Health, Social Care, and Sport Committee

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill Call for Views – Summary of Evidence

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Introduction

The Health, Social Care, and Sport Committee conducted a call for views to inform its scrutiny of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill between 10 October and 14 November 2025.

The Committee sought views in two ways:

- Public consultation on the Your Priorities platform, inviting consumers and providers of non-surgical cosmetic procedures to share their experiences.
- Structured call for views on the Citizen Space platform, seeking written evidence from stakeholder organisations on the Bill's provisions.

The public consultation asked questions relating to Part 1 of the Bill. The structured call for views asked questions relating to both Part 1 and Part 2 of the Bill. Both aimed to understand public and stakeholder perspectives on the Bill and highlight areas for scrutiny. This report summarises the key issues raised.

Understanding the context for this call for views

The responses gathered through the call for views are not intended to provide a representative sample of the population. They offer a snapshot of the experiences, opinions and concerns shared by those who chose to respond. This approach ensures that a wide range of perspectives can be considered by Members. While the submissions provide useful insight into the issues surrounding the Bill, they should not be interpreted as reflecting the overall public view.

The Committee received:

- 11 responses to the public consultation. Four respondents self-identified as consumers, six self-identified as providers, and one self-identified as both a consumer and a provider of non-surgical procedures.
- 142 responses to the structured call for views. 96 respondents self-identified as individuals, these included responses from consumers, providers and other interested parties. 46 respondents self-identified as responding on behalf of an organisation, these included providers, professional bodies and other interested parties.

Of the responses to the structured call for views:

- 138 respondents answered questions on Part 1. 95 of these self-identified as individuals, and 43 self-identified as responding on behalf of organisations.
- 20 respondents answered questions on Part 2. 13 of these self-identified as individuals, 7 self-identified as responding on behalf of organisations.

Questions in the call for views

Part 1

The public consultation asked respondents the following question:

- What are your experiences of non-surgical procedures and how might the Bill affect you?

The structured call for views asked the following questions in relation to Part 1:

1. In your view, what impact will the Bill have on:
    a. People wishing to access non-surgical procedures detailed in Schedule 1?
    b. The level of risk to people who wish to access these procedures?
    c. Local businesses and individual practitioners?
    d. Organisations and staff who currently operate within a premises that meets the definition of permitted premises?
2. What are your views on inspection, offences and enforcement powers set out in the Bill? For example, do you think they are fair and appropriate?
3. Do you have any further comments about Part 1 of the Bill?

Part 2

The structured call for views asked the following questions in relation to Part 2:

1. What are your views on the Bill's amendments to the two following aspects of the Certification of Death (Scotland) Act 2011:
    a. To extend the circumstances in which an interested person can request a review of a Medical Certificate of Cause of Death (MCCD) and to extend the power of medical reviewers to reject an application.
    b. To remove the requirement for a medical reviewer to authorise cremation of a person's body in Scotland where that person has died outwith Scotland but within the United Kingdom.
2. Do you have any further comments about Part 2 of the Bill?

The provisions of the Bill

This SPICe briefing provides an overview of the provisions made in the Bill and highlights some of the areas Members might wish to consider in scrutiny of the Bill at Stage 1. This analysis should be read alongside the full briefing for context.

Part 1: Key issues raised in the Health, Social Care and Sport Committee's call for views

Do respondents support or oppose the Bill?

Overall, respondents supported regulation of the non-surgical procedures sector. Most respondents agreed that regulation is necessary to improve safety, accountability, and professional standards.

There was a clear divide among respondents on what the regulation should involve and how it should be applied. Many agreed with principles like licensing (though this sits outside the Bill and relates to the Scottish Government's wider policy), inspections, and minimum training standards. However, there was disagreement over the proposed model of regulation in the Bill.

On the whole, professional healthcare, medical and regulatory organisations strongly supported the provisions of the Bill. These organisations emphasised patient safety, age restrictions, and permitted premises as necessary and proportionate and they generally welcomed the inspection and enforcement powers. However, some argued that the provisions in the Bill did not go far enough and could be strengthened.

Conversely, aesthetics businesses and practitioners, consumers and groups that represent them generally argued that the Bill is too restrictive, will reduce access to services and increase inequalities for consumers, and increase costs and force closures for non-medical practitioners. Many also warned of unintended consequences that could arise from the Bill which could increase safety issues instead of decreasing them, contrary to the Bill's aims.

Consumer-focused organisations were broadly supportive of safety measures but raised concerns about accessibility and affordability.

Safety, risk and public protection

There was broad agreement of the importance of public safety as a priority. One individual respondent who stated "I have only accompanied those who have accessed, primarily laser and injectable procedures" had a negative opinion of accessing non-surgical procedures. The respondent said:

"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." Respondents from professional healthcare, medical and regulatory organisations, stressed that non-surgical procedures can carry real risks. The Royal College of Surgeons outline "serious complications associated with some of these procedures including infections, blocked arteries, necrosis, blindness and stroke." Many respondents believe the Bill will reduce these risks by requiring treatments to be carried out in regulated premises and managed by qualified healthcare professionals. They feel that this would introduce safeguards such as clinical assessment, informed consent, emergency care, and proper prescribing practices.

Some responses outlined that certain groups face higher risks from non-surgical procedures than others and argued that the Bill should include extra safeguards. For example, in its submission the Cleft Lip and Palate Association (CLAPA) argued for the Bill to include checks on anatomy and surgical history, clear risk discussions, specialist referral options, and a cooling-off period before treatment:

> "The risk of adverse outcomes is higher for individuals with cleft lip or palate due to: altered anatomy (e.g., scar tissue, graft sites, previous surgeries), possible reduced vascular or lymphatic drainage, asymmetry, and the need for specialist knowledge of their lip/face history… We believe the Bill should go further in emphasising that higher-risk sub-populations (including those with congenital facial difference) require enhanced safeguards"

Supporters of the Bill argue that regulation will close gaps where procedures are currently performed in unregulated settings, improve hygiene standards, and ensure practitioners have the necessary training and pharmacological knowledge. The Norup clinic, which is a medical aesthetics clinic, states in its submission that:

> "The Bill will significantly reduce risk. Currently, non-surgical cosmetic interventions are often delivered by individuals with variable or inadequate training, sometimes in unsuitable premises and using products that are not FDA approved[1] and imported illegally with no consequence for any practitioner registration. Restricting these procedures to HIS-registered settings and qualified healthcare professionals introduces essential safeguards—clinical assessment, informed consent, management of complications, and access to emergency care. This framework will also ensure that practitioners have the pharmacological knowledge and clinical judgement necessary for safe prescribing and treatment delivery—skills uniquely held by doctors, dentists, and nurse prescribers."

However, many aesthetics businesses and practitioners argued that not all procedures listed in Schedule 1 are high risk and require this level of regulation.

[1] The Food and Drug Administration (FDA) regulates medicines and medical devices for the United States, while the Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines and medical devices for the United Kingdom.

They felt including treatments such as superficial peels and microneedling was unnecessary. For example, Zest Group Scotland Ltd., a multi-site Edinburgh business, argues:

> "In relation to Skin Peels and Skin Needling only: these procedures are low risk, non-invasive procedures that do not require this level of regulation. The proposal to include these is non-sensical."

The British Association of Medical Aesthetic Nurses (BAMAN), a professional association for nurses carrying out cosmetic treatments in the UK, held a different view. Its submission stresses that while injectable treatments like botulinum toxin and dermal fillers are high-risk medical procedures, other 'lower risk procedures' do 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."

The Bill is seen by many as a way to ensure treatments are carried out in safe, regulated environments by qualified practitioners. While most stakeholders agree that regulation will improve safety, some warn that overly strict rules could have negative unintended consequences. Many respondents thought that if access becomes too limited or costs rise, consumers may turn to unregulated or underground providers, where standards are poor and risks are far higher. This could undermine the Bill's purpose by increasing harm rather than reducing it. The response from Vikki Soloman Aesthetic's Ltd, a business offering a wide range of beauty and non-surgical cosmetic treatments, states:

> "Restricting who can deliver these treatments, or requiring unnecessary on-site supervision, would limit public access, reduce client choice, and create longer waiting times. More importantly, it risks driving members of the public towards unregulated or unsafe providers, which would ultimately increase risks to patient safety rather than reduce them."

A similar concern was raised by Jordan Morrison on behalf of Mr Skulpt Aesthetics Ltd in Petition PE2137: Fair regulation for non-medical aesthetic injectors.

Several submissions also raised concerns around cosmetic tourism and argued that the provisions in the Bill could lead to a rise of consumers travelling to both the rest of the UK and abroad, where treatments can be accessed more freely and at lower cost. As an example, A self-employed salon owner said in her submission that "safety risks rise as people turn to unregistered injectors or travel across borders for cheaper procedures."

Respondents state that this kind of cosmetic tourism harms local businesses and undermines public safety. In relation to this concern, Consumer Scotland calls for:

> "A consistent, UK-wide approach[2] is necessary to ensure the effectiveness of this regulatory regime, to help minimise the risk of consumers travelling to areas which may have weaker regulatory safeguards."

Other respondents thought that the enforcement powers in the Bill would deter rogue practitioners and illegal activity, such as use of counterfeit products. One individual respondent stated her view that the enforcement, as part of regulation, was welcome:

> "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[3] all the people currently administering medication imported from Korea and China which has been bought online."

Some respondents saw the Bill as an opportunity to raise the reputation of the aesthetics industry by removing unqualified or unsafe operators. Others emphasised the importance of public education and awareness, commenting that having clear rules would reduce the risk of harm and improve trust in the industry. For example, Riverbanks Wellness, a doctor-led medical aesthetic clinic, argued that regulation would give the public assurance that treatments are provided in clinical environments meeting safety and hygiene standards.

Public messaging and advertising

Many respondents stressed the need for clear, accessible education on the risks and benefits of non-surgical procedures, the importance of choosing regulated practitioners and premises, and the dangers of visiting unlicensed providers. One individual respondent noted that "the general public need to be made aware as currently they think anyone administering injectables must be suitably qualified" and 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." This concern appears repeatedly in the responses, often linked to calls for better education, clearer advertising, and mandatory public information campaigns to ensure informed consent and reduce harm.

Healthcare Improvement Scotland urges that "a campaign of public health messaging is taken forward regarding the new legislation," while the Royal Pharmaceutical Society Scotland highlights that "the benefits of the Bill will only be seen if it's transparent and well publicised in a way that is accessible to all and considering all levels of health literacy." Save Face notes in its submission that the

[2] This is discussed further within the section on Approaches to regulation.

[3] The MHRA approach to enforcement is detailed in its enforcement strategy. Legislation for managing all medicines, including controlled drugs, lies with the UK Parliament. The legislation applies to all parts of the UK. Healthcare Improvement Scotland (HIS) have an explicit governance role in the safe management of controlled drugs. They liaise with MHRA and other UK regulators during inspections and scrutiny activity.

Financial Memorandum contains no budget allocation for public awareness campaigns.

There was support for collecting data and reporting incidents to monitor adverse events and improve policy. Some respondents 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. In its submission, Consumer Scotland calls for stronger transparency and accountability in non-surgical cosmetic procedures. The organisation's recommendations include mandatory disclosure of risks, expected outcomes and aftercare instructions. The submission also propos es publishing success rates, requiring professional registration, insurance and indemnity, clear signposting to regulatory and complaints bodies, and accessible routes for redress when things go wrong.

Respondents also called for collaboration with advertising regulators to prevent misleading claims. In its response, the Advertising Standards Authority (ASA) sets out a secondary effect of the Bill for the advertising non-surgical procedures. ASA stresses its existing rules require ads to be responsible, evidence-based, and not targeted at under-18s, with strict prohibitions on promoting prescription-only medicines like Botox. It warns that the Bill could create practical challenges in determining whether advertisers are legally permitted to offer procedures and calls for clarity on enforcement responsibilities and referral mechanisms. The response also states that advertisements for non-surgical cosmetic procedures must not put undue pressure on people or trivialise the decision to undergo a treatment, such as offering limited-time promotions that encourage rushed decisions.

Access, choice and cost

Throughout the responses from consumers, aesthetics businesses and practitioners there was a strong concern that the enactment of the Bill will restrict access to non-surgical procedures as a result of limiting them to HIS-registered premises.

One consumer of non-surgical procedures, outlines various reasons why she objects to requiring procedures only be undertake in medical settings, including loss of choice, higher costs, overly clinical environments and a lack of personalised care:

> "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.

Several respondents echoed these concerns and argued that the Bill will:

- Create significant barriers for rural and remote areas, where prescribers and compliant clinics are scarce. The response from Enhanced Aesthetics Scotland, states that "my clients in Orkney will have no access to these treatments" under the Bill. It also states that there are there are currently no HIS locations available to work from and no prescribers trained in aesthetics in Orkney.

- Reduce choice, as clients lose the ability to select trusted non-medical practitioners, forcing a shift to larger, medical-led clinics. The response from the Lip Lounge Clinic states that "this bill will dramatically restrict access to treatments" and a sole trader beauty therapist, argued that "freedom of choice will be taken away from people."

- Increase costs for businesses due to HIS registration fees, prescriber requirements, and compliance expenses, with the resulting effect of making treatments less affordable for many, particularly in lower-income communities. A submission from Red Aesthetics argues that "there will be a massive increase in prices," and an individual respondent warns that the Bill forces "non medics to potentially need to double or triple the treatment costs to cover funding a medic to be on site."

Several respondents linked these to previously discussed safety concerns such as driving people to unregulated or unsafe providers, and across borders. For example, the submission from Brows & Aesthetics argues:

> "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… you have isolated a group of people who have studied for several years and have ample qualifications, knowledge & training to be able to perform non surgical procedures… minimum standard of training, premises licensing, person license with regulatory body is all thats required… not to put thousands of good people out if business overnight."

Other stakeholders acknowledged the safety benefits that would arise from the Bill, but most agreed that affordability and choice would suffer, which would disproportionately affect/impact? rural communities and lower-income clients.

Age

Most respondents supported the provisions in the Bill that would make it an offence to provide a non-surgical procedure to a person under 18. There was no significant opposition to the provisions, but a few respondents raised concerns about unintended consequences, such as under-18s seeking treatments from unregulated providers or abroad. Other respondents highlighted the administrative burden of enforcing age checks and the potential impact on small businesses.

Organisations such as BAPRAS, Royal College of Surgeons, Royal Pharmaceutical Society, and the Law Society highlight that facial and body structures continue developing into early adulthood, making under-18s more vulnerable to complications like muscle atrophy, tissue damage, and long-term health effects.

The Royal College of Nursing Scotland (RCN) calls for further consideration to be given to introducing additional safeguards for younger people above the age of 18, including "limiting the number of times a procedure can be accessed, or requiring a GP review or healthcare professional to carry out all procedures on younger people."

Mental Health and Wellbeing

Several respondents argue that the Bill could harm mental health by limiting access to non-surgical cosmetic treatments. They argued that higher costs and reduced availability would negatively affect people who rely on these procedures to manage issues such as acne, scarring, premature ageing, or chronic sweating. One individual respondent stated that "this will negatively affect a lot of self confidence and mental health, especially for those who have self confidence issues due to real aesthetic issues." Others highlighted that restricted access could lead to anxiety, low confidence, and body dissatisfaction, particularly for individuals who strongly associate these treatments with their self-image.

Another individual respondent outlined her view that non-surgical cosmetic procedures can have major psychological effects - which can be both positive and negative. She argues that:

> "While these treatments can enhance self-esteem and confidence for many patients, we must not underestimate the potential for adverse psychological effects. In my opinion, the psychological impact of cosmetic interventions has been greatly underestimated, and this is an area that requires urgent attention within the regulatory framework."

The response outlines the importance of oversight of healthcare professionals in undertaking non-surgical procedures, in order for them to assess both physical and psychological suitability. The respondent states that they are "trained to identify red flags, such as body dysmorphic disorder (BDD), unrealistic expectations, or other contraindications that may make a patient unsuitable for treatment" and are ethically bound to refuse treatment if it could harm the patient. The respondent also calls for mandatory psychological screening as a part of patient assessments, citing a legal requirement in Australia as an example. She argues that "screening tools can help practitioners identify patients who may not be suitable for treatment due to psychological or emotional factors. This ensures that only those who are likely to benefit from the procedure, both physically and mentally, are treated."

Fairness and equality

Some respondents, particularly those from consumers, aesthetics businesses and practitioners, or groups representing them, expressed strong concerns about fairness and equality in the proposed Bill.

Many of these responses highlighted a perceived bias toward medical professionals, arguing that non-medics with advanced training feel unfairly excluded despite their competence. Several respondents called for inclusive regulation that recognises competence, not just job titles. One of several responses attributed to 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."

When answering a question on the impact of the Bill on organisations and staff who currently operate within a premises that meets the definition of permitted premises, Tina Duff, representing Flawless Aesthetics and responding as a founding member of Scottish Aesthetics Safety Standards (SASS) said:

> "Nothing will affect people who already operate within a premises that meets the bills proposals at the minute. This is why the bill is so unfair, biased and fueled by money grabbing medics trying to push non medics out of the industry with fabricated false statistics."

However, a provider with existing HIS registered clinic disagreed setting out their view that the Bill achieves fairness in an already unfair sector by creating a level playing field:

> "I feel this Bill removes the unfair disparity between HIS registered clinics and those that are not, by making this a fair playing field it assures members of the public that they are receiving safe regulated procedures from an ethical and moral practitioner in an environment which is safe."

Equality concerns were also raised, with respondents arguing that the changes could disproportionately impact women-led businesses in the aesthetics sector as well as consumers on lower incomes, and those in remote and rural communities. The Professional Standards Authority for Health and Social Care (PSA) stated in its response:

> "We encourage the Committee to consider the Bill's impact on equality, particularly for groups disproportionately affected by cosmetic pressures (e.g. young women), and to ensure access to safe procedures is not unduly restricted for marginalised communities."

The response from Skin religion aesthetics, a small business in Arbroath, argues that "the Bill, in its current form, will significantly reduce access to non-surgical cosmetic

procedures for the Scottish public—particularly in rural, island, and economically deprived areas."

Impact on businesses and livelihoods

Respondents across the board acknowledged the impact of the Bill on businesses and livelihoods. However, aesthetics businesses and practitioners, consumers and the groups that represent them, expressed deep concerns about closures, job losses, and financial hardship, particularly among small, independent, and women-led businesses.

The response from Adore aesthetics, describes how the proposed changes in the Bill would personally affect 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 safety and always put my clients' safety first. I'm a single mum that done 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 claming benefits I'm trying so so hard to provide for my family 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."

Many respondents highlighted what they perceived as a disproportionate effect on home-based and rural businesses, warning that HIS registration requirements and prescriber-on-site rules are unworkable for sole traders. Respondents stressed that the measures in the Bill would increase costs and compliance burdens, reduce autonomy, and threaten the survival of legitimate operators. The response from Vikki Soloman Aesthetic's Ltd states:

> "The Bill's requirements mean I would need to find a medical professional to register my clinic with HIS and to have a prescriber physically on-site at all times to deliver treatments. This places significant operational and financial burdens on small businesses like mine and makes it extremely difficult to continue trading, despite already providing safe, professional services…
>
> "The requirement for frequent inspections, strict registration conditions, and the risk of offences for non-compliance could place significant administrative and financial strain on small, non-medical businesses like mine. Many of us already follow robust safety protocols, hold professional insurance, and undertake continuous training. Adding multiple layers of oversight and penalties risks punishing compliant practitioners rather than targeting unsafe operators."

Clinic 22, a HIS registered independent healthcare clinic operating across two sites in Kilmarnock and Saltcoats currently employs five staff members including nurse prescribers and prescribing paramedics. In its response, it described its experience adapting to new requirements but illustrates how compliance helped their organisation strengthen policies and manage risks more effectively:

> "Initially it may feel daunting and stressful navigating the new regulations however in the long term it will ensure they are practicing(sic) safely and upholding there(sic) standards of care which will only benefit organisations and individual practitioners. Having registered with HIS almost 10 years ago I can say it was a very beneficial exercise and ensured the business had appropriate policies and procedures in place to manage risks and issues which previously hadn't been considered."

This response from Red Aesthetics, highlights how additional or ongoing costs could result in businesses closing:

> "Businesses may face closures if HIS is not possible due to no fault of their own whether it is cost issues or the building itself. Some people may be locked into lengthy building leases if they need to close their business."

In its submission, Consumer Scotland summarises a number of these issues and highlights the subsequent impact on consumers:

> "The Scottish Government accepts that the proposed regulatory regime may decrease competition in certain areas, and may have the effect of increasing costs for businesses due to the potential need for non-healthcare practitioner led businesses to employ prescribing healthcare professionals, register with HIS, undertake further training and possibly make alterations to their premises to comply with HIS standards. They may also experience a potential loss of revenue from not being able to offer certain procedures if they do not take these steps. It is unclear whether such effects may result in price increases for consumers, or whether the model of delivery may change to accommodate new requirements."

Some respondents also raised concerns of the potential impact on local communities, services and high streets, should small businesses close. One individual respondent said that in her view:

> "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."

BAMAN emphasises its view that the importance of maintaining high standards to protect patient safety and quality of care, rather than lowering requirements for reasons of convenience or accessibility.

> "While we recognise that some businesses may be required to adapt their operations to meet new regulatory requirements, we do not accept that

> inconvenience or commercial disruption is a valid reason to delay or dilute standards that are essential for public protection... The Bill should not make allowances for unqualified individuals to continue operating on the basis that they have built a business around an unregulated loophole. Patient safety must take precedence over commercial interest."

Approaches to regulation

While most respondents 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.

Generally, professional healthcare, medical and regulatory organisations supported Healthcare Improvement Scotland (HIS) registration for permitted premises. However, within this cohort, there were concerns raised around mechanisms for regulation and some thought the regulation proposed was not strong enough.

In its submission, the RCN states that in its view the proposed regulatory framework will be fragmented across three separate mechanisms, which corresponds to the Scottish Government's risk groupings from its initial consultation on regulating non-surgical procedures. It argues that this split approach could create complexity and uncertainty for practitioners and regulators:

> "The Scottish Government has essentially chosen to follow this proposal, with this draft legislation setting out the procedures which must be carried out in a HIS regulated premises (broadly including those procedures which were categorised as 'Group 2' procedures. 'Group 1' procedures will be able to be carried out by a non-healthcare professional in a local authority licensed regime and this will be established via a licensing Order under powers contained in the Civic Government (Scotland) Act 1982. Those procedures identified as 'Group 3' in the Scottish Government's consultation will be considered in discussion with the UK Government as limiting certain procedures to specific medical professionals is a reserved matter in so far as they involve regulating the provision of certain medications to patients. The regulatory regime for these procedures will therefore be split across three different pieces of legislation; this Bill; Orders under the 1982 Act and unspecified amendments to reserved medicines regulations."

Many professional organisations call for stronger regulation and safeguards. Organisations, including the British Association of Medical Aesthetic Nurses (BAMAN), the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), the Royal College of Surgeons of Edinburgh and the Royal College of Nursing Scotland all raised concerns that under the Bill, some procedures listed in Schedule 1 could be carried out by someone who is not regulated, even if doing so under the direction of a regulated healthcare professional. The Royal College of Surgeons raises this issue and goes further:

> "The legislation allows for procedures to take place on premises managed by a clinician, leaving scope for procedures to be carried out by those that lack

> training and qualifications, which clearly poses a risk to patients. Although, there will be clinicians on hand to deal with any complications, and they will be held accountable for managing the practice. We believe the likelihood of risks would be further reduced if the legislation made explicit reference to who was allowed to carry out these procedures. Due to the high complexity of some procedures we would go further in that we believe deeper chemical peels, dermal microcoring, thread lifting and cellulite subcision, all currently categorised under Schedule 1 of the Bill, should be restricted to surgeons."

In its submission, Save Face questions the wording in the Bill, noting that "the critical lack of clear definition for what constitutes 'supervision' or 'management' by a healthcare professional (HCP) creates profound ambiguity".

Some organisations explicitly call for the regulation of individual practitioners as well as the regulation of premises. The British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) submission argues:

> "The Bill should be amended – as a priority - to specify minimum practitioner qualifications for each Schedule 1 procedure (e.g., require registered healthcare professionals for all injections and medium depth peels; restrict listed complex procedures to surgeons)…There should be a requirement for an explicit licensing or competency framework (training, accreditation, continuing professional development) for all practitioners permitted to perform Schedule 1 procedures"

Respondents also questioned who should count as an 'appropriate practitioner,' with Allied Health Professionals such as radiographers and paramedics seeking inclusion, and some organisations criticising the proposals due to the exclusion of trained non-medics. The Allied Health Professionals in Aesthetics (AHPA) said:

> "Allied Healthcare Professionals registered with the HCPC should be included on the list of appropriate practitioners…We are regulated HEALTHCARE professionals.… Paramedics are autonomous practitioners who are able to prescribe, manage serious health and live threatening scenarios like anaphylactic shock. A paramedic is arguably more competent than a pharmacist or nurse or dentist managing an anaphylaxis complication while working solo on their own in clinic."

Other respondents have concerns over the descriptors of procedures as set out in Schedule 1 of the Bill and associated categorisation of risks. BAMAN calls for "the clear separation of procedures into risk categories" as a "necessary component of a functioning regulatory system" but also call for "further clinical precision in how those categories are defined". They go on to argue that:

> "Terms such as superficial, outermost layer of skin, and low risk must be revisited to ensure they are meaningful in practice. Without accurate clinical language, there is a risk that procedures which can carry significant complications in certain skin types or patient groups are categorised as low risk and allowed to be delivered by individuals with minimal training. For example, a superficial chemical peel in a patient with a history of post-

> inflammatory hyperpigmentation or an undiagnosed skin condition may not be low risk at all. Similarly, procedures using microneedling devices or fractional lasers may be technically superficial but can still provoke adverse reactions if not carried out with care and proper patient selection. Clear definitions are not just helpful for enforcement; they are essential for ensuring that patients receive treatments appropriate to their skin, medical history, and expectations."

Aesthetics businesses and practitioners, and groups that represent them generally argue for more competency-based regulation rather than rules based solely on professional titles or types of premises. The submission from Glamlounge states:

> "Many non-medical practitioners undertake extensive, accredited training and demonstrate exceptional skill, ethics, and commitment to client care. Regulation should focus on ensuring consistent standards and accountability across the industry, not restricting access based solely on professional background."

Several respondents also proposed tiered, risk-based systems to reflect the different procedures. However, this was centred around more of a focus on 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. The submission from 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."

Many practitioners also expressed concern about creating a fragmented UK regulatory landscape. One respondent noted what they felt to be disparities around approach to regulation and licensing between Scotland and the rest of the UK, calling for greater consistency across the country:

> **"**I believe that HIS should be for group 3 treatments and Group 1 and 2 can operate on a two tired Local Licensing system. Uk government have announced that Botox and dermal fillers are in a low risk category and can safely be offered in local authority licensed premises. I fail to understand why it is classed as medium risk just because we cross the border."

The response from Vikki Soloman Aesthetic's Ltd also argues that risk levels are comparable across both nations and that treatments in England are safely delivered by qualified practitioners under remote prescribing arrangements. The response calls for a 'balanced framework' that recognises the competence of trained, insured non-medical practitioners and permits remote prescribing, rather than imposing restrictive on-site requirements. This, they suggested, would maintain safety standards while protecting public access and supporting businesses.

In terms of regulatory misalignment, Save Face, also challenges the appropriateness of applying HIS standards to standards for cosmetic clinics under a regulatory scheme. The submission states that those rules were designed for very sick patients, not for people having elective aesthetic treatments:

> "Save Face has long questioned the fundamental appropriateness of applying Healthcare Improvement Scotland (HIS) standards, originally developed for regulating hospitals that care for seriously ill and vulnerable patients to the regulation of healthcare professionals practicing aesthetic medicine."

Training, education and standards

There was consensus among respondents about the need for robust, accredited training and national standards to ensure patient safety. Many non-medical practitioners also highlighted they had invested a lot of money in high quality training which should be acknowledged and valued.

Many businesses and practitioners called for mandatory qualifications, such as Office of Qualifications and Examinations Regulation (Ofqual) Level 6 or 7[4] or similar accredited training as the benchmark for competence, alongside compulsory CPD and competence checks. Respondents felt this was necessary to be on the face of the Bill and not left to regulations. The submission from Scottish Aesthetics Safety and Standards states:

> "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."

In relation to qualifications, the submission from Save Face states that "the Level 7 qualification… represents a significant financial burden for practitioners, with costs varying from £2,000 to £15,000". It also states:

> "It is important to note that HIS currently has no requirement for practitioners already registered with them and providing non-surgical cosmetic procedures to hold a Level 7 qualification, and no evidence has been put forward by HIS that the absence of this qualification within their current framework has caused harm to the public."

The Joint Council for Cosmetic Practitioners also states in its submission that practitioners must show they have the right qualifications, including infection control training, to prove they are safe and competent including "Royal Society of Public Health Level 3 qualification in Health Protection/Infection Control".

[4] The Office of Qualifications and Examinations Regulation (Ofqual) regulates qualifications, examinations and assessments in England.

Submissions from providers also detail criticism of short or online-only courses and concern about poor training providers undermining standards. An aesthetics nurse working in a medical aesthetics clinic commented that "the level of infection risk is high if carried out in an un-clinical practice with someone with a 1 day CPD course for sure". The submission from Kt Beauty and Aesthetics states:

> "It's frustrating to see unqualified individuals offering high-risk treatments after completing basic online courses. This puts clients at serious risk of harm and damages the reputation of those of us who have invested time, effort, and money into doing things the correct way. The sector urgently needs stronger regulation to protect the public and to recognise trained professionals who meet proper standards of education, hygiene, and safety…Unfortunately, many people complete quick online courses that offer no real one-to-one guidance, supervision, or practical assessment. They often lack the in-depth knowledge, understanding, and ethical awareness that are essential to ensure client safety."

Overall, respondents across all groups supported guidance, training standards and accredited pathways. Many stressed the need for clear national training standards, infection-control requirements, and ongoing professional development as essential safeguards for public protection. A prescriber in a HIS premises stated a reticence to prescribe for non-healthcare providers who may not have formal training or standards:

> "As a prescriber I personally would not risk my professional career to prescribe for a non healthcare provider. There are currently no educational standards so there is no way of being assured these individuals have had a recorded and regulated standard of training."

HIS also raise this a concern in relation to its role in regulating non-surgical procedures:

> "Without minimum defined education standards in place, Healthcare Improvement Scotland (HIS) cannot promote consistency in its role as a regulator."

In its submission, the British Standards Institution (BSI), appointed by the UK Government as the UK's National Standards Body, draws the Committee's attention to BS EN 16844, which is a voluntary European best practice standard providing recommendations for aesthetic non-surgical medical treatments. The BSI recommends that the standard can support the Bill in several ways including providing detailed safety and hygiene standards that can be adopted or referenced in regulatory frameworks and outlining training and competency expectations and ethical responsibilities, helping define what "qualified" means in practice.

Several respondents also highlighted concerns about the role of nurses and the potential for the Bill to cause strain on NHS capacity. One respondent set out their concerns around "prescribers leaving vital NHS roles to facilitate private clinics, the amount of people enrolling onto nursing degrees with no intention of being a Nurse" and another respondent stated that "If prescribers must be physically present in

clinics, nurses and pharmacists are pulled from already overstretched NHS services."

Offences, inspection and enforcement

Overall, respondents agreed on the need for enforcement but differed on approach: some prioritised strict enforcement for safety, while others warned that overly rigid rules risk harming livelihoods and reducing access without improving outcomes.

Most respondents supported the offences in the Bill for providing non-surgical procedures under-18s or for those operating outside permitted premises. While professional healthcare, medical and regulatory organisations described these as appropriate and necessary, businesses and practitioners stressed they should be proportionate and focused on unsafe practice rather than minor administrative breaches.

Similarly, many of these respondents supported inspections in principle, however, with a caveat that they should be fair, proportionate, and focused on tackling unsafe or unqualified practice. For example, the submission from Glamlounge states that inspection and enforcement "must be fair, proportionate, and applied equally across all practitioner backgrounds" and that "inspections should focus on ensuring all practitioners "maintain proper hygiene, consent, and complication management protocols".

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 that "we need severe and serious enforcement powers and consequences." Ken Stewart, a consultant plastic surgeon said it was "essential that both HIS and environmental health have robust oversight of all facilities…accompanied by a national framework of standards."

However, many non-medical practitioners and small businesses argue that the proposals felt overly strict and punitive. They fear that frequent inspections, rigid premises requirements, and broad enforcement powers could impose heavy costs, create administrative burdens, and force compliant businesses to close. Concerns also centred around the potential for criminalising minor administrative breaches, with calls for improvement notices and education before sanctions, and reserving severe penalties for reckless or unsafe practice. The response from Holly Be Glam argues:

> "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."

In contrast, some wanted tougher penalties and deterrence with one respondent to the public consultation likening the proposed fines in the Bill to "as insignificant as a parking ticket and easily ignored". An individual respondent states:

> "I think this is fair, and where possible should involve further stricter sanctions. £5000 in today's money is nothing. It should be significantly increased."

Professional healthcare organisations and regulators supported the Bill's offences, and inspection and enforcement powers viewing them as essential for patient safety and accountability. They argue that regular, transparent inspections and reporting, clear penalties, and strong oversight would help eliminate unsafe practices and reinforce public confidence in clinical standards. For example, the BAMAN submission states:

> "Inspection and enforcement powers are critical. Without meaningful enforcement, regulation becomes symbolic rather than protective."

Regulators, like the Professional Standards Authority, welcomed the approach but urged that enforcement be paired with education and guidance to avoid a purely punitive system. The response from Flawless Aesthetics suggests that "enforcement should follow a clear ladder: advisory notice → improvement notice → re-inspection → civil penalty, with criminal sanctions only for serious breaches".

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. An individual respondent stated that "Regulators should work collaboratively with practitioners to raise standards, provide guidance, and allow time for compliance before any penalties are applied." The PSA also commented:

> "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."

There were also calls in the submissions for transparent and fair appeal processes, so practitioners can challenge enforcement decisions without fear of bias or complexity. For example, one respondent commented:

> "Enforcement powers are appropriate provided they are exercised transparently, proportionately, and with opportunities for appeal or remediation before sanctions are imposed."

Resourcing and capacity for inspection and enforcement

Several organisations highlighted practical concerns, which included Healthcare Improvement Scotland's capacity to deliver consistent inspections and the need for clear processes and adequate resourcing to make these powers effective. The Royal College of Surgeons of Edinburgh emphasise the importance of active oversight for patient safety, but also cautioned that appropriate resource would be necessary:

> "HIS should be adequately resourced to conduct regular inspections, enforce compliance, and respond to public complaints effectively."

The submission from HIS raises several operational and resource challenges with implementing the Bill's inspection and enforcement powers. It warns that key definitions, such as responsibility for governing competence, delegation and supervision of healthcare professionals, are unclear and risk confusion. The submission also calls for a clear delineation of responsibilities between HIS and local authorities under existing licensing arrangements.

HIS also raises concerns about the new powers of entry, search and seizure in the Bill, noting that the organisation has never enforced in unregistered settings and lacks the resources, systems and processes to do so. The response further highlights that HIS currently operates under an intelligence-led model and does not proactively detect unregistered services. It calls for clear protocols, adequate resourcing and improved data systems to make the Bill workable.

The response also raises concerns around enforcement relationships and operational capacity, citing an undefined enforcement role with COPFS, the need for new administrative and legal frameworks, and funding gaps.

Part 2: Key issues raised in the Health, Social Care and Sport Committee's call for views

Most respondents supported the proposed changes in Part 2 of the Bill.

Application for review of medical certificate of cause of death

Extending the circumstances under which families can request a review of a Medical Certificate of Cause of Death (MCCD) was widely welcomed as a way to improve transparency, accountability, and public confidence.

The Death Certification Review Service (DRCS), part of HIS, expresses support for expanding review rights stating that it previously seemed unfair when the law stopped a review from happening even when new information came to light. The response indicated that the DCRS first requested this change in the 2018-2019 DCRS annual report (available on request from the DCRS).

Some respondents stressed the need for clear guidance to prevent misuse and ensure timely processes, particularly for bereaved families and faith groups where delays to burial can cause distress. The Jewish Council of Scotland submission explains 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...the shivah (initial period of mourning) cannot begin until after the burial has taken place, and consequently any postponement will delay the grieving process, and inevitably cause great psychological distress to the bereaved."

The submission also welcomes the recent introduction of the Advance Registration Procedure, which enables the bereaved to apply for permission to proceed with burial before the completion of an MCCD review. The submission states that provided "the Advance Registration Procedure continues, and will be available to the bereaved whenever, and by whomever a review is requested, we are content with the provision proposed in the Bill".

The East Ayrshire Health and Social Care Partnership submission welcomes the proposal but highlights that there may be "resource and capacity implications in extending these rights which will need consideration".

There was also broad agreement on giving medical reviewers the power to reject inappropriate or duplicate applications, provided decisions are transparent and based on clear criteria.

However, a few respondents raised concerns that the wording could allow overly broad discretion, risking unfair refusals. One respondent didn't think an application should be able to be rejected if "there is questions over the death" and another thought that "extending the power to reject applications must come with strict criteria and oversight to maintain public trust." Another respondent felt the proposed rule change could let reviewers refuse a review too easily:

> "The extended reasons to reject a review in the proposed substitution of Section 4 (3) has the effect of allowing a medical reviewer unlimited opportunity to deny a review. The addition of subsection (3)(c) "considers it otherwise appropriate to do so". While a reason must be provided to the requester, this open-ended clause provides opportunity for wrongdoing to go undetected."

Authorisation of cremation by medical reviewer

Removing the requirement for Scottish authorisation of cremation when death occurred elsewhere in the UK was generally supported as a practical step to reduce duplication and delays, while maintaining safeguards.

The HIS response sets out that the change removes confusion and confirms that Scotland will respect death certification processes in other UK nations. If a death is registered elsewhere in the UK, no extra review is needed in Scotland for burial or cremation. The submission states that this aligns with existing practice and 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."

The Jewish Council of Scotland support the change "in order to expedite matters for those who wish to use cremation" under Progressive Judaism.

Some respondents disagreed with this proposal. These responses stated that a medical reviewer should continue to give authorisation. It is unclear whether all respondents had fully understood the nature and intent of the provision. Explanatory

notes were provided within the survey, but these may not have been read. It is possible that some respondents might have interpreted this as meaning that there would be no medical review prior to cremation for deaths elsewhere in the UK, while the explanation set out that this is no longer required due to equivalent legislation now in place elsewhere in the UK.

One respondent thought that the Bill could contain further provisions to update the Certification of Death (Scotland) Act 2011. She calls for a full review of death certification in Scotland, commenting that there are current discrepancies in the system of reporting deaths. The respondent argues that Scotland does not have a "comparable system of scrutiny for all death certificates or route of escalation of concerns" to that in England and Wales. The response also states that there is potential for "death certificates to mislead and effectively conceal homicide, medical error or neglect."