businesses.
14. The Committee recommends that the Scottish Government engages meaningfully with independent aesthetic practitioners to understand how they will be impacted by the Bill, what forms of support would be most helpful and to ensure they are kept informed during the implementation process.
15. The Committee is therefore strongly supportive of a staged approach to enforcement that gives responsible operators the time and support they need to achieve full compliance while appropriately punishing those irresponsible operators that commit repeat offences and show no signs of taking the necessary steps to comply with the law.
16. The Committee has heard concerns as to whether Healthcare Improvement Scotland has sufficient capacity and resources to be able to enforce the Bill effectively once implemented. While acknowledging Healthcare Improvement Scotland’s long term ambition that its enforcement functions will become self-financing from registration fee income, the Committee seeks assurances from the Scottish Government that, in the short term, it is committed to putting in place the necessary additional funding to allow HIS to properly enforce the Bill from the outset and to amend the Financial Memorandum accompanying the Bill to reflect this.
17. The Committee calls on the Scottish Government to publish an implementation route map to ensure HIS has the systems and resources in place to adequately inspect and enforce the provisions of the Bill should it become an Act. This should include details and timescales for when suitable training, digital systems and evidence handling processes will be in place. It should also include details of how HIS will be expected to work with other agencies including Police Scotland and local authorities to enforce the provisions of the Bill and the related licensing scheme that is proposed to be regulated under the Civic Government (Scotland) Act 1982.

Data-gathering

18. The Committee has concluded from evidence that the implementation of this Bill offers an opportunity to gather much more systematic data on non-surgical procedures, including rates of complication and rates of success by individual procedure. More systematic data-gathering is also a prerequisite for effective implementation and enforcement of the Bill and to monitor and evaluate its impact.
19. The Committee further notes suggestions that Health Improvement Scotland would be well placed to fulfil a data-gathering function as part of its enforcement of the Bill but that fulfilling such a role would require the commitment of additional resource. The Committee therefore calls on the Scottish Government, in responding to this report, to set out what additional data-gathering it anticipates taking place as part of the Bill's implementation, who will be responsible for gathering this data and what, if any, additional resources will be made available to support data-gathering.

Public awareness

20. The Committee notes a general consensus in evidence around the need for the Bill's implementation to be accompanied by a public information campaign to raise awareness of the risks associated with certain non-surgical procedures and to explain how the law is changing in this area. The Committee therefore calls on the Scottish Government to commit the necessary resources to support such a campaign and to amend the Financial Memorandum accompanying the Bill to reflect this.

Wider issues

21. While acknowledging that the regulation of advertising of non-surgical procedures is outside the scope of the current Bill and is a policy area largely reserved to the UK Government, the Committee calls on the Scottish Government to set out what further steps it intends to take, in collaboration with the UK Government where appropriate, to tackle the negative impact of misleading advertising of non-surgical procedures.
22. The Committee is similarly concerned by evidence it has received regarding the classification and regulation of certain substances used in non-surgical procedures. It therefore calls on the Scottish Government to indicate what further action it will take to address these concerns, where appropriate in coordination with the UK Government and the Medicines and Healthcare products Regulatory Agency.
23. The Committee acknowledges concerns that a rise in costs and reduced accessibility of procedures covered by the Bill resulting from its implementation could result in some consumers engaging in cosmetic tourism to access these procedures elsewhere in the UK or abroad. The Committee concludes that this risk further reinforces the case for a public information campaign to accompany the Bill's implementation to allow individuals to make properly informed decisions

about whether, how and where they access these procedures.

Part 2: Certification of death and authorisation of cremation

24. The Committee is supportive of the changes proposed in Part 2 of the Bill, noting that allowing interested persons to request a review of a MCCD even when it has already been randomly selected for review will make the process more fair and that removing the need for further authorization when someone has died outwith Scotland but within the UK will avoid unnecessary delays and duplication of work.

Recommendation on the general principles of the Bill

25. In conclusion, the Health, Social Care and Sport Committee draws its conclusions and recommendations on the Bill to the attention of the Parliament and recommends that the general principles of the Bill be agreed to.

Introduction

26. The Scottish Government introduced the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill in the Scottish Parliament on 8 October 2025. The Health, Social Care and Sport Committee was designated as lead committee for Stage 1 consideration of the Bill on 28 October 2025.
27. Under the Parliament's Standing Orders Rule 9.6.3, it is for the lead committee to report to the Parliament on the general principles of the Bill. In doing so, it must take account of views submitted to it by any other committee. The lead committee is also required to report on the Bill's Financial Memorandum, taking account of any views submitted to it by the Finance and Public Administration Committee.
28. The Bill and its accompanying documents are available on the [Scottish Parliament website](#).
29. The Scottish Parliament Information Centre (SPICe) has published a [briefing on the Bill](#).
30. The Bill is comprised of two parts, which are unrelated to one another.
31. Part 1 of the Bill will make it illegal to provide certain types of procedures to people under the age of 18. It will only be legal to provide these services from properties that meet certain requirements. The procedures covered by the Bill are ones that:
 - pierce or penetrate the skin;
 - are not provided as part of the health service;
 - are not provided by a health care provider for the purposes of treating illness, and;
 - are not regulated under a type of licensing scheme set out in the Civic Government (Scotland) Act 1982.
32. [The Civic Government \(Scotland\) Act 1982 \(Licensing of Non-surgical Procedures\) Order 2026](#) was laid by the Scottish Government on 9 January 2026. The Order establishes a new licensing scheme for certain lower risk aesthetic and beauty procedures that will not be regulated under this Bill, as mentioned above. The Order will be scrutinised by the Committee separately from the Bill. The Policy Note published with the Order explains the Scottish Government's two tiered approach to regulation:

” The Scottish Government has grouped procedures into those which require the input of a health care professional, whether for initial consultation and the prescribing of medicines or to treat any complications which might arise, and those which do not. The former category are the subject of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill and the latter are to be subject to a licensing regime run by local authorities put in place by this Order. This Order and primary legislation form a suite of legislation which will regulate non-surgical procedures, ensuring they take place in appropriate settings where standards of hygiene and safety can be met. ¹

33. A full list of the procedures included is contained in schedule 1 of the Bill. The Bill includes a power for this list to be changed in the future. These procedures might be done for cosmetic or for wellbeing purposes. They could include a dermal filler injection or a stronger chemical peel.
34. The Bill also allows the Scottish Government to introduce more restrictions and requirements for these types of procedure in the future. This could include:
 - saying who can provide them;
 - what sort of training or qualifications are needed to provide them;
 - how the rules around them are enforced.
35. Part 2 of the Bill changes the Certification of Death (Scotland) Act 2011, it will:
 - change when someone can request a review of a medical certificate of cause of death, and when a request for a review can be rejected;
 - remove the need for authorisation of applications for cremation when someone dies outwith Scotland, but in another part of the UK, and is going to be cremated in Scotland.

Background to Part 1 of the Bill

36. Following introduction, Jenni Minto, the Minister for Public Health and Women's Health, stated on 9 October 2025:
- ” Our aim is to ensure there is robust and proportionate regulation in place so that anyone who chooses to have these procedures can do so safely.
- We have worked with a range of stakeholders including business owners, healthcare professionals, non-healthcare practitioners, environmental health officers and professional regulators to develop our proposals.
- Our priority is to address the public safety concerns that exist in this sector, whilst ensuring businesses that may be impacted are able to access support.²
37. For many years, there have been reports of people having suffered harm caused by 'botched' cosmetic procedures. Scotland was recently dubbed the 'worst in Europe' for such cases as [reported by the BBC](#).
38. The Bill's Policy Memorandum notes that:
- ” When procedures go wrong, this can lead to harms ranging from mild to more serious, including permanent disfigurement. Some of these harms can require treatment from the NHS, adding pressure to these already-stretched services. While the Scottish Government is not aware of any reported deaths in Scotland, in September 2024 media reported the death in England of a 33-year-old woman following complications after undergoing a liquid buttock augmentation procedure.³
39. The Medical and Dental Defence Union of Scotland (MDDUS) conducted a survey in October 2024 which asked medical professionals about their experiences treating patients who had been injured by unregulated cosmetic procedures. [Reported widely in the media](#), the survey found that, for respondents working in a medical field in Scotland:
- 35% had treated patients who have needed care following complications from unregulated cosmetic procedures;
 - 86% thought that the number of patients each year seeking care following complications in unregulated cosmetic treatments has increased;
 - 1% had treated someone under the age of 16, and 16% had treated someone between the ages of 16 and 20 following complications from unregulated cosmetic procedures.

Provisions of the Bill

40. This section will consider the main provisions of the Bill.

Part 1: Non-surgical procedures

41. The main aim of Part 1 of the Bill is to regulate the provision of non-surgical procedures. Section 1(a) defines a non-surgical procedure. Section 1(b) outlines procedures that are exempt from the Bill.

42. Section 2 creates an offence of providing a non-surgical procedure to a person under the age of 18.

43. Section 3 create an offence of providing a non-surgical procedure outwith a permitted premises and section 4 goes on to define "permitted premises".

44. Section 5 of the Bill gives Scottish Ministers the power to make regulations that set rules, qualifications, and enforcement measures for non-surgical procedures, tailored to different risk levels and subject to parliamentary approval. Through these regulations Scottish Ministers can:

- apply different rules to non-surgical procedures based on their risk level, including setting hygiene standards or restricting certain treatments for people with certain health conditions
- set rules on who can perform or supervise non-surgical procedures, and what qualifications or training they must have, while ensuring these rules align with existing UK medicines legislation
- assign responsibility for enforcing the rules on non-surgical procedures to specific relevant bodies
- create offences, such as performing procedures without proper qualifications, with penalties capped at a level 5 fine.

45. Section 5 of the Bill gives Scottish Ministers the power to make regulations that set rules, qualifications, and enforcement measures for non-surgical procedures, tailored to different risk levels and subject to parliamentary approval. Through these regulations Scottish Ministers can:

- apply different rules to non-surgical procedures based on their risk level, including setting hygiene standards or restricting certain treatments for people with certain health conditions
- set rules on who can perform or supervise non-surgical procedures, and what qualifications or training they must have, while ensuring these rules align with existing UK medicines legislation
- assign responsibility for enforcing the rules on non-surgical procedures to specific relevant bodies
- create offences, such as performing procedures without proper qualifications,

with penalties capped at a level 5 fine.

46. Sections 6-10 of the Bill provide new inspection powers for Healthcare Improvement Scotland (HIS) under enforcement, to investigate unregistered settings suspected of breaching the law. These powers include:
- Entering Premises - A person authorised by HIS can enter places where they suspect non-surgical procedures are being provided illegally, for example, in an unregistered salon.
 - Searching and Seizing Evidence - A person authorised by HIS can search the premises and take items (like equipment or records) if they believe the law is being broken, to gather evidence to help with legal action or prosecution.
47. Section 11 create an offence of a person to deliberately obstruct, fail to comply with a direction from or fail to provide information or assistance to a person authorised by HIS while they are investigating an offence.
48. Section 12 sets out penalties for a person who commits an offence under section 2, 3 or 11, who will be liable on summary conviction to a fine not exceeding level 5 on the standard scale (under the Criminal Procedure (Scotland) Act 1995 this currently means a fine of £5,000).
49. Section 14 introduces schedule 2 of the Bill, which makes amendments to the National Health Service (Scotland) Act 1978. These changes clarify that HIS has responsibilities under the Bill, including helping to improve how non-surgical procedures are provided. If a service registered with HIS does not meet the required standards, HIS can treat this as a breach under the 1978 Act and may propose to cancel its registration if it does not improve within the time given in an improvement notice.

Part 2: Certification of death and authorisation of cremation

50. Part 2 of the Bill focuses on updating the processes by which Medical Certificate of Cause of Death (MCCDs) are processed in Scotland. The main aims of this part of the Bill are to:
- allow more MCCDs to be reviewed, by expanding the types of death certificates that can be checked by a medical reviewerⁱ, and
 - simplify cremation rules, by removing the need for a medical reviewer to authorise cremation if the person died elsewhere in the UK but outside Scotland.
51. Section 16 of the Bill updates the rules set out in the Certification of Death (Scotland) Act 2011 about when an interested person, for example, a family

ⁱ A Medical Reviewer is a senior doctor working for the HIS Death Certification Review Service (DCRS) who independently reviews MCCDs to ensure accuracy and quality.

member or carer, can ask for a review of a death certificate.

52. The Bill extends the circumstances in which an interested person can request a review of an MCCD. This makes it possible for more than one review to be conducted under section 4 of the 2011 Act, for example, where new evidence has come to light.
53. It also expands the grounds on which a reviewer may decide to reject an application (rather than solely on the basis that it is deemed 'vexatious'). A medical reviewer can now also reject a request for review if:
- it is identical or very similar to one already being reviewed
 - the reviewer thinks it's not appropriate for other reasons.

If a request is rejected, the reviewer must explain why to the person who applied.

54. Section 17 of the Bill updates cremation rules set out in the Certification of Death (Scotland) Act 2011. Under the 2011 Act, medical reviewers have the function of ensuring that it is safe to cremate the body of anyone who dies overseas, or in the rest of the UK, and who is to be cremated in Scotland. For example, the medical reviewer will check medical records to see if the person has any implants or a pacemaker that would need to be removed prior to cremation.
55. The Bill updates this rule so that medical reviewers only undertake this review if a person dies outwith the United Kingdom and cremation is intended in Scotland. The [Policy Memorandum](#) states that this is because when a death occurs in another part of the UK the MCCD would already have gone through the requisite review processes and further review in Scotland would not be required. The amendment to the 2011 Act is intended to recognise the reciprocal checks within the UK, avoiding unnecessary duplication.

Part 3: Final provisions

56. Sections 18 to 21 of the Bill cover ancillary provision, regulation-making powers, commencement and short title.

Consideration by other committees

57. The Finance and Public Administration Committee issued a call for views on the estimated financial implications of the Bill as set out in its accompanying Financial Memorandum. This was open for submissions between 31 October 2025 and 26 November 2025 and received [46 responses](#). The Finance and Public Administration Committee agreed to forward the submissions to this Committee and take no further action.
58. The Delegated Powers and Law Reform (DPLR) Committee considered the Bill at its meetings on 28 October, 25 November and 9 December 2025.
59. The DPLR Committee published a [report](#) on 10 December 2025 in which it set out conclusions and recommendations. In particular, the DPLR Committee raised questions regarding the rationale for introducing the Bill before the United Kingdom Internal Market Act (UKIMA) position is resolved and the breadth of the enabling power in section 5(1) which it put to the Minister in charge during an evidence session. The DPLR Committee highlighted to the Health, Social Care and Sport Committee the breadth and unusually open-ended nature of the power in section 5(1) and recommended that the lead committee considers whether the power could be limited, for instance, by adding statutory consultation requirements or guiding principles to ensure its use is evidence-based and compatible with public health.

Health, Social Care and Sport Committee consideration

60. The Committee issued two calls for views which were open for submissions between 10 October 2025 and 14 November 2025:

- A structured call for views for stakeholders and organisations. The [responses](#) have been published on Citizen Space.
- A digital platform aimed at gathering the views and experiences of individuals who have experience of accessing and receiving, or providing, non-surgical procedures. The [responses](#) have been published on Your Priorities.

The Committee received a combined total of 153 responses to the calls for views. The Scottish Parliament Information Centre (SPICe) published a [summary of written submissions](#) on the Scottish Parliament website.

61. The Committee took formal oral evidence on the Bill during December 2025 (see further Annex A):

- On 2 December 2025, the Committee held a private session with the supporting Bill teams from the Scottish Government. The Committee also took evidence from a panel representing consumers and individual practitioners, and then from a panel of industry representatives
- On 9 December 2025, the Committee took evidence from a panel of healthcare representative bodies, and then from a panel of regulators, enforcers and inspectors
- On 16 December 2025, the Committee took evidence from a panel focused on Part 2 of the Bill. The Committee then concluded its oral evidence programme by taking evidence from the Minister for Public Health and Women's Health and supporting officials from the Scottish Government.

62. The Committee thanks everyone who provided evidence as part of its Stage 1 consideration of the general principles of this Bill.

Part 1 - Regulation of non-surgical procedures

63. This section will consider the evidence the Committee has gathered during its scrutiny of Part 1 of the Bill.

Non-surgical procedures - definitions and exemptions

64. This part of the report considers the definition of "non-surgical procedure":

- Section 1 of the Bill defines the meaning of "non-surgical procedure".

65. Section 1(1) of the Bill provides a general definition of what a non-surgical procedure is, that is a procedure that:

- pierces or penetrates a person's skin, including by means of a needle, chemical, medicine, heat, cold, light, laser, sound or electricity; and
- is set out in schedule 1 of the Bill (see examples of procedure at Annexe C).

It does not include a procedure:

- that is provided by a person acting for or on behalf of the health service,
- by a health care provider for the prevention, diagnosis or treatment of an illness, or
- is designated by an order under section 44(1)(b) of the Civic Government (Scotland) Act 1982 as an activity for which a licence is required under Part 1 of that Act.

66. Therefore, procedures that are provided by healthcare providers for the prevention, diagnosis or treatment of an illness are exempt from the Bill's provisions. The definition of "healthcare provider" is defined in section 1 of the Bill as including, an independent health care service that is registered with HIS, a regulated health care professional, or a person who, in providing the procedure, is acting in accordance with the directions of a regulated health care professional. Section 1(3) of the Bill includes the full list of regulators as set out in existing legislation and defines "regulated health care professional" to mean a person regulated by one of the following:

- the General Medical Council
- the General Dental Council
- the General Optical Council
- the General Osteopathic Council
- the General Chiropractic Council
- the General Pharmaceutical Council
- the Nursing and Midwifery Council
- the Health and Care Professions Council

67. In written correspondence to the Committee, Scottish Government officials have explained that the reason for exempting procedures provided by a regulated healthcare professional for the prevention, diagnosis or treatment of an illness is to ensure that:

” The Bill will not interfere with the delivery of health care. Schedule 1 of the Bill sets out the procedures which are to be regulated and some of these procedures may be provided for a health care purpose ... Without the health care exclusion set out in section 1(1)(b)(i) and (ii) of the Bill, a range of procedures capable of being provided for a health care purposes would be inadvertently captured by the Bill. ⁴

68. During the inquiry, some members of the Committee expressed concern that this exemption created a potential loophole. This concern was addressed by Scottish Government officials, who explained:

” Members were concerned that the exemption could be misused to allow regulated health care professionals to carry out procedures with a purported, but contrived, health care purpose. We cannot exclude the possibility that a regulated health care professional could seek to misuse the exemption in this way. However, as noted above, in section 4(3), the Bill requires specified persons to provide or manage non-surgical procedures within a permitted premises. Therefore, if a concern was raised that a regulated health care professional was providing non-surgical procedures outwith the permitted premises listed in section 4 of the Bill and for a purpose which did not fall within the health care exclusion in section 1(1)(b), Healthcare Improvement Scotland (HIS) would be able to investigate this using the powers set out in the Bill.⁴

The officials added that, where a regulated healthcare professional claimed to have undertaken a procedure for a health care purpose, this claim could be considered through legal proceedings, and they could be successfully prosecuted.

69. Under the exemption from the Bill’s provisions for procedures provided by health care providers for the prevention, diagnosis or treatment of an illness, the Committee notes that regulated healthcare professionals (who qualify as health care providers in this context) are defined as persons regulated by any of the eight councils listed in section 1(3). The Committee acknowledges that section 4(3) of the Bill goes on to define a shorter list of healthcare professionals who can provide or manage non-surgical procedures in an independent clinic registered with HIS – one of the categories of ‘permitted premises’ defined by the Bill. However, the Committee is concerned that listing these eight councils could create the impression that any of the healthcare professionals regulated by these eight councils could deliver these procedures in an independent clinic. Therefore, the Committee would recommend making clear in guidance accompanying the Act that, in order for an independent clinic to qualify as “permitted premises”, there must be a healthcare professional who meets the narrower definition in section 4(3) either providing the services or managing them.

Permitted premises - the Scottish Government's proposed approach

70. This part of the report considers provisions in the Bill that relate to "permitted premises":

- Section 3 of the Bill creates an offence of providing a non-surgical procedure outwith permitted premises
- Section 4 of the Bill defines the meaning of "permitted premises".

71. One of the main provisions of the Bill is that it will become an offence to provide a non-surgical procedure outwith permitted premises. "Permitted premises" are

defined in the Bill as:

- Independent Hospitals that are registered with Healthcare Improvement Scotland (HIS).
- Independent clinics that are registered with HIS, and where those services are provided or managed by specific qualified individuals (defined in section 4(3) of the Bill).
- Certain NHS-related premises (subject to conditions) including:
 - Dental surgeries providing general dental services under section 25 of the National Health Service (Scotland) Act 1978 (this does not include dwellings (for example private homes) or care homes).
 - GP practices listed in agreements under section 17C or contracts under section 17J of the 1978 Act, where primary or general medical services are provided (as above, this does not include dwellings or care homes).
- Registered pharmacies, defined under section 74 of the Medicines Act 1968.

72. Only independent clinics whose services are provided or managed by certain persons who are listed in subsection (3) fall within the definition of “permitted premises” (see subsection (1)(b)(ii)). The persons listed in subsection (3) are—

- a registered medical practitioner
- a person registered in the dentists register under the Dentists Act 1984,
- a nurse independent prescriber
- a midwife independent prescriber
- a pharmacist independent prescriber

73. The Bill's Policy Memorandum explains why the Scottish Government feel this is the best approach:

” The Bill will ensure that those non-surgical procedures regulated by the Bill are only provided from appropriate settings (referred to in the Bill as ‘permitted premises’). It will be an offence for a person to provide a procedure outwith permitted premises ... Where procedures take place in a Healthcare Improvement Scotland (HIS) regulated setting, HIS will be able to use existing powers to support high standards of safety and quality. The Bill also provides a new enforcement power for HIS to inspect settings which are not required to register with them, but where they have reasonable grounds to believe that an offence under the Bill has been/is being committed, or the setting is being used in connection with an offence.³

Alternative approaches

74. The Committee heard throughout its scrutiny that while most stakeholders agreed that stronger regulation is needed to improve safety and raise standards across the non-surgical procedures and aesthetics sector, views differed on how that

regulation should work.

75. The Committee heard from many stakeholders that the Bill as proposed is likely to have a significant impact on the businesses and livelihoods of independent aesthetic practitioners. In particular, the requirements of HIS registration, particularly the need for a healthcare professional to supervise procedures, to meet the definition of "permitted premises" would be impractical for many small businesses and sole traders. Many respondents to the Committee's call for views argued that the impact would unfairly disadvantage independent women-led businesses and that this may lead to financial hardship should businesses have to close.
76. Some respondents also raised concerns of the potential impact on local communities, services and high streets, should small businesses close. One individual respondent expressed a view that:
- ” Many businesses will close, putting pressure on national finance due to a rise in benefit claims. Health services will be affected because of a decrease in mental health. High streets will suffer, which leads to less tax revenue and public spending losses. This will create a snowball effect of job losses and lack of public services.⁵
77. In a written submission, aesthetic business Adore Aesthetics described how the proposed changes in the Bill would personally impact the respondent as a small business owner:
- ” I run a small business in aesthetics I have a cabin in my garden I have ran this business for 4 years. I work safely and always put my clients' safety first. I'm a single mum that did dental nursing for 12 years before I trained in aesthetics. I have worked so so hard to build my business up and now can earn enough for me and my family. I can't afford this to change for me and my kids' future ... I have 2 kids, I'm a single mum not claiming benefits. I'm trying so so hard to provide for my family. I run my own business from home now my business can close because of the new proposals I can't make the same income on facials. I will not go into nursing just to do aesthetics it's not morally right at all to use the NHS to then leave to do the job I'm doing. There needs to be some kind of outcome to help people like me stay in business without having to be HIS registered.⁶
78. During oral evidence, Louise Caithness from Zest Group Scotland argued that the Bill would make it difficult for more flexible business models such as home working arrangements to continue:
- ” We have seen a huge increase in practitioners working from home or in, say, cabins in their gardens—that sort of arrangement—and that approach has been working extremely well, allowing predominantly women and mothers to carry the burden of childcare and work in a safe environment at home and in an environment that is accessible to their clients, too. Under the HIS framework, it would be virtually impossible for such practitioners to convert their place of work and meet the necessary arrangements, just because of the practicalities of where they are working from, and because of financial considerations, too.⁷
79. Several non-medic aesthetic businesses and practitioners proposed an alternative

tiered approach reflecting the risk levels of different procedures. This was centred around including more procedures in a local authority licensing model, similar to what they describe as England's risk-based model, rather than restricting them further to healthcare professionals. As noted, above certain lower risk non-surgical procedures will be regulated by a separate licensing scheme, however, some stakeholders felt more procedures should be regulated in this way. The written submission from aesthetics clinic Flawless Aesthetics states:

” A phased, risk-based licensing model for both premises and practitioners would better maintain access while raising standards...I recommend adopting a dual licensing system (practitioner + premises) with tiered risk levels, a transition period, and clear recognition of existing safe practice supported by prescribers.
8

80. During oral evidence, Tina McCaffery from Skin Religion Aesthetics and the Non-Medics Aesthetics Committee told the Committee that:

” All of our members say that they would prefer the licensing route, as it would mean the industry being governed in a very similar way to the licensing that is already available for various things such as microblading, tattooing and so on, in comparison with what is going on in Scotland. There is also a lot of concern about how the Scottish approach to regulation and the licensing approach in England will work together, given that the two models are so different in style.⁷

81. Many responses to the Committee's call for views highlighted a perceived bias in the Bill in favour of medical professionals, arguing that non-medics with advanced training feel unfairly excluded from the regime created by the Bill, despite their view that they are competent to provide the procedures included. Several respondents called for inclusive regulation that recognises competence as opposed to a focus on job titles. One written submission from the aesthetics clinic LMA states:

” I believe Part 1 of the Bill shows a clear bias towards medical professionals, despite the fact that many aesthetic procedures are safely and effectively carried out by trained, experienced non-medics. Treatments such as microneedling are not medical procedures and should not be treated as such. Requiring aesthetic treatments to be carried out only in medical settings is unnecessary and unrealistic.⁹

82. In oral evidence, Louise Caithness from the Zest Group Scotland proposed that the Bill should be more focused on training requirements. In particular, she argued that qualifications held by non-medical aesthetic practitioners should be recognised and that the current focus on supervision by a healthcare professional does not guarantee that those supervising have sufficient knowledge of aesthetics procedures:

” For the bill, the committee must consider a fair framework that ensures that we look really hard at robust training. Doing a general nursing, medical or dental degree is not a necessary prerequisite for the delivery of treatments that are less invasive. We must look at what the regulatory framework of training produces and ensure that people who want to work in the industry follow that particular framework, regardless of what their background is. There are practitioners working in the industry at the moment who are working very safely but who do not come from medical backgrounds, and they should not be unfairly disadvantaged because of a new bill.⁷

83. Conversely, healthcare professionals, who provide aesthetic procedures in HIS regulated clinics already, argued that the Bill would create a level playing field by ensuring all providers have to meet the same standards. For example, the written submission from the British Association of Medical Aesthetic Nurses (BAMAN) argued:

” For healthcare professionals who already work to high standards, including BAMAN members, the introduction of this Bill will formalise and validate the practices they have upheld for years. It will protect their patients, enhance their professional reputation, and begin to remove the unfair commercial advantage currently enjoyed by unregulated competitors who do not carry the same responsibilities. For these practitioners, the Bill will help to level the playing field by ensuring that all providers are held to the same minimum standards of safety, training, and accountability.¹⁰

84. During oral evidence, Jacqueline Cooney from the Scottish Medical Aesthetics Safety Group expressed a similar view, arguing that healthcare professionals already adhere to HIS regulation:

” 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.¹¹

85. Correspondence received by the Committee from the British College of Aesthetic Medicine argued that negative commercial impacts on some businesses was justified to prioritise patient safety:

” Some non-medical practitioners and unregulated businesses may be adversely affected, particularly those who cannot meet HIS standards or lack appropriate qualifications. However, from a patient safety perspective, this is a justified outcome. The Bill prioritises protection over commercial interest.¹²

86. The Committee heard throughout its scrutiny that the Bill is likely to impact access to procedures for consumers. Some respondents raised the issue that there may not be enough prescribers available to oversee procedures. For example, Lynsey Wilson from Scottish Aesthetics Safety and Standards highlighted during oral evidence that:

- ” The Scottish Government does not have any data on how many prescribers are qualified in aesthetics and can therefore oversee that process. There might be a risk of prescribers leaving NHS services and moving into private clinics, or of clinics being forced to close if we cannot find enough prescribers to facilitate them, which will mean consumers not having the safe access to treatment that they previously had.⁷
87. Correspondence sent to the Committee by Tina McCaffery, on behalf of the Non-Medics Aesthetics Committee and Skin Religion Aesthetics, highlighted that access to procedures in rural areas is particularly likely to be impacted by the availability of prescribers:
- ” Rural and island areas (Highlands, Western Isles, Orkney, Shetland, Argyll & Bute) have very limited prescriber coverage, with some areas relying on a small number of clinicians covering vast geographic regions. Many existing aesthetic prescribers already work at or near capacity and provide remote or sessional support, rather than being physically present full-time. This geographical imbalance means that a regulatory model requiring on-site or constant prescriber presence is structurally incompatible with large parts of Scotland ... The Government's own Island Communities and Equality & Fairer Scotland Impact Assessments acknowledge that distance, affordability and workforce shortages already limit access. If HIS becomes the sole gateway to legal treatment provision, those barriers increase significantly.¹³
88. Some consumers of non-surgical procedures submitted written responses to the Committee's call for views expressing concern that they would have less choice to have procedures done in their preferred environment under the Bill's proposed regulations. For example, one consumer said:
- ” As someone who would like to access these treatments and procedures, I would not feel comfortable having my only choice being a medical setting or HIS regulated clinic. I feel these treatments are elective cosmetic treatments and I, as a consumer, would like to have the choice to go to a beauty salon or skin clinic for these treatments as we have done so for many years safely. The cost would most likely be much more in a medical setting, I do not find the client care is there as it seems they do not have the passion needed for this profession and everything is far too clinical. I also do not want to be referred to as a patient as I am not ill. This will put me off from booking these treatments in the future if I am going to be stopped from going to my preferred Beauty Salon.¹⁴
89. Louise Caithness from the Zest Group Scotland told the Committee during oral evidence that the Bill was likely to make procedures too expensive for some consumers and limit choice:
- ” The cost of treatment has to be considered as well. If this becomes a hugely costly exercise for businesses, the burden of cost will be passed on to the consumer. We will not be accessible for those who are priced out of our reach, so it is an economic issue. Moreover, we have an audience of clients who do not want to go to a medical space for treatments and who take great comfort in visiting a non-healthcare or non-medical environment.⁷

90. On the other hand, Jacqueline Cooney from the Scottish Medical Aesthetics Safety Group argued during oral evidence that, while procedures may become more expensive for consumers due to the impact of the Bill, the current low cost of some procedures may point to the use of unlicensed devices (products or equipment that lack official approval for medical use e.g. medicines without a Medicines and Healthcare Products Regulatory Agency (MHRA) licence or devices without UK Conformity Assessed (UKCA) or CE marking or used outside their certified purpose):

” 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. ¹¹

91. During oral evidence, Victoria Brownlie from the British Beauty Council described the proliferation of procedures being provided at lower prices and the increased demand for procedures as a risk to patient safety:

” In relation to the accessibility and availability issues, we found that there has been a huge influx of people offering these treatments, because they have seen an easy and accessible way to make good money and careers out of them. I should say, and I have said previously, that a lot of people who are doing that are doing so with great levels of training and competence and are having very few things go wrong. However, there are others who are taking part in what is essentially a race to the bottom—a race to cheap prices—and they are in competition with each other because becoming a provider is so much more accessible than it was five or 10 years ago. That puts at risk vulnerable adults—especially young adults, who are impressionable ... 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. ⁷

92. The Bill's Policy Memorandum outlines alternative approaches that the Scottish Government has considered and the reasons for choosing the approach proposed in the Bill. It explains that the Scottish Government did consider if it would be possible to regulate all non-surgical procedures that pierce or penetrate the skin via a local authority licensing scheme, such as the one proposed for lower risk procedures (The Civic Government (Scotland) Act 1982 (Licensing of Non-surgical Procedures) Order 2026). However, the Scottish Government felt there were several factors this approach would not take account of:

” That many of these procedures are performed in independent health care settings that are or should be regulated by HIS; that they require anatomical or physiological knowledge which necessitates an aspect of medical expertise in their regulation; that some procedures require the use of prescription-only medications, which have their own regulatory environment outwith the sphere of knowledge of EHOs [Environmental Health Officer]; and that some procedures should only be undertaken or supervised by a healthcare professional with the appropriate level of anatomical and physiological training and so that regulation can only effectively be undertaken by individuals who understand what that requires. HIS was the obvious choice to carry out that more specialist regulation.³

93. The Policy Memorandum also addresses concerns about disparity with the regulations proposed in England saying that:

” These proposals would currently appear to place a greater range of procedures under local authority licensing, but the model of supervision that would be required has not yet been settled. The Scottish Government remains confident that its proposed model is the most appropriate one for Scotland.³

94. The Committee acknowledges concerns expressed by some of those businesses currently providing non-surgical procedures about the Scottish Government's proposed approach to regulation of these procedures.

95. To alleviate these concerns, the Committee asks the Scottish Government to provide appropriate support and guidance to help responsible providers of non-surgical procedures to make the transition successfully to the new regulatory framework.

96. At the same time, the Committee recognises that patient safety must be the overriding priority. It supports the two-tiered approach being taken by the Scottish Government where higher risk procedures will only be permitted to be undertaken in permitted premises under supervision from authorised medical practitioners, and lower risk procedures will be subject to a licensing scheme to be introduced via secondary legislation.

Clinical oversight, risk and public safety

97. This part of the report considers provisions in the Bill that relate to "permitted premises":

- Section 4 of the Bill defines the meaning of "permitted premises".

This part of the report will also discuss the provisions in the Bill to create powers for Scottish Minister to make further restrictions on training requirements in relation to non-surgical procedures:

- Section 5 of the Bill creates power to make further provision about non-surgical procedures.

98. As noted above, the Bill seeks to protect public safety by restricting certain non-surgical procedures to permitted premises that are registered with HIS and whose services are provided or managed by a healthcare professional (defined in section 4(3)). The Committee has heard from many practitioners that for some procedures included in the Bill this level of oversight is not necessary due to the risk level of the procedures. For example, Louise Caithness from the Zest Group Scotland argued during oral evidence that some of these procedures can be safely provided by non-medical aesthetic practitioners with extensive training such as the relevant Office of Qualifications and Examinations Regulation (Ofqual) Level 7 in aesthetics. She argued that it is unfair to exclude these individuals from providing these procedures and conflate them with the people with very little or no training, who she argued were the ones causing the most harm:

” To put those with a non-medical background into one category with those who are defined as “wild west” is very unfair and nonsensical. We should consider the delivery of the treatments that are ultra-low risk. What is called a “skin peel” by name does not, by design, peel the skin at all, and the same can be said for skin needling. Those are very superficial, non-invasive treatments that pose an ultra-low risk. They are elective and nonmedical ... It is absolutely not necessary to have a medical individual present on site for certain procedures; after all, they are not medical treatments. ⁷

99. Conversely, the written submission to the Committee's call for views from BAMAN stressed that, while injectable treatments like botulinum toxin and dermal fillers are high-risk medical procedures, other ‘lower risk procedures’ also carry a level of risk:

” At present, procedures such as microneedling, superficial peels, and IPL treatments are routinely offered by people with no healthcare background, minimal training, and no obligation to adhere to standards of infection control, consent, or aftercare. This places patients at risk of complications that range from avoidable burns and infections to scarring and long-term dermatological damage. ¹⁰

100. In its written submission, the Royal College of Surgeons highlighted evidence that there can be “serious complications associated with some of these procedures including infections, blocked arteries, necrosis, blindness and stroke.” ¹⁵

101. During oral evidence Victoria Brownlee from the British Beauty Council highlighted that:

” The accessibility of the treatments that we have now has made procedures seem somewhat more frivolous than they perhaps were seen maybe a decade ago. Regulation and oversight from, say, Healthcare Improvement Scotland will be vital in hitting home the fact that these are procedures with a risk of complication and of things going wrong. ⁷

She went on to argue that healthcare professionals should be present to address possible complications:

- ” If there is an instance of an adverse reaction to injectables, I do not feel that non-healthcare practitioners have the competency, knowledge and availability of prescription-only medication to deal with such complications swiftly and as necessary. If we say that the primary focus of the bill is to address the risk to the public, we cannot have non-healthcare practitioners touching injectables. ⁷
102. Several witnesses agreed that the issue of complications in particular meant that healthcare professionals should be providing or closely supervising non-surgical procedures. During oral evidence, Jacqueline Cooney from the Scottish Medical Aesthetics Safety Group highlighted particular risks related to adverse reactions to the injection of hyaluronic acid:
- ” 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. ¹¹
103. In its written submission, Advice Direct Scotland presented a case study of lack of accountability and redress in the aesthetics sector when treatments go wrong:
- ” We recently handled a case for a customer in which they attended an aesthetician within a beauty salon for a consultation for facial filler. At this consultation, the customer was upsold dermal filler in multiple parts of the face that they did not initially request consultation for. Following the procedure being carried out, the customer experienced extreme swelling and pooling of fluid under the eyes. Upon contacting the aesthetician to inform of this, they were told it was an allergic reaction and to take antihistamines. When this did not work to bring down swelling, the customer then paid a further fee for some of the dermal filler to be dissolved, which only partially rectified the issue ... Although our adviser was able to provide advice on the next steps the customer could take from a consumer protection standpoint, they were left feeling that they had very limited avenues for meaningful recourse. Despite experiencing significant pain, investing considerable time, and paying £725 for the procedure which they were not happy with, they found few mechanisms to hold the aesthetician to account. The absence of a robust, industry-wide complaints or redress system meant that their options were largely confined to informal resolution which relies on the practitioner’s willingness to engage. As a result, the customer was left dissatisfied with both the process and the outcome of their treatment. ¹⁶
104. The Committee heard that many stakeholders are concerned that the Bill does not clearly define what the requirements for clinical oversight should be. Several witnesses raised the issue that the Bill should more clearly define the meaning of supervision, including whether the supervising medical professional would be required to be physically present at the premises. For example, Amanda Demosthenous from BAMAN argued that there should be clearer requirements for the maximum number of practitioners that a single prescribing medical professionals could supervise at the same time:

” 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. ¹¹

105. Douglas White from Consumer Scotland called for clarity on what clinical oversight should look like to help consumers understand what to expect:

” The Scottish bill, in referring to what happens when regulated healthcare practitioners are on site, includes language about procedures being undertaken under their management or “in accordance with” their direction. It would be helpful to have some more clarity on that so that consumers know what exactly it means in practice. ⁷

106. During oral evidence, Victoria Brownlee from the British Beauty Council raised the issue that different types of procedures will need different levels of supervision, arguing that:

” You cannot have a one-size-fits-all approach to supervision. Some procedures will require a person to be physically in the room to oversee a procedure when it takes place, whereas other, much lower-risk procedures will still require some level of supervision—for example, by a listed person who can be on the other end of a phone should something go wrong. ⁷

107. During oral evidence, the Minister for Public Health and Women’s Health told the Committee that the provisions of the Bill will improve the safety of procedures while still allowing non-healthcare professionals to provide procedures under supervision:

” Permitted premises will be safe, hygienic settings that will be subject to regulatory oversight and from which healthcare professionals will provide or manage services. The involvement of healthcare professionals also supports safe and appropriate prescribing and will enable those healthcare professionals to intervene in the event of complications ... There is room for a thriving nonsurgical procedure sector and an important continuing role for non-healthcare professionals in that sector but with some changes to current practice to support safety. ¹⁷

Training, competency and standards

108. Among respondents to the Committee’s call for views and oral evidence given, there was a general consensus on the need for robust training and national standards to ensure patient safety. The Committee heard from many people who felt that training standards should be included on the face of the Bill, while others felt these could be left to secondary regulations.

109. During oral evidence, Victoria Brownlee argued that there should be robust training both for the people supervising procedures and those who will be providing the procedures included in the Bill:

- ” There is no stipulation in the bill as to what education and training there should be. We can say until we are blue in the face that a Health[care] Improvement Scotland premises can offer only certain types of treatments, but ultimately there will still be non-healthcare practitioners potentially offering those treatments with supervision, and there is nothing in the bill to say that those people have to have a regulated or accredited qualification. There is nothing on the supervision and training requirements for the person who is undertaking the supervision and oversight.⁷
110. During oral evidence, Laura Boyce from HIS told the Committee she would appreciate further clarification around training requirements either in the Bill itself or as part of secondary legislation, suggesting that:
- ” 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.¹¹
111. During oral evidence, Paula McLaren from the Nursing and Midwifery Council similarly argued that:
- ” 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.¹¹
112. Several people argued that there should be training requirements for people supervising and providing aesthetic procedures regardless of medical background as training to be a healthcare professional does not necessarily mean someone has received training in aesthetic procedures specifically. Stefan Czerniawski from the General Dental Council argued that, while dentists are highly qualified healthcare professionals and so could act as supervisors under the Bill, they may not be trained in the specifics of aesthetic procedures:
- ” 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.¹¹
113. During oral evidence, Remmy Jones from Allied Health Professionals in Aesthetics argued that both a professional registration and specific training in aesthetic procedures should be required for those giving clinical oversight:
- ” 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.¹¹

114. Many businesses and practitioners called for mandatory minimum qualification for all practitioners, such as Office of Qualifications and Examinations Regulation (Ofqual) Level 7 as the benchmark for competence, alongside compulsory Continuing Professional Development (CPD) and competence checks. The written submission from Scottish Aesthetics Safety and Standards concludes:

” Risk of serious complications is extremely rare when a practitioner has undergone a high level of Aesthetics Qualifications such as the Level 7 which is a government approved qualification, the level 7 in aesthetics practice is currently the highest level of training that is provided for both healthcare and non healthcare professionals. This qualification covers pharmacology, anatomy, client consultation and assessment, managing complications, professional ethics and law and practical injection techniques. ¹⁸

115. Other stakeholders also suggested specific training and competencies practitioners should be expected to obtain before practising. For example, The British Beauty Council and the British Association of Beauty Therapy and Cosmetology provided suggested training requirements in their written submissions to the Committee:

” To avoid unwarranted variation in public safety, we urge the Committee to ensure the following are embedded in the legislative roadmap:

- UK-Wide alignment: We strongly recommend that the Scottish Government agrees on a UK-wide minimum standard for education and training – designating approved regulated qualifications as well as awarding bodies to prevent unscrupulous and poor quality course providers from operating.
- Infection control: All licensed practitioners should be required to demonstrate they hold the equivalence of a Royal Society of Public Health (RSPH) Level 3 qualification in Health Protection/Infection Control.
- Broad competency scope: Assessments must go beyond anatomy and technique to include patient mental health screening (psychological risk), informed consent, and complication management. ^{19, 20}

116. Similarly, during oral evidence Tina McCaffery from Skin Religion Aesthetics argued that training should include an understanding of the potential psychological impacts of aesthetic procedures, which she explained is included in the Ofqual Level 7 training:

” All practitioners must be required to have proper training in identifying clients who walk through the doors who are psychologically vulnerable to body dysmorphia. Although that is covered in the qualifications, nothing is really set out in the bill to ensure that such training happens. ⁷

117. The Committee heard that a complex training landscape has emerged in the aesthetic sector in recent years, with Douglas White from Consumer Scotland arguing that this makes it challenging for consumers to navigate and assess risks:

- ” At the moment, we have a range of different levels of qualifications in the market. We have regulated healthcare professionals delivering procedures, we have practitioners who have undertaken a lot of training and gone through specific qualifications to deliver procedures, and we have other practitioners who have very limited or even no training in delivering procedures. From a consumer perspective, it is clear that that system is far from ideal, because it is often not straightforward or easy for consumers to know what type of qualifications different practitioners might have and to understand what that means in terms of undergoing a safe procedure. The bill allows ministers to specify detailed requirements in relation to training and qualifications in secondary legislation, and we very much support that being taken forward.⁷
118. During oral evidence, Lynsey Wilson from the Scottish Aesthetics Safety and Standards highlighted the particular risks posed by training academies delivering inadequate training:
- ” For a number of years, there has been an influx of training academies offering substandard one and two-day training courses, which has resulted in a rise in complications across the industry. We believe that it is important to introduce training and qualifications to ensure that practitioners offering the treatments are competent, qualified, knowledgeable and able to offer safe treatments.⁷
119. Amanda Demosthenous from BAMAN similarly called for a "clampdown" on training academies:
- ” 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.¹¹
120. The Bill's Policy Memorandum explains that the Scottish Government has not included specific regulations about supervision and training due to the effects of the United Kingdom Internal Market Act 2020 (UKIMA):
- ” The Scottish Government also proposes that it is necessary to restrict the type of person who can undertake specific procedures. Under these proposals some procedures should only be performed by one of the healthcare professionals listed in the definition of permitted premises, and who has the appropriate experience and expertise, because of the high level of anatomical or physiological skill required. Other procedures do not appear to require this level of protection and can be safely carried out by a suitably trained non-healthcare practitioner under the supervision of a healthcare professional. It has however not been possible to include these provisions in the Bill due to the effects of the United Kingdom Internal Market Act 2020 (UKIMA).³
121. Part 3 of UKIMA establishes a UK-wide system for recognising professional qualifications – referred to as the automatic recognition principle. The automatic recognition principle means that if a person is authorised to practise a regulated profession in one part of the UK, they are entitled to practise that profession in any

other part without needing to re-qualify. If the Bill were to include qualification requirements or restrictions on who can undertake certain procedures, for example by requiring certain training or limiting procedures to specific healthcare professionals, it may engage Part 3 of UKIMA.

122. While regulations on training have not been included as part of the Bill, section 5 creates powers to make further provision about non-surgical procedures. This would give Scottish Ministers the power to make regulations that set rules, qualifications, and enforcement measures for non-surgical procedures, tailored to different risk levels and subject to parliamentary approval. In relation to training and qualifications, this could:

- specify persons, or descriptions of persons, who may provide, or supervise the provision of, a non-surgical procedure
- specify requirements about the training or qualifications of persons who may provide, or supervise the provision of, a non-surgical procedure.

123. The Committee highlights significant evidence from its Stage 1 scrutiny that the Bill lacks detail on the question of clinical supervision including minimum requirements for supervision, clinical as well as managerial aspects of supervision, and minimum qualification requirements for those providing supervision. While acknowledging that a lot of this detail will need to be addressed in secondary legislation, the Committee calls on the Scottish Government, in responding to this report, to set out its proposed approach, including what precisely that secondary legislation will cover and provide the Committee with an update on discussions with the UK Government regarding UKIMA.

124. The Committee has gathered extensive evidence of a huge variability in the quality of training and qualifications available to and held or undergone by those currently providing non-surgical procedures. The Committee is firmly of the view that establishing clear and appropriate standards in this area will be critical to the Bill's successful implementation and enforcement. In this context, the Committee seeks assurance from the Scottish Government that secondary legislation related to the Bill (including Scottish and UK legislation) governing training, qualifications and standards will address the following:

- UK-wide alignment of education and training standards;
- ensuring all providers are suitably trained and qualified in health protection and infection control;
- ensuring all providers are similarly suitably trained and qualified to be able to undertake patient mental health screening and to ensure properly informed consent;
- ensuring all providers have a suitable level of training and qualification to be able to manage complications safely and effectively should they arise;
- ensuring that people are unable to act as providers if the training they have received falls short of recognised standards.

125. As highlighted earlier in this report, the Committee has also heard evidence that having the status of a regulated health care professional does not, of itself, demonstrate any prior experience of the non-surgical procedures covered by the Bill that would be necessary to fulfil the supervisory responsibilities envisaged by the Bill to a suitably high standard. The Committee therefore reiterates its call for the Scottish Government, in responding to this report, to set out what minimum training and qualification standards within the discipline of non-surgical procedures covered by the Bill supervising clinicians will additionally be required to demonstrate.

Age restriction

126. This part of the report considers provisions in the Bill that relate to age restrictions set out in the Bill:
- Section 2 of the Bill creates an offence of providing a non-surgical procedure to a person under the age of 18.
127. In the Bill's Policy Memorandum the Scottish Government explained that they received considerable evidence from stakeholders during the consultation stage arguing that non-surgical procedures are unsuitable for those under the age of 18:
- ” Advice from clinical experts, evidence from professional bodies such as the Nuffield Council on Bioethics and the British Association of Aesthetic Plastic Surgeons, along with feedback from stakeholders, including responses to the Scottish Government’s public consultation on the regulation of non-surgical cosmetic procedures (which also covered some ‘wellbeing’ procedures such as vitamin infusions), made clear the view that these procedures are not suitable for young developing bodies, and that the potential physical and psychological harms that inappropriate procedures could do to young people mean they should only be carried out on adults.³
128. The Bill also contains a defence for an accused person to prove that they had taken reasonable steps to establish the person’s age, and that they reasonably believed them to be 18 or over. A non-exhaustive list of the types of documents that could be used to prove age is included.
129. There was widespread support for the offence proposed in the Bill for providing non-surgical procedures to under-18s. For example, Lynsey Wilson from the Scottish Aesthetics Safety and Standards said during oral evidence that: "We absolutely support the point that the treatments should not be carried out on anyone under 18,"⁷ while Louise Caithness from Zest Group Scotland agreed, arguing:
- ” For treatments that are purely about aesthetics and appearance, again, I do not think that it is good practice to deliver those to under-18s, and I agree that that restriction should definitely be covered in the bill.⁷
130. In its written submission to the Committee's call for views, Advice Direct Scotland

reported that it had received complaints about practitioners providing Botox injections and dermal fillers to individuals as young as fifteen. It felt that creating an offence of providing a non-surgical procedure to a person under 18 would "help to reduce the risk of harm to young people."¹⁶

131. In its written submission, BAMAN argued in favour of the proposed age restriction, raising the issue that young people are sometimes targeted by marketing for non-surgical procedures:

” The offence of providing a non-surgical procedure to a person under 18 is entirely appropriate and necessary. There is no medical justification for administering botulinum toxin or dermal fillers to children in a cosmetic context. Despite existing voluntary standards and professional guidance, these procedures have been marketed to and accessed by minors in some parts of the UK. Codifying this as a criminal offence sends a clear message that aesthetic treatments are medical interventions, not consumer products, and that children must be protected from the risks they carry.¹⁰

132. Amanda Demosthenous from BAMAN suggested that even 18-year olds may be too young to access these procedures as they are unlikely to be clinically justified. However, she went on to say, "I can absolutely see that, from a consent perspective, at the age of 18, people are likely to have an understanding of treatment procedures."¹¹ There was general agreement amongst witnesses that 18 was an appropriate age threshold for consenting to procedures.

133. One individual who responded to the Committee's call for views felt that the Bill's restrictions on non-surgical procedures would have a positive impact on young people who can sometimes be influenced and misled:

” I believe it will positively impact young people like me, injectables cause immense damage to the body and aren't as dissolvable as practitioners make out. The proliferation of these procedures I have seen skew the way women see themselves, and I would hope the bill could help mitigate this for its youngest users.²¹

134. In accordance with the evidence it has received during its scrutiny, the Committee strongly supports the provisions of the Bill that would make it an offence to provide any non-surgical procedure covered by the Bill to someone under the age of 18.

Enforcement powers and implementation

135. This part of the report considers provisions in the Bill that relate to offences and their enforcement:

- sections 2 and 3 create the two main offences (of providing a procedure to someone under the age of 18, or providing a procedure outwith permitted premises)

- sections 6 to 10 provide HIS with powers of entry, search and seizure to enable them to investigate whether offences under section 2 or 3 have been committed
 - section 11 creates a further offence of obstructing or failing to assist HIS in those investigations,
 - section 12 specifies the maximum penalties for the section 2, 3 and 11 offences, and
 - section 13 allows individuals as well as organisations to be prosecuted.
136. Overall, the Committee has heard that there is widespread support for the need for enforcement powers but there were differences of opinion on the best approach to this. Some prioritised strict enforcement for safety, while others warned that overly rigid rules risk harming livelihoods and reducing access without improving outcomes.
137. Medical-led providers largely supported robust inspection and enforcement as vital for patient safety and public confidence. Dr Nestor Demosthenous from the Mayfield Clinic commented in a written submission that “we need severe and serious enforcement powers and consequences.”²² Ken Stewart, a consultant plastic surgeon, said in his written submission that it was “essential that both HIS and environmental health have robust oversight of all facilities ... accompanied by a national framework of standards.”²³
138. The Committee heard concerns from oral and written evidence about operational and resource challenges with the provisions already proposed in the Bill. Given the new powers of entry, search, and seizure for unregistered premises granted to HIS, some organisations expressed concern about HIS’s capacity to enforce effectively. This was of particular concern as this will be a new power for HIS, as it currently only inspects premises that are already registered or applying for registration. During oral evidence, Douglas White from Consumer Scotland warned that if regulations are not enforced effectively some practitioners may choose to operate outwith the law:
- ” If regulation is to be meaningful, it is essential that appropriate resources are provided for enforcement. Otherwise, there is a risk that the system would be undermined—it could create a higher level of risk for consumers if there were a significant number of businesses operating outwith the new regulatory system. It will therefore be essential that there are sufficient resources to enable the new system to be enforced.⁷
139. Several witnesses raised the issue that HIS may not have the experience or resources to proactively seek out and target practitioners who may continue operating illegally. For example, Lynsey Wilson from Scottish Aesthetics Safety and Standards argued during oral evidence that:

” I believe that effective enforcement targets unqualified practitioners and illegal or rogue injectors who are offering unlicensed treatment. They are the people who are causing harm in the industry ... My concern is how you find those people and what is in place to seek them out. We know that they sometimes operate from their homes or other premises. I would like to know what measures will be in place to enforce the bill and ensure that rogue injectors are found and sanctioned.⁷

140. During oral evidence, Brett Collins from Save Face similarly raised concerns about the capacity of HIS to enforce regulations proactively, particularly with regards to the most irresponsible of practitioners. He argued that, under the current system, clinics run by healthcare professionals are required to register with HIS but that this may not be well enforced. He further argued that the Bill does not take account of the costs involved if enforcement is to be successful:

” 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 ... This is a completely different landscape ... 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 ... 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.¹¹

141. The written submission from HIS itself raised a number of operational and resource challenges with implementing the Bill’s inspection and enforcement powers. The organisation noted the following issues that need further clarification:

- **Overlap between HIS and local authorities:** There needs to be a clear delineation of responsibilities between HIS and local authorities under existing licensing arrangements.
- **Enforcement powers:** The organisation has never enforced in unregistered settings and lacks the systems, processes, and resources to do so. This will require new administrative processes, legal oversight, and infrastructure. HIS also lacks data on unregistered services.
- **Detection:** HIS’s current intelligence-led model does not proactively detect unregistered services, meaning new duties will require additional staff and infrastructure. It also stresses it doesn't have systems for proactive detection and enforcement in unregistered settings.
- **Additional standards for prosecutions:** HIS would need to meet strict evidential standards for prosecutions, including corroborated proof of offences. This would require digital infrastructure and GDPR-compliant systems for secure evidence handling, which are not currently in place.
- **Surveillance powers:** Legal frameworks such as the Regulation of Investigatory Powers (Scotland) Act 2000 may also apply if covert surveillance is needed to investigate illegal practices.
- **Practical issues:** This includes issues such as secure storage and chain-of-

evidence for seized items, including counterfeit medicines. HIS currently has no capability for this, meaning enforcement could be compromised without significant investment.²⁴

142. The Bill's Financial Memorandum states that:

” The Scottish Government does not consider that the Bill will lead to additional costs that need to be met by the Scottish Administration, as these costs will be met from within existing resources or through increased fee income – with the increased number of registrations leading to an increase in both expenditure on regulatory activity and fee income.²⁵

143. However, during oral evidence representatives from HIS explained that while they would be working towards a self-financing model this could take time and there would likely need to be initial additional funding provided to HIS to ensure they had the resources and workforce competence to put the new enforcement powers into practice. Eddie Docherty from HIS argued that:

” 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.¹¹

Offences and Penalties

144. All offences within the Bill would be liable on summary conviction to a fine not exceeding level 5 on the standard scale (currently £5,000). This scale is set out in section 225 of the Criminal Procedure (Scotland) Act 1995.

145. The Committee heard from several stakeholders that this penalty may not be strong enough to act as a deterrent for practitioners. For example, Jacqueline Cooney from the Scottish Medical Aesthetics Safety Group said in a written submission that:

” I have concerns over the summary conviction if it is only a fine. I believe not all summary convictions that carry fines are recordable offences. I feel that there are many individuals that will continue to flout the law and simply pay the fine over and over treating it like a parking ticket. £5000 may sound a high sum but there are many businesses who earn £100,000 per year or more so this is not proportionate. I feel it would be a better Bill if it also carried a recordable criminal offence. This would be proportionate if after one fine there are reoffending individuals, a recordable offence would be a better deterrent.²⁶

146. One individual respondent to the Committee's call for views similarly argued the fine would not be significant enough to deter some individuals:

” I don't feel that the enforcement powers are strong enough. A clinic can easily make £5000 in a day of trading, so it really isn't a disincentive to stop them with a possible £5000 max fine.²⁷

147. Some witnesses were also concerned that the offence is not recordable and that

there was no provision for an escalation of penalties for repeat offenders. Remmy Jones from Allied Health Professionals in Aesthetics argued during oral evidence that it would be more fair to offer first-time offenders an opportunity to improve whilst having tougher penalties for those who continue to offend:

” 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.¹¹

148. During oral evidence representatives from HIS were asked how they would like to see the system handle repeat offenders. Laura Boyce from HIS responded to say that they do not currently have an indication of how significant this problem might be. She went on to explain that HIS do already work closely with Police Scotland to share intelligence should threats to public safety warrant criminal proceedings.¹¹

Compliance

149. While most stakeholders felt that robust enforcement was vital to ensure the Bill's effectiveness, some argued that making the regulations overly punitive or too complex and onerous may lead to a lack of compliance. In a written submission, aesthetics clinic Holly Be Glam argued that:

” The powers as currently outlined appear to be too heavy-handed and risk criminalising practitioners or businesses who may unintentionally fall short of compliance due to unclear guidance or overly complex requirements.²⁸

150. Some stakeholders expressed concern that the new regulations may even increase the number of aesthetic procedures being provided unsafely as some practitioners may choose to operate illegally if they cannot meet the costs of HIS registration. A written submission from Brows & Aesthetics argued that if prices of procedures go up due to increased regulation consumers may decide to risk going to unregulated providers at lower costs:

” You are going to limit the access to the public as the costs of treatments are going to be pushed up now as you are limiting providers ... therefore you are going to push people to go more to back door treatments and even do themselves.²⁹

151. Conversely, during oral evidence, Jacqueline Cooney from the Scottish Medical Aesthetics Safety Group argued that unsafe practices are already happening and that the Bill will act as a deterrent:

” 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 ... 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 ... stop a lot of that activity happening, and people would be more afraid of that. ¹¹

152. Many respondents stressed the need for clear, accessible guidance on compliance, enforcement, and practitioner requirements, calling for published standards, timelines, and criteria to avoid confusion. Regulators, like the Professional Standards Authority, welcomed the approach set out in the Bill in their written submission to the Committee's call for views, but argued that enforcement should be paired with education:

” We recommend that implementation be accompanied by public education and clear guidance to ensure understanding and compliance and to avoid the risk that workarounds or loopholes are sought by those seeking to access procedures. ³⁰

153. HIS was generally in favour of a supportive approach to enforcement which Laura Boyce explained during oral evidence is how they currently work with unregistered premises to bring them in line with regulations:

” 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. ¹¹

She went on to argue in favour of an implementation time frame that would allow for supportive engagement with practitioners and business owners who may want to become HIS registered, adding that it was difficult at present to quantify how many businesses this would include:

” 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 ¹¹

154. The Committee has heard from many independent non-medical aesthetic practitioners who feel they have not been meaningfully engaged with by the Scottish Government in the consultation process for the Bill and would welcome further engagement as the Bill progresses. For example, in a report sent to the Committee by Scottish Aesthetics Safety and Standards it outlines its concerns:

” Although it is estimated non-medical practitioners make up approximately eighty percent of the aesthetics industry in Scotland, there was a severe lack of engagement with non-medical practitioners in the pre-consultation phase which does not support good practice. ³¹

155. The [Policy Memorandum](#) notes that advanced aesthetics training can be a major financial commitment. It highlights that qualifications equivalent to Ofqual Level 7 are offered by several training providers, with costs ranging from £2,000 to £15,000, depending on the training provider, the practitioner's prior experience, and whether the course is delivered in person or online. This illustrates the significant investment many practitioners have already made to gain the skills required.
156. The [Financial Memorandum](#) states that businesses will bear the costs of complying with the legislation. The level of cost will depend on how each business chooses to adapt its model to meet the requirements. For example, if it become a HIS registered clinic it will need to pay the registration fee and adapt their clinic to meet regulations. On the other hand, if it decides to only undertake lower risk procedures that are not included in the Bill it may experience a loss of earnings. This has led some independent practitioners to suggest that financial incentives should be offered to businesses to assist them in making the necessary changes. The Scottish Government's [Equality and Fairer Scotland Duty Impact Assessment](#) for the regulation of non-surgical procedures states that the Scottish Government is: "also engaging with business gateway support services to investigate ways of supporting businesses in the transition to compliance with the proposed regulation".
157. The Minister for Public Health and Women's Health told the Committee that, should the Bill be passed, the Scottish Government plan to bring the Act fully into force by 6 September 2027 (the same date that the related licensing scheme under the Civic Government (Scotland) Act 1982 will become operable). The Minister said that a route map to full implementation would be published to support businesses and others with the changes and that she would consider whether an education campaign for businesses and a phased approach might be necessary.¹⁷
158. The Committee has heard strong evidence to suggest that, as currently set out, the level of sanctions against those committing offences under the Bill will be an insufficient deterrent to those bad actors willing to commit repeat offences who may consider repeat fines to be an acceptable cost of continuing to operate outside the law. The Committee, therefore, calls on the Scottish Government to set stronger penalties for offences committed under the terms of the Bill.
159. The Committee also recognises that it may take time for responsible operators that want to comply with the law to take the steps necessary to achieve full compliance – and that there will also be a need for additional information and support to be provided to accompany the Bill's implementation to help providers to take the steps necessary to comply with the law. The Committee calls on the Scottish Government to set out its plans in this area, including whether it plans to provide any financial support to businesses.
160. The Committee recommends that the Scottish Government engages meaningfully with independent aesthetic practitioners to understand how they will be impacted by the Bill, what forms of support would be most helpful and to ensure they are kept informed during the implementation process.
161. The Committee is therefore strongly supportive of a staged approach to enforcement that gives responsible operators the time and support they need to achieve full compliance while appropriately punishing those irresponsible

operators that commit repeat offences and show no signs of taking the necessary steps to comply with the law.

162. The Committee has heard concerns as to whether Healthcare Improvement Scotland has sufficient capacity and resources to be able to enforce the Bill effectively once implemented. While acknowledging Healthcare Improvement Scotland's long term ambition that its enforcement functions will become self-financing from registration fee income, the Committee seeks assurances from the Scottish Government that, in the short term, it is committed to putting in place the necessary additional funding to allow HIS to properly enforce the Bill from the outset and to amend the Financial Memorandum accompanying the Bill to reflect this.
163. The Committee calls on the Scottish Government to publish an implementation route map to ensure HIS has the systems and resources in place to adequately inspect and enforce the provisions of the Bill should it become an Act. This should include details and timescales for when suitable training, digital systems and evidence handling processes will be in place. It should also include details of how HIS will be expected to work with other agencies including Police Scotland and local authorities to enforce the provisions of the Bill and the related licensing scheme that is proposed to be regulated under the Civic Government (Scotland) Act 1982.

Data-gathering

164. The Committee heard from witnesses that there is general support for collecting data on aesthetic procedures and reporting incidents to monitor adverse events and improve policy. Some respondents to the call for views thought a national public register of licensed premises and practitioners would help consumers make informed choices. Some respondents felt the Bill should require systematic data collection and incident reporting to ensure transparency and guide future improvements.
165. Tina McCaffery from Skin Religion Aesthetics highlighted to the Committee the need for better data reporting to inform policy decisions:
- ” At present, Scotland has no centralised adverse event reporting system, national register, minimum training or qualification standards or data on the real scale of complications or illegal practitioners. That means that we are trying to regulate without a really accurate picture of the risk, which is unsafe for the public.⁷
166. In its written submission, Consumer Scotland called for greater transparency and accountability in non-surgical cosmetic procedures. It suggested that the Bill would improve the ability to gather data about clinics providing non-surgical procedures and recommended this be monitored:

” The effects of the Bill must be monitored. Regulation making powers will allow data about businesses offering non-surgical procedures to be captured by local authorities or HIS. This means that future monitoring will be possible, for example of the type of services offered, the location of businesses and the types of healthcare professional being employed by otherwise non-healthcare businesses.³²

167. In oral evidence Lesley Blair, representing the British Association of Beauty Therapy and Cosmetology and the Confederation of Beauty Therapy and Cosmetology, highlighted the current lack of data on non-surgical procedures:

” There absolutely is a lack of data at the moment. It is not being collected because there is no requirement to do so from a legal perspective, but it should be collected as a matter of good practice. However, we do not have a lot of that in the industry at the moment. If that were to be a mandatory requirement, it could only help us over the years. Building up data would allow us to assess who should be doing what, and where it should be being done, and also to look at patterns to see what is going wrong.⁷

168. There was consensus amongst witnesses that a centralised reporting mechanism would be helpful, particularly in understanding trends in complication and success rates. For example, Lynsey Wilson from Scottish Aesthetics Safety and Standards argued that "There should also be a mandatory complications database".⁷

169. Amanda Demosthenous from BAMAN also highlighted during oral evidence that the lack of data and the particular issue that there is not currently a specific International Classification of Diseases (ICD) code for aesthetic procedure complications:

” Save Face and JCCP gather some stats, but there is not really a centralised reporting mechanism for gathering facts and data ... 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.¹¹

170. Amanda Demosthenous from BAMAN and Jacqueline Cooney from Scottish Medical Aesthetics Safety Group explained that some aesthetic practitioners would use the Yellow Card system to report issues with products used in procedures to the Medicines and Healthcare products Regulatory Agency (MHRA). However, they expressed concern that non-medics may not have received training on this procedure.

171. Some witnesses suggested that, under the Bill's new regulations, HIS may be well placed to gather data. HIS itself reported in its written submission that it currently lacks data to allow it to assess the resources that it would need to implement the new responsibilities proposed in the Bill:

” At present it is not clear, nor is it possible to reasonably estimate, how many services that are currently ‘non-healthcare professional operated aesthetic services’ will be able to employ an appropriate healthcare professional to enable conversion to an independent clinic. ²⁴

172. HIS went on to highlight concerns that additional resources and training would be needed to establish and run a reporting system:

” HIS does not actively detect unregistered services but responds to intelligence ... Establishing a reporting system for potential unregistered services could be considered, but would require digital infrastructure, technical support, and compliance with General Data Protection Regulation (GDPR) and information governance requirements – none of which are currently resourced or within HIS’s operational scope. ²⁴

173. During oral evidence Brett Collins raised the concern that a lack of data means that it is particularly challenging to understand the issues presented by aesthetic practitioners who are not regulated and may not operate from a fixed address, which he described as “the real issues”:

” 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. ¹¹

174. The Committee has concluded from evidence that the implementation of this Bill offers an opportunity to gather much more systematic data on non-surgical procedures, including rates of complication and rates of success by individual procedure. More systematic data-gathering is also a prerequisite for effective implementation and enforcement of the Bill and to monitor and evaluate its impact.

175. The Committee further notes suggestions that Health Improvement Scotland would be well placed to fulfil a data-gathering function as part of its enforcement of the Bill but that fulfilling such a role would require the commitment of additional resource. The Committee therefore calls on the Scottish Government, in responding to this report, to set out what additional data-gathering it anticipates taking place as part of the Bill’s implementation, who will be responsible for gathering this data and what, if any, additional resources will be made available to support data-gathering.

Public awareness

176. The [Financial Memorandum](#) states that the Scottish Government may consider a public information campaign to raise awareness about the new licensing and regulatory regime. It further states lower and upper cost estimates. The Financial Memorandum also notes that no decision has been made yet about whether a public information campaign is appropriate.
177. Several respondents to the Committee's call for views called for a public awareness campaign to alert providers and consumers to the changes made by this legislation. Many also argued that the new legislation would present a good opportunity to educate the public. It was argued that current understandings of the risks involved in procedures and how to assess whether a particular practitioner is qualified is currently low amongst some consumers. One individual respondent argued that "the general public need to be made aware as currently they think anyone administering injectables must be suitably qualified."³³ Another individual respondent commented that "Members of the public don't understand fully the risks of treatment, even after being provided with written and verbal information."³⁴
178. During oral evidence, Douglas White from Consumer Scotland argued that the implementation of the Bill presented a good opportunity to increase public awareness about the potential risks of non-surgical procedures and to regulate the information that practitioners must give to consumers to allow them to make an informed decision and what to do when something goes wrong:
- ” I agree that public awareness is extremely important and one of the fundamentals for making the bill work effectively. Public awareness-raising materials and campaigns are needed to let the public know about the new regulatory system, the standards that are being set and what that means for different procedures and who is able to provide them. There is an opportunity to go a little bit further with the bill and give ministers the opportunity to specify information that providers must give to consumers when they come to undergo a procedure. Many practitioners already do that, but making it part of the regulatory system would make the information consistent across the board. If providers were required to give consumers information about the level of risk that is involved in a procedure, the aftercare instructions, success rates, staff qualifications, how to make a complaint if something goes wrong and any other information that is vital to help consumers make an informed choice about the procedure that they want to undergo, that would be a really important step towards ensuring that consumers and the public are well informed.⁷
179. Remmy Jones from Allied Health Professionals in Aesthetics similarly argued during oral evidence that:
- ” 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 judgement 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.¹¹

180. Victoria Brownlee from the British Beauty Council and Lesley Blair from the British Association of Beauty Therapy and Cosmetology and Confederation of International Beauty Therapy and Cosmetology also said they would support a public education campaign to ensure consumers know how to assess whether their chosen practitioner is following regulations and understands the risks of procedures.
181. In its written submission Save Face raised the issue that public awareness of existing regulations is currently low and that the Bill will create a more complex regulatory landscape. It expressed concern that "the Financial Memorandum contains no budget allocation for public awareness campaigns, which will be absolutely crucial if the public is ever to understand and navigate these new, complex regulatory distinctions."³⁵
182. The Committee notes a general consensus in evidence around the need for the Bill's implementation to be accompanied by a public information campaign to raise awareness of the risks associated with certain non-surgical procedures and to explain how the law is changing in this area. The Committee therefore calls on the Scottish Government to commit the necessary resources to support such a campaign and to amend the Financial Memorandum accompanying the Bill to reflect this.

Wider issues

183. The Committee heard evidence on a number of issues related to non-surgical procedures that while outwith the direct provisions of the Bill, nonetheless require attention from the Scottish Government. Some of these include reserved matters that will require the Scottish Government to work with the UK Government.

Advertising

184. The Committee heard concerns from both written and oral evidence that advertisement of non-surgical procedures were at times found to trivialise the risks of procedures, pressure people into getting procedures by exploiting insecurity around body image and offering time limited deals or discounts. Witnesses felt this was a particular issue with advertisements on social media platforms which are often targeted towards young women and girls.
185. Respondents to the call for views also call for improved collaboration with advertising regulators to prevent misleading claims. In its written response, the Advertising Standards Authority (ASA) highlighted that it already has rules in place around the advertisement of aesthetic procedures:

” Our rules and our work are already focussed on ensuring the content and targeting of ads for medicines, medical devices, health-related products, treatments and beauty products are responsible. That includes requiring that claims about the efficacy or safety of a treatment, or the qualifications of a healthcare practitioner are backed by suitably robust evidence, and that they’re targeted away from under-18 audiences ... ads for non-surgical cosmetic procedures must not put undue pressure on people or trivialise the decision to undergo a treatment; for example, sales promotions related to cosmetic interventions should be undertaken with caution and countdown clocks and claims such as “Hurry, offer must end Friday” should not be used. ³⁶

186. ASA went on to caution that the Bill could create practical challenges in determining whether advertisers are legally permitted to offer procedures and asked for greater clarity on enforcement responsibilities:

” It is not currently clear if and how the regulation of non-surgical procedures and the legal prohibition on procedures being provided outwith permitted premises, as set out in the Bill, will relate to advertising by non-permitted premises and providers. We would therefore welcome discussions on the intent of the Bill in relation to advertising, the practicalities of enforcing any advertising restrictions, clarification on which body we would engage with and possibly refer non-compliant advertisers to, and the knock-on effect on any guidance we provide to advertisers. ³⁶

187. In an oral evidence session, Douglas White from Consumer Scotland called for the Scottish Government to work with ASA on the regulation of advertisements for non-surgical procedures arguing for:

” The need to work with the Advertising Standards Authority to ensure that advertising procedures are accurate, do not mislead and do not make consumers feel pressured into making choices ... Engagement with the ASA to make sure that its guidance is being applied by all practitioners will be important. ⁷

188. Several other witnesses expressed concern about irresponsible advertising of non-surgical procedures and the psychological impact of this, especially on young women and girls. For example, Lesley Blair from British Association of Beauty Therapy and Cosmetology and Confederation of International Beauty Therapy and Cosmetology commented that:

” With the growth of social media, TikTok and everything else that is out there on all the different channels, we are seeing unrealistic expectations. That is especially the case with young girls. It really worries me when I see their ideal of what beauty should look like—it is all filtered and it is not how people look, but they think that they have to look like that. That is giving rise to mental health issues. ⁷

189. Victoria Brownlee from the British Beauty Council argued during oral evidence that while the ASA has already put regulations in place these should be strengthened:

” We need a much more robust system, with penalties for misusing advertising and putting up unsuitable advertising. We also need greater penalties for the social media companies. I do not know whether you have been through your social media feeds recently, or whether you are an avid Instagram user, but every other post now is an advertisement.⁷

190. Similarly, Jacqueline Cooney argued that while the ASA has already imposed fines on certain clinics for breaking rules around advertising this has not been strong enough to deter repeats of this due to how lucrative such advertising methods can be.

191. In oral evidence, Eddie Docherty from Healthcare Improvement Scotland agreed that restrictions on advertisements for non-surgical procedures were an area that should be further investigated but raised concerns about the challenging nature of policing this:

” 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.
11

192. Laura Boyce, added that HIS already has established relationships with ASA which will help it to share intelligence should it come across information that may fall within its remit.

Regulation of substances

193. The Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines and medical devices for the United Kingdom, and legislation for managing all medicines, including controlled drugs, lies with the UK Parliament. The Committee heard from some respondents to its call for views that the Bill was an opportunity to address concerns about the use of illegal, unlicensed substances in non-surgical procedures. For example, one individual respondent argued that HIS should be working with Medicines and Healthcare products Regulatory Agency MHRA to strengthen enforcement on this issue:

” There needs to be enforcement. Stop illegal trade of drugs and injections on the black market ... A lot of trade in unlicensed medication is linked to organised crime and these people need to be held to account and fines or prison for non-compliance. HIS need to work with MRHA to prosecute all the people currently administering medication imported from Korea and China which has been bought online.³³

194. Members of the Committee also raised concerns that some substances used in non-surgical procedures, such as injectable hyaluronic acid, do not require a prescription and are classed as medical devices rather than a medication, whereas the antidote to an adverse reaction to hyaluronic acid does need a prescription.

195. During oral evidence, Jacqueline Cooney from the Scottish Medical Aesthetics Safety Group highlighted that there are particular risks related to hyaluronic acid being injected, explaining that:
- ” 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.¹¹
196. During oral evidence, Eddie Docherty from HIS responded to questions on this issue by explaining that HIS would work with MHRA on this, along with other issues such as the control of illicit substances:
- ” 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.¹¹

Cosmetic tourism

197. Several written submissions to the Committee's call for views raised concerns around cosmetic tourism and argued that the provisions in the Bill in Scotland could lead to an increase in the number of consumers travelling to both the rest of the UK and abroad, where treatments could be accessed more readily and at lower cost.
198. For example, in its written response to the Committee's call for views, Vikki Soloman Aesthetic's Ltd argued that if procedures become more expensive in Scotland than in England people may travel across the border to receive treatments:
- ” Such restrictions ... could drive clients towards unregulated providers or even to England for cosmetic procedures, where treatments can be accessed more freely and at lower cost. This kind of cosmetic tourism harms local businesses and undermines public safety, as clients may seek treatment outside Scotland's regulatory framework.³⁷
199. The written submission to the Committee's call for views from the Professional Standards Authority for Health and Social Care similarly cautioned that a lack of consistency across the UK may result in an increase in cosmetic tourism:
- ” A variable approach across the different countries of the UK could have a similar effect of encouraging consumers to take part in 'cosmetic tourism'. However, a coordinated four-country approach could help to achieve consistency and clarity for practitioners and the public.³⁰
200. During oral evidence Laura Boyce from HIS raised the issue of health tourism and the particular issue of procedures being offered at conferences and exhibitions:

” 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.¹¹

201. While acknowledging that the regulation of advertising of non-surgical procedures is outside the scope of the current Bill and is a policy area largely reserved to the UK Government, the Committee calls on the Scottish Government to set out what further steps it intends to take, in collaboration with the UK Government where appropriate, to tackle the negative impact of misleading advertising of non-surgical procedures.
202. The Committee is similarly concerned by evidence it has received regarding the classification and regulation of certain substances used in non-surgical procedures. It therefore calls on the Scottish Government to indicate what further action it will take to address these concerns, where appropriate in coordination with the UK Government and the Medicines and Healthcare products Regulatory Agency.
203. The Committee acknowledges concerns that a rise in costs and reduced accessibility of procedures covered by the Bill resulting from its implementation could result in some consumers engaging in cosmetic tourism to access these procedures elsewhere in the UK or abroad. The Committee concludes that this risk further reinforces the case for a public information campaign to accompany the Bill's implementation to allow individuals to make properly informed decisions about whether, how and where they access these procedures.

Part 2 - Certification of death and authorization of cremation

This section will consider the evidence the Committee has gathered during its scrutiny of Part 2 of the Bill.

Interested person reviews

204. In Scotland, every death must be certified by a doctor using a [Medical Certificate of Cause of Death \(MCCD\)](#). Some of these certificates are chosen at random to be reviewed by HIS's [Death Certification Review Service \(DCRS\)](#) for the purpose of improving accuracy, public health data, and clinical governance. This does not include sudden or suspicious deaths, both of which need to be reported to the Procurator Fiscal. It also does not include stillbirth.
205. The [SPICe briefing](#) on the Bill explains that National Records of Scotland randomly selects around 10% of MCCDs for Level 1 review each year, and 2% for Level 2

review, resulting in approximately 6,000 reviews annually.

- Level 1: The medical reviewer checks the content of the MCCD and speaks with the certifying doctor, with the review typically completed within one working day.
- Level 2: The medical reviewer checks the MCCD content, the patient's medical records, and speaks with the certifying doctor. This is a more in-depth review which is usually completed within up to three working days.

206. In addition to these random checks, section 4 of the [Certification of Death \(Scotland\) Act 2011](#) allows an interested person to request a review of a specific MCCD. The main purpose of this is to offer extra reassurance by allowing concerns about the certificate's content to be investigated more thoroughly than through random selection alone.
207. The 2011 Act specifies that an interested person who can apply for a review may be:
- Anyone legally required or qualified to give information about the death under the Registration of Births, Deaths and Marriages (Scotland) Act 1965. The 1965 Act specifies that this includes any relative of the deceased, anyone who was present at the death, the deceased's executor or legal representative, the occupier of the premises where the death occurred, or if none of these are available, any person with knowledge of the details to be registered.
 - A healthcare professional or carer involved in the person's care before death.
 - The funeral director handling the funeral arrangements.
 - The person in charge of the place where the body is buried or cremated.
 - Any other person specified by Scottish Ministers.
208. Currently, if a MCCD is randomly selected for review by the DCRS, it cannot also be reviewed at the request of an interested person. Section 16 of the Bill extends the circumstances in which an interested person can request a review of a MCCD. This makes it possible for more than one review to be conducted under section 4, for example, where new evidence has come to light. This would allow interested person reviews, even when a random review has already taken place, to enable a more thorough investigation when needed.
209. Senior Medical Reviewer, Dr George Fernie, from the DCRS explained to the Committee during oral evidence that this change would be beneficial because the current system "seemed inherently unfair" to those who would like to request a further, fuller review but were unable to do so. He explained that this change will only relate to a very small number of cases.¹⁷
210. Many respondents to the Committee's call for views supported broader rights to request a review of a MCCD, provided the process remains fair and proportionate. Many saw this as a way to improve transparency, accountability, and public confidence, particularly when new evidence emerges after the initial certification. Respondents emphasised that families should have the right to seek reassurance about the accuracy of a death certificate, but they also call for clear guidance to

- prevent misuse and avoid unnecessary delays. Stakeholders felt that given the small number of cases this new legislation would not require additional resources or increased workforce capacity.
211. Section 16 of the Bill also expands the grounds on which a reviewer may decide to reject an application (rather than solely on the basis that it is deemed 'vexatious').
212. While most respondents to the Committee's call for views agreed that medical reviewers should have the ability to reject requests that are clearly vexatious or duplicate, there is concern about granting overly broad powers. The proposed wording, which allows a reviewer to refuse an application if they think it is not appropriate, is seen as too open-ended and lacking safeguards.
213. Dr Fernie argued that it is "unlikely that we would reject a request for a review."¹⁷ He explained that the most likely reason for this would be if one family member has already requested a review and it has been undertaken, then another family member subsequently requested a review for the same reasons, this would most likely be rejected as it would be unlikely to reveal any new information. He said that he would support an appeals process in principle although this was not something being actively considered by HIS.
214. In its written submission, the Jewish Council of Scotland said that it was happy with the changes proposed in the Bill as long as they were not expected to cause delays to burial. It explained that Jewish law requires that, once death has occurred, "there should be as little interference with the body as possible. Ideally, it should not be left unattended, and burial should take place as early as possible."³⁸ The Council asked that the Advance Registration Procedure, which enables the bereaved to apply for permission to proceed with burial before the completion of an MCCD review, would stay in place.
215. Dr Fernie told the Committee that delays were not expected as a result of the Bill as Level 2 reviews would still be completed within three working days.

Cross-UK cremation authorization

216. Section 17 of the Bill updates cremation rules set out in the Certification of Death (Scotland) Act 2011. Under the 2011 Act, medical reviewers have the function of ensuring that it is safe to cremate the body of anyone who dies overseas, or in the rest of the UK, and who is to be cremated in Scotland. For example, the medical reviewer will check medical records to see if the person has any implants or a pacemaker that would need to be removed prior to cremation.
217. The Bill updates this rule so that medical reviewers only undertake this process if a person dies outwith the United Kingdom and cremation is intended in Scotland. The [Policy Memorandum](#) states that this is because when a death occurs in another part of the UK the MCCD would already have gone through the requisite review processes and further review in Scotland would not be required. The amendment to the 2011 Act is intended to recognise the reciprocal checks within the UK, avoiding unnecessary duplication.
218. Most respondents to the Committee's call for views supported removing the

requirement for Scottish authorisation of cremation when a death has already been certified elsewhere in the UK, seeing it as a practical way to reduce duplication and delays.

219. HIS, which run the DCRS, explained in its response that, in its view, the change would remove confusion and serve as confirmation that Scotland will respect death certification processes in other UK nations. Its written submission argued that this aligns with existing practice that, if a death is registered elsewhere in the UK, no extra review is needed in Scotland for burial or cremation and, in so doing, makes the law clear:

” This change to the Act ensures that the process SG have instructed DCRS to adopt over the last 10 years is both clear and lawful.²⁴

220. Some respondents expressed concerns about how data will be shared across jurisdictions and how exceptional cases, such as repatriations or incomplete documentation, would be handled. The written submission from the East Ayrshire Health and Social Care Partnership states:

” We would also note the importance of robust data sharing and communication arrangements, supported by clear national guidance.³⁹

221. The Committee is supportive of the changes proposed in Part 2 of the Bill noting that allowing interested persons to request a review of a MCCD even when it has already been randomly selected for review will make the process more fair and that removing the need for further authorization when someone has died outwith Scotland but within the UK will avoid unnecessary delays and duplication of work.

Recommendation on the general principles of the Bill

222. The Health, Social Care and Sport Committee draws its conclusions and recommendations on the Bill to the attention of the Parliament and recommends that the general principles of the Bill be agreed to.

Annexe A: Extracts from Committee minutes

This annexe sets out relevant extracts from the minutes of the Health, Social Care and Sport Committee throughout the inquiry. Each main heading links to a web-page that gives access to:

- the agenda and public papers for the meeting
- the Official Report of the meeting (public business only), and
- minutes of the meeting.

[27th Meeting, 2025 \(Session 6\), Tuesday 07 October 2025](#)

Proposed non-surgical procedures Bill (In Private): The Committee agreed its approach to scrutiny of the proposed Bill at Stage 1, including two consultation exercises using Citizen Space and Your Priorities, a provisional programme of oral evidence, and to delegate to the Convener responsibility for finalising witnesses to be invited to give oral evidence.

[33rd Meeting, 2025 \(Session 6\), Tuesday 02 December 2025](#)

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Douglas White, Director of Policy and Advocacy, Consumer Scotland;

Louise Caithness, Founder, Managing Director, The Zest Group Scotland;

Lynsey Wilson, Co-Chair, Scottish Aesthetics Safety Standards Group;

Tina McCaffery, representing, Skin Religion Aesthetics;

and then from—

Lesley Blair MBE, Chief Executive, British Association of Beauty Therapy and Cosmetology and Confederation of Beauty Therapy and Cosmetology;

Victoria Brownlie, Chief Policy and Sustainability Officer, British Beauty Council.

[34th Meeting, 2025 \(Session 06\), Tuesday 09 December 2025](#)

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Jacqueline Cooney, Director, Scottish Medical Aesthetics Safety Group;

Stefan Czerniawski, Executive Director of Strategy, General Dental Council;

Amanda Demosthenous, Non-Executive Director, Board Member, British Association of Medical Aesthetic Nurses;

Remmy Jones, Allied Health Professionals in Aesthetics;

and then from—

Eddie Docherty, Director of Quality Assurance and Regulation;

Laura Boyce, Chief Inspector of Regulation, Healthcare Improvement Scotland;

Brett Collins, Director, Save Face;

Paula McLaren, Senior Advanced Practice Advisor, Nursing and Midwifery Council.

[35th Meeting, 2025 \(Session 06\), Tuesday 16 December 2025](#)

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Dr George Fernie, Senior Medical Reviewer and Caldicott Guardian, Healthcare Improvement Scotland Certification Review Service;

Annemarie MacAlpine, President, Association of Registrars of Scotland;

Jim Murdoch, Senior Manager, Wellbeing Planning and Performance, East Ayrshire Health and Social Care Partnership;

and then from—

Jenni Minto MSP, Minister for Public Health and Women's Health,

Rachel Coutts, Lawyer,

Owen Griffiths, Legislation Team Leader,

Alison McLeod, Lawyer,

Katrina McNeill, Team Leader - Burial and Cremation, and

Lucy Orren, Lawyer, Scottish Government.

Annexe B: Evidence and information gathered

This annexe provides links to:

- oral evidence taken (links to the Official Report of relevant meetings), together with associated written submissions and follow-up correspondence;
- other correspondence;
- SPICe briefings and blogs.

Oral evidence (and associated submissions and correspondence)

The Committee took oral evidence on the Bill at the following committee meetings:

33rd Meeting, 2025 (Session 6), Tuesday 02 December 2025

- [Official Report](#)

At this meeting the Committee took evidence from the following stakeholders-

- Consumer Scotland - [written submission](#)
- The Zest Group Scotland - [written submission](#)
- Scottish Aesthetics Safety Standards Group - [written submission](#) and [correspondence](#)
- Skin Religion Aesthetics - [written submission](#) and [correspondence](#)
- British Association of Beauty Therapy and Cosmetology and Confederation of Beauty Therapy and Cosmetology - [correspondence](#)
- British Beauty Council - [correspondence](#)

34th Meeting, 2025 (Session 06), Tuesday 09 December 2025

- [Official Report](#)

At this meeting the Committee took evidence from the following stakeholders-

- British Association of Medical Aesthetic Nurses – [written submission](#)
- Allied Health Professionals in Aesthetics – [written submission](#)
- Scottish Medical Aesthetics Safety Group
- General Dental Council
- Healthcare Improvement Scotland – [written submission](#) and [correspondence](#)

- Save Face – [written submission](#)

35th Meeting, 2025 (Session 06), Tuesday 16 December 2025

- [Official Report](#)

At this meeting the Committee took evidence from the following stakeholders-

- Health Improvement Scotland Certification Review Service (DCRS) – [written submission](#)
- Association of Registrars of Scotland
- East Ayrshire Health and Social Care Partnership – [written submission](#)

and then from—

Jenni Minto MSP, Minister for Public Health and Women's Health,

Rachel Coutts, Lawyer,

Owen Griffiths, Legislation Team Leader,

Alison McLeod, Lawyer,

Katrina McNeill, Team Leader - Burial and Cremation, and

Lucy Orren, Lawyer, Scottish Government.

Other correspondence

HSCS Committee

- Correspondence from the General Chiropractic Council, [19 January 2026](#)
- Correspondence from the Minister for Public Health and Women's Health to Karin Smyth MP, Minister of State for Health, [16 January 2026](#)
- Correspondence from the British Chiropractic Association, [14 January 2026](#)
- Correspondence from the Minister for Public Health and Women's Health, [16 December 2025](#),
- Correspondence from the Minister for Public Health and Women's Health, [15 December 2025](#)
- Correspondence from Beautiful u Beauty, [11 December 2025](#)
- Correspondence from the Scottish Government Bill Team, [11 December 2025](#)
- Correspondence from British College of Aesthetic Medicine, [10 December 2025](#)
- Correspondence from Convener of the Delegated Powers and Law Reform Committee, [10 December 2025](#)

- [Correspondence from the Minister for Parliamentary Business and Veterans, 3 December 2025](#)
- [Correspondence from Thomas Kelly, 3 December 2025](#)
- [Correspondence from the Royal Environmental Health Institute Scotland, 25 November 2025](#)
- [Correspondence submitted on behalf of independent aesthetic practitioners, 13 January 2026](#)

DPLR Committee

- [DPLR Committee report at Stage 1 - published 10 December 2025;](#)

SPICe briefings and blogs

- [Research briefing on the Non-surgical Procedures and Functions of Medical Reviewers \(Scotland\) Bill](#)
- [Blog on Non-surgical Procedures and Functions of Medical Reviewers \(Scotland\) Bill: Key Questions on Part 1 of the Bill](#)
- [Blog on Non-surgical procedure regulation: How Scotland's Bill compares to past consultations and the UK approach](#)
- [Blog on The Bill and the Order: What do they mean in Scottish cosmetic procedures legislation?](#)

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