



# Women and Equalities Committee

## Oral evidence: Health impacts of breast implants and other cosmetic procedures, HC 869

Wednesday 22 October 2025

Ordered by the House of Commons to be published on 22 October 2025.

[Watch the meeting](#)

Members present: Sarah Owen (Chair); David Burton-Sampson; Rosie Duffield; Kirith Entwistle; Samantha Niblett; Rachel Taylor.

Questions 191 - 256

### Witnesses

**I:** Victoria Brownlie MBE, Chief Policy & Sustainability Officer, British Beauty Council; Lesley Blair MBE, CEO and Chair, British Association of Beauty Therapy & Cosmetology (BABTAC) and Confederation of International Beauty Therapy & Cosmetology (CIBTAC).

**II:** Karin Smyth MP, Minister of State for Health (Secondary Care), Department of Health and Social Care; Gavin Larnar, Director of Workforce, Department of Health and Social Care; Professor Aidan Fowler, National Director of Patient Safety, NHS England, and Deputy Chief Medical Officer, Department of Health and Social Care.

Written evidence from witnesses:

[\[BIP0047\]](#) Joint Council for Cosmetic Practitioners (JCCP), British Beauty Council (BBCo)

[\[BIP00143\]](#) Department of Health and Social Care



## Examination of witnesses

Witnesses: Victoria Brownlie MBE and Lesley Blair MBE.

**Chair:** Welcome to the Women and Equalities Committee. We have a very interesting session, but it is the last session of our inquiry into the health impacts of breast implants and other cosmetic procedures. On our first panel today—I know that it is a very busy week for you both, given it is British Beauty Week—I am delighted to introduce Victoria Brownlie MBE, chief policy and sustainability officer at the British Beauty Council, and Lesley Blair MBE, CEO and chair of the British Association of Beauty Therapy and Cosmetology. Wow, that is a mouthful, and a long title. I am glad we did not put your title underneath your name. Welcome to you both. Before we start, if there is anything that you think you want to answer more fully or with data that you think would be useful for us to see, please do not feel that you have to cram it into the answer, you can always follow it up in an email afterwards.

Q191 **Kirith Entwistle:** I want to start with the consultation on non-surgical cosmetic procedures. The original one took place in October 2023. The Government have now said further consultation is needed. What is stopping the Government from getting on with it, and what are the risks of further delay? I will go to you first, Lesley, if that is all right.

**Lesley Blair:** I can maybe answer the risks of us not going ahead with it because that is really, really important. We have increased pressure on the NHS due to more botched procedures and things going wrong. The NHS already has enough on its shoulders. What is happening with the lack of regulation presently is that people are presenting themselves at A&E when they have a complication from one of the treatments that is not adequately managed by the injector, the therapist or the practitioner. That is definitely a big one.

We have people working below the radar. For me and Victoria, being in organisations where we are very much into standards and fit-for-purpose qualifications, that is very frustrating because we have people out there operating who are putting profit over standards, which is really, really scary; we have poor hygiene standards. That is a risk to consumer and public safety because we do not have that monitoring. A lot of people who do not hold the correct qualifications are in it for the money and for profit, so they are probably not practicing to the levels that they should be; we have misdiagnosis and poor judgment because unfortunately, again, people are putting profit before standards and proper treatments. That is huge.

Lack of accountability is a huge one. In our industry, because we are not overseen with any regulation, we are not accountable for anything that goes wrong. That is really, really important. It definitely makes you think a bit harder when you are doing things if you have that accountability, where if you do not do it correctly, not only do you have your ethics, but there is a chance you are not going to be able to practice going forward;



there is the unethical marketing, where people are sending out claims that are just absolutely preposterous and mostly untrue; we have body dysmorphia that people are really working on. That is really, really bad, especially with all the problems with social media and how ladies and gentlemen are meant to look now in the eyes of social media.

We have high-profile cases that are really harming the public's view of our sector. It is a sector that I am very proud of. I have been in it for over 35 years as a practising therapist, so standards are very, very important to me; we have black market treatments. People are buying all these things from overseas, and we do not know what is in them. You hear of high levels of rat poison and different things, and different injectables and so on. That is definitely very apparent out there; we have no oversight on the devices. There is oversight there, but because it is not monitored, we can easily buy these things.

**Q192 Kirith Entwistle:** The risks around delay are just that the current issues will continue but also increase, basically?

**Victoria Brownlie:** It has created this policy vacuum. We are really grateful to the Government for the work they have done to date and the fact that we had this announcement over the summer about moving forward with these red procedures. I do not know whether to go over the red, amber and green. Lesser risk is green, medium risk is amber, treatments that should really be a surgical procedure or performed only by a medical practitioner are red. The Government's commitment to moving ahead with that red is hugely welcome and something that Lesley and I have been pushing for, for many, many years.

But the main issues and areas where things go wrong are generally in the amber category. That is where we are really waiting for regulation or some kind of licensing scheme. Until we have that, we are going to continue to see problems where we have this policy vacuum. More and more unregulated qualifications are being made, people are offering short courses saying that they are going to be Government compliant, when we do not actually know what the Government are going to require of people.

It has just created a system where we know that the Government are moving forward with something, but because there is that lack of clear timeline, people are jumping on the bandwagon of creating things to say, "Oh, don't worry because this is going to be absolutely fine for the regulation when it comes in," when we just do not know that that is the case.

**Q193 Kirith Entwistle:** Do you have an idea of what might be holding the Government back from actually moving ahead?

**Victoria Brownlie:** There is a complexity around what the qualifications and training standards should be. There is going to be a period where people who are already qualified have to undergo some kind of



## HOUSE OF COMMONS

assessment to check that they still meet the criteria of the new level of training qualification standard. That will be difficult, and I completely understand that, and so will the training of Environmental Health and Trading Standards officers who will ultimately be enforcing it.

Both those things will take time, but the Government essentially have an open door here. We have Environmental Health officers, we have the industry, and we have medical practitioners and the NHS all saying, "Go for it. We want licensing, we want regulation in this space." They are pushing an open door. For us, it is a case of let us go. We are all here to help give you the expertise that you may need to go forward in those bits that may be slightly trickier areas, but we just need that timeline so that the industry can prepare itself.

**Lesley Blair:** Also from a cost perspective, maybe the Government are thinking, "Can we fund it?" But it would be very much self-funded if we have a paid licensing scheme. We believe that that would be self-funding, and it would be easily managed with the licence fee.

Q194 **Kirith Entwistle:** Just around licensing, does the proposed tiered licensing system adequately reflect the risks associated with the different non-surgical cosmetic procedures, and do you think it will be effective? Have you had any feedback from members on the proposals, particularly around oversight?

**Victoria Brownlie:** Yes. From our perspective, it needs to be as simple as it possibly can be, understanding the huge breadth of different procedures that will currently fall within the proposals, while also future-proofing it for the rate at which innovation is moving in this space. When we think back to when the original consultation took place, that is when things like vitamin infusion injections were really kicking off. Now it is weight loss injections and various other modalities and innovations that we just did not even know about a couple of years ago, so goodness knows where we will be in a couple of years.

That part of it is really tricky, but we need to get to a point where we are equipping the enforcers with everything they need in order to do it. For us, that categorisation is really important. CQC will be regulating and ultimately monitoring the red category. That is medical practitioners only. It is already overseeing those people anyway, so it is just additional activity that it will be doing in respect of people who are already on its watch list.

The amber section is where it gets a little trickier. We agree that there needs to be a level of oversight here, but I should probably caveat this by saying we, as the council—I know BABTAC is the same—have in our consultation responses said that we believe injectables should be under red categorisation as well. But we are mindful of the fact that the Government are unlikely to do that, that they are likely to keep it in the amber category. But for us, there is a huge range in what we think the



## HOUSE OF COMMONS

level of supervision should be in that amber space, and that will be difficult for enforcers.

There should be very different levels of supervision required for an injectable and for someone administering a prescription-only medication, for example, and what could perhaps go wrong with that, with people having to give special antidotes and things that are prescription-only, versus something that is much, much lower level. Lesley can speak to this much better than I can.

**Lesley Blair:** Yes. As Victoria just mentioned, we obviously have complications management. To put it basically, if you have an injectable done, if you have a filler, you can have a blockage in the artery if it goes wrong, and then you need prescription-only medication in order to break that down. That can be one of the problems. That is why we need somebody who has the correct credentials to be the overseer of that. That needs a much, much higher level of oversight than, for example, if somebody was to be doing some sort of peel.

That is where we have said that in the beauty industry, if you are sitting at a level 4, you are very, very qualified to apply peels, to do skin needling and so on. But there are different levels of deepness and results that you are going to get. A beauty therapist at a level 4, to a certain level is fine, there should not really be any oversight needed. When we go a bit more ablative and deeper into the tissue, then that needs a bit more oversight. It is just managing these parameters and knowing what is what, and making that the overseer has the correct credentials because what we do not want to be doing is just opening up the gates to medical practitioners thinking, "Great, we can oversee all these different modalities," when they do not have the correct qualifications.

At the moment, you can go and do a half-day peel training or skin needling training. Just because you are a doctor does not mean you can do skin needling or peels. Our training is a lot longer than that. What we would ask is that, if at all possible, everyone has that even playing field, we have parity across the board, and the medic, the beauty therapist and the beauty professionals are doing it to the same level. Let us all do what we are able to do and stay in our lane. That is a good way of putting it.

**Victoria Brownlie:** When we say level 4, that is the qualification.

Q195 **Kirith Entwistle:** I just wanted to ask as well, do you think the Government are correct to restrict the highest-risk procedures, for example, liquid BBLs, to, "Suitably qualified health workers," or do you think there should be a total ban?

**Victoria Brownlie:** Well, you would be lucky to find a medical practitioner who would do a BBL, to be honest. The majority I speak to, the opinion across the board for more respected practitioners is that they would not do that under any circumstances because of the risk. That is ultimately what it is about. It is about a medical practitioner



## HOUSE OF COMMONS

understanding those risks and putting the client's safety first. For something like a BBL, you would be lucky to find a UK-based practitioner who would be willing to do it.

**Lesley Blair:** By putting it in that red category and making it surgical-only, we are probably fixing the issue, because as Victoria rightly says, we are probably not going to have medics actually wanting to perform these legitimately.

**Kirith Entwistle:** In effect, it is basically a ban without actually banning it.

Q196 **Chair:** Victoria, I just wanted to come to your point about how the biggest complications and issues could fall into the amber category. As you rightly said, in the last 10 years on our high streets, online, everywhere, the beauty industry has been revolutionised. The technological advances have been great, and they are so fast: the minute something comes out on the market, it is old within two months, it has been superseded by something else. How do you envisage a licensing scheme like this being able to keep up with the pace of change and scale of innovation within the beauty industry?

**Victoria Brownlie:** Yes, it is a really difficult question. It is going to have to be within the wording of the regulation as it comes through that there is constant review of this. We are quite covered within the wording under section 180 of the Health and Care Act 2022 that the types of procedures that will be covered under the licence are broad. It gives us that freedom in those areas: laser, light, heat and all those kinds of things. But it is a problem area.

As I said, what we have to do is just make sure that there is that constant review and oversight with the correct people in the room. That is both Environmental Health and, ultimately, the enforcers talking about what they are seeing on the ground. It is also the industry talking about new technologies and making sure that they are linked to occupational standards, training and education, and not just some flash in the pan thing that has come out from another country that should not perhaps even be done in this country.

**Lesley Blair:** We need to keep the narrative open. When we finally get some sort of licensing in place, it is about having regular meetings with industry and with Environmental Health, as Victoria so rightly said, so that we can manage this innovative industry that we are in. That is what makes it such a wonderful industry, but it also poses its problems because we are so fast moving. With us at BAPTAC, with Victoria at the British Beauty Council, we are probably at the forefront of hearing what is going on, and sometimes I feel as though I am not keeping up with it either. It is really such a fast-moving industry, but we need to keep it safe. That is the main thing here.

Q197 **Chair:** And safe in all parts of the UK. I have come on to devolution. How



## HOUSE OF COMMONS

do the proposals in England differ from those in Scotland? Is there a risk that the lack of regulation in Wales and Northern Ireland could just lead to cross-border issues? You could just get something done in Wales that you could not get somewhere else, or you could get your hands on something that is not licensed in England that is just completely unlicensed somewhere else. Should additional steps be taken to deal with these cross-border issues?

**Lesley Blair:** Yes. We were chatting about this earlier. When we had the covid situation, in Scotland we kept the masks on a lot longer than everyone else, for some reason. All that was happening was people were going across the border to get treatments. We had lots of therapists going underground, a lot of the time to make a living as well. There needs to be parity across the four nations in order for us to make this work, or we are just going to get these muddy waters here.

At the moment, in Wales you need a licence to pierce ears, but you do not in England. If people have salons or businesses in both, they just do it in the one that does not need a licence. That is already happening, and it is something that is relatively straightforward and not a massive safety issue. Yes, we would absolutely want it to be cross-border to have parity.

Q198 **Samantha Niblett:** I heard you touch on it earlier, but I would like to come on to training qualifications and oversight. How should the Government define and enforce minimum training qualification standards for practitioners who are performing non-surgical cosmetic procedures? Sorry if I am putting words in your mouth, but should there be a national curriculum or central accreditation body for aesthetic training, maybe? How can you ensure consistency across the providers?

**Lesley Blair:** We have national occupational standards that the industry all works together towards. Something that I bang on about all the time is using the correct terminology. Since a number of years ago, we have made sure that when we talk about a qualification, it is something that is fit for purpose, it is within the regulatory framework, and it is governed by the likes of Ofqual, which is a government regulator. We would not call a one-day course a qualification. That is a training course. A qualification is something that is robust and on the register. That gets people thinking of the difference between them.

The national occupational standards are there, and if you have a regulated qualification, that will work to the national occupational standards. That would be a benchmark of standards out there for what training should be and for fit-for-purpose training.

We already have those, and we are constantly developing them. They are put together, and they are reviewed very regularly. But at the moment, because we do not have any licensing that requires you to have the qualifications in order to practice the procedures and the treatments, that is where a lot of the problems are. I could go and do—I did—all my qualifications, you could go and do none, but you could advertise yourself



as a practitioner and still get insured, which is a total other minefield out there. That is where we have this disparity out there. I always say, "All that glitters is not gold." When you see a certificate on the wall, it does not mean to say that it is a fit-for-purpose qualification, but unfortunately consumers do not realise that. All this is about consumer awareness, too.

**Q199 Samantha Niblett:** It might be putting words in your mouth, but on that point, is there an argument to say that actually Government should consider pre-existing experience? If you get accreditation, accreditation is almost gold standard, but you might have experience.

**Lesley Blair:** That gives us a benchmark. It is an easily judgable benchmark. We have that all in place, so it would definitely be prudent to use that as the standard because otherwise what standards do you judge by? That should be the absolute minimum that we are looking for here. Again, all that we have been asking for throughout is that we have an even playing field because there are just so many different variables out there, and everyone should be working to the same standard. People have maybe been a practitioner for 20 years. That does not mean to say they are good, but it also does not mean to say they are bad. It is about putting in process an easy pathway in order to gain that qualification, to make them fit for purpose, to reach the standards in order for them to practice and get a licence.

That is what we would be advocating. We are not saying that after practicing for many years you need to go back to square one and start training again. We would imagine some sort of oversight from awarding bodies and regulatory bodies where somebody can go in, assess them, see where the gaps are, fill the gaps and let them do a practical assessment, which is very, very important, and a theoretical assessment. If they do that, then they are good to go, because they have reached that standard that has been viewed across the industry as a minimum standard we should be working to. Then insurance companies should insure only this standard too.

**Victoria Brownlie:** That is so essential from an enforcement perspective as well. You need a really clear level that the enforcers are going and checking. In our opinion, it has to be a central database of practitioners who have a licence, and within that, they have had training from a central database of listed providers who are doing a government-mandated qualification. We essentially get rid of this issue where we have people offering—as Lesley mentioned—these short, two-day, often only virtual courses. They are not actually having to do any practical assessments, and then they are going and doing Prosecco Botox parties in people's living rooms.

**Lesley Blair:** Better than the ones who are doing it on YouTube, to be fair, though. That is a step up.

**Q200 Samantha Niblett:** Would it help if being a regulated healthcare professional was the only requirement needed to perform or oversee non-



## HOUSE OF COMMONS

surgical procedures in the amber category?

**Victoria Brownlie:** Not to necessarily perform. In the red category, absolutely, it should be healthcare practitioners only.

**Lesley Blair:** Surgical.

**Victoria Brownlie:** Sorry, surgical. As Lesley mentioned, there is a correct pathway for non-medical practitioners to be able to go and get a degree-level qualification, but just not with the £70,000 worth of university debt that you might have to get to go through university. We need to always bear that in mind. There has to be safety but also accessibility for people. In our industry, we are an over 80% female-led industry. They are working mothers doing this in and around other responsibilities in their lives.

We have always championed the fact that we are able to offer these things to women. That is fantastic, but they have to do that in a safe way that meets a minimum standard, which Lesley so rightly pointed out earlier. It should not be that you can only get these qualifications if you are prepared to go to university. There has to be an apprenticeship route, a level 1, 2, 3 and 4 route where you can work your skills up, but it should just be through the proper training methods rather than a two-day course.

Q201 **Chair:** I just wanted to ask a question about the promotion of some procedures. You mentioned people doing it on YouTube and Prosecco and Botox parties, and quite often it is influencer-led, but they are advertising something. Do you think tech companies should take more responsibility for what is promoted on their sites and the adverts that they allow on to their sites in this area? Victoria?

**Victoria Brownlie:** I would love that. Technically, that should already exist currently. The problem that we have is that ultimately it is a case of having vigilant people who are willing to report these things, and then they are inevitably taken down. But it is the wrong way around, it is after the fact, and therefore the damage has already been done. If that person has a following of 20,000 or 30,000 people, then essentially the problem has already happened there.

We experience this "Love Island" effect, essentially, of these kinds of treatments being much, much more accessible, which a decade ago would have been accessible only to celebrities or people with very significant levels of income. By seeing these kinds of people who had these kinds of procedures on television, it created a situation where more people wanted these kinds of treatments. It was a race to the bottom of more and more practitioners filling a void of need from people and a race to the bottom of cost and price. That is where you had these short courses and others coming up saying, "Well, you could go through levels 1 to 7, which will take you—" How many years?

**Lesley Blair:** Three years, probably.



## HOUSE OF COMMONS

**Victoria Brownlie:** "Lots and lots of time and some cost to you, or you can go through a much, much shorter route, and no one's going to ask you the difference." We find this all the time. How many times do you actually go to a practitioner and say, "Can I just check your certification or whatever?" You usually go because a friend has recommended them to you or something like that.

**Lesley Blair:** Nobody has ever in my whole career asked me to see my certificates. When I was practicing, I spoke to clients about this and we did various surveys, and they just said, "Oh, I just took it that you were qualified." I alluded to this earlier, but the word "qualified" is very, very widely used and not always in the correct way as well.

**Chair:** That is not just in the beauty industry, I will say.

**Lesley Blair:** Yes, of course. This happens with the word "qualification" or "level". We also do insurance for the beauty industry, and we get so many people coming with a qualification that they think is fit for purpose because it says level 4 or level 5 on the certificate. We check every single certificate, and if it is not something that is on our landscape we investigate it, because we do not insure you unless you have a regulated qualification. The number of times that it comes up that it has been a one-day or two-day course, but they have been given a certificate that says, "level" on it, and they thought they had a qualification.

Q202 **Rachel Taylor:** Victoria, Lesley has quite clearly told us about some problems with the public not understanding the certificates and not knowing what to ask for. What measures do you think are necessary to improve public awareness of the risks associated with certain procedures and how to choose safe providers?

**Victoria Brownlie:** To me, it goes hand in hand with anything that we do in the licensing scheme. Yes, absolutely, the licence needs to be self-funded, but there needs to be a portion of that money that is put towards education in this space as well. Part of the licensing scheme should be that there is always a cooling-off period and that the practitioner has gone through alternatives and what the potential side effects could be—the things that may go right, the things that may go wrong—giving the person who is looking to have these treatments the time to make that decision. It should never be that you go and have a consultation, and you can have the treatment straight away. There should always be that cooling-off period.

A lot of the time the public are not really aware of that, but if we can create this licensing scheme where all these things are a mandatory element of the licence, then to me it becomes normality for the consumer that they come to expect that. It has to go hand in hand with that public education campaign of what to do if things go wrong and what you should be looking for in a practitioner. Lesley has a fantastic campaign, the TIME campaign, which BABTAC has run for many years now, which we support. But ultimately, the consumer still needs much, much more education



## HOUSE OF COMMONS

across the board—Government led and industry led—to really hit those messages home.

**Lesley Blair:** Yes, can I jump in there? As Victoria has just said, we have our TIME campaign, which we launched at the House of Commons, we have also this year launched it with the Scottish Government. That is a campaign to get people talking and to get the consumer talking, to make people comfortable and equip them with how to ask the question of, “Okay, so where did you train? How long did you train for? Oh, you’re insured. Where do you buy your products?” All these things are very, very important for safety for the consumer.

We have done that, and it has been very successful. We have had massive reach. I will just read from here, “Total reach was 361 million,” our PR company came back and told us, and over 100 media coverage. Pieces of—

Q203 **Rachel Taylor:** Thanks, Lesley. Can I stop you there? We need to try to get some details out. Victoria, can I push you a bit? What steps do you think will be required to ensure that unregulated and illegal practitioners are not able to practice once we have the licensing scheme in place?

**Victoria Brownlie:** Good question. Ultimately, if the practitioner does not have the adequate level of qualification, they would not be granted a licence. For me, in the same way as with the Botox and filler regulation for under 18s that came in in 2021, it should be ultimately that it is an offence to then continue to operate by offering those services, and therefore, there is then the legal side of that.

Q204 **Rachel Taylor:** So there needs to be some regulatory framework around that and around criminal sanctions?

**Victoria Brownlie:** It needs to be essentially around the breach of a licence. In the US, you have to have a licence to be able to offer any essential beauty or aesthetics services, in order to be able to practice. If not, then there are fines, potential prison time and so on.

Q205 **Rachel Taylor:** Do you see that being enforced through local authorities, Environmental Health officers, or Trading Standards? How would you see that enforcement?

**Victoria Brownlie:** At the moment, Environmental Health and Trading Standards are trying to do the best they can within the regulations that currently exist, and so they probably are best equipped to do it because they are seeing what is going on on the ground. With the Botox and fillers regulation, that would actually come under police oversight and enforcement. There is an element of both: there will be fines or further action, depending on the seriousness of what has gone wrong.

Q206 **Rachel Taylor:** Lesley, I want to talk a little about insurance because I know that is something that your organisation covers. The Government stated that appropriate indemnity insurance will be a requirement for



licensing. What sort of minimum coverage should be required to protect consumers, and has there been any information obtained about the likely cost of that insurance for providers?

**Lesley Blair:** Well, at the moment, there is no requirement to be insured to do these. Across the industry, the majority of people are insured, if I am honest. Unfortunately, there is no oversight for insurance companies either. We have a lot of situations where people can just be insured when they do not have the fit-for-purpose qualifications. What we would really want would be that the only way you could get insured is if you had a licence and qualifications.

From a cost perspective, it is definitely very much in correlation with the prices charged. I would not say that that was a big cost to businesses; that would just be a cost that is expected by businesses to have to pay. For normal insurance, for the more basic modalities, it is £99 a year. That includes a full membership, and that is £6 million of indemnity for the practitioner. We have not had any claims in the beauty industry in the UK that have ever gone anywhere near £1 million. The £6 million is there probably just as a—

Q207 **Rachel Taylor:** There is obviously a need for an amount of indemnity insurance per claim but also a total amount for all claims, is there not? Are you saying that that level should be set at £1 million for a single claim or £2 million?

**Lesley Blair:** Well, it would be unusual to even get to the £1 million, to be honest. We do not insure the advanced aesthetics, just because we do not have that level of oversight that we can actually adhere to when we are giving out insurance. For the normal beauty modalities, maybe £50,000 to £60,000 would be the payout claim. If you were doing it for colonic irrigation, which is a bit more intrusive, it is about £250,000. Again, we do not insure that, so I cannot comment on it.

Q208 **Rachel Taylor:** I am guessing that would be different with the licensing scheme? Perhaps Victoria, if you had amber and red, there would be different levels of insurance for different procedures?

**Lesley Blair:** The doctors are doing it anyway because they are already covering themselves for their medical procedures that they are doing.

**Victoria Brownlie:** I am pretty sure that under CQC regulation a medical practitioner would already have to have insurance.

**Lesley Blair:** They do, yes.

**Victoria Brownlie:** As Lesley mentioned, the majority of practitioners already have insurance, but I am sure a lot of it is not fit for purpose. The problem that we have is that for some insurance providers, you do not have to send any proof of physical qualification. Like Lesley mentioned, this could just be a piece of paper that actually means nothing, and how are they to know? Because we do not have a regulated standard of, "This



## HOUSE OF COMMONS

is what the proper level of training is," the insurance providers, to be fair to them, are working within the constraints of what it is that currently exists.

**Q209 Rachel Taylor:** It is quite frightening that insurance would cost £99. I was involved in law before I became an MP, and our indemnity insurance cost tens of thousands of pounds per annum, as opposed to £99. That was just for financial losses, as opposed to loss of health or potentially loss of life.

**Lesley Blair:** That is full cover they are getting for that as well; they have the £6 million payout. We pay I think 99% of claims, because we do it properly, we check to make sure that people are qualified. The problem that we see in other areas is that because they have not checked the qualifications, when it comes to the time of claim and they then present these certificates, they say, "Oh, no, this is not a qualification so we can't pay out," and they are not actually covered. That can be a problem as well.

**Chair:** I have David and then Rosie for some supplementary questions on this section, please. David?

**Q210 David Burton-Sampson:** This one is probably for you, Victoria. If a medical practitioner is perhaps under investigation for malpractice or for some sort of failure, what restrictions are currently applicable to that practitioner during that period? What restrictions should be applicable to that practitioner during that period of investigation?

**Victoria Brownlie:** I cannot speak to medical practitioners. I would not profess to have knowledge in that space. Lesley, you may know differently. From a non-medic side, this is the problem that we have currently: at the moment, if you were to have botulinum toxin, an injectable in your face, and something was to go wrong, and you wanted to seek recourse for that—you wanted to have that practitioner stop, you wanted to claim some level of insurance to have some kind of follow-up procedure to fix it or something like that—there is nothing in place currently that can stop that person from operating. A local authority cannot get involved unless it is at a level where someone has caused grievous bodily harm or something like that, and you can utilise funny pieces of regulation. But there is nothing in place now that can actually stop that person from operating.

We see cases all the time where people are contacting us saying, "There is a person who has given me some kind of injectable treatment. I've written to them, they have blocked me on this and this and this platform so that I can't talk to people about the level of service that they give, and they are still the next day giving 10, 20 treatments to other people and going on." There is literally nothing we can do about it.

That is absolutely why we need to be bringing in regulation in this space, because the Environmental Health officers' hands are essentially tied. We



## HOUSE OF COMMONS

have had cases where even when the Environmental Health officers have been able to utilise strange bits of regulation to stop people from operating in certain local authorities, they just move to the next local authority. You have to rely on the possibility you will have equally diligent and astute Environmental Health officers, who are going to go through all those rings and hoops again with very limited resource, for them to hop on to another area and another area. We just cannot continue in that way.

**Q211 David Burton-Sampson:** How would you prevent that from happening?

**Victoria Brownlie:** How would I prevent it from happening? Well, ultimately the regulation would mean that if an issue was raised to the local authority, the local authority officers or the Trading Standards officers would be able to go and do an assessment and check what was going on there. If they felt that something had gone wrong and that the person was not following the standards required within the licence, then they could be stopped from being able to practice. But it would depend on the evidence and what we could see had happened. I agree with you, those are the kinds of areas where we need further clarification on what levers we can pull on with Government and regulation as it currently stands, and what we need to do more of, and which parties would need to be available for each part of that.

**Q212 David Burton-Sampson:** We could potentially have a national register of restricted practitioners as well.

**Lesley Blair:** That is why I have said this cross-border parity is so important.

**Q213 Rosie Duffield:** When we first started this inquiry, I got completely hooked on the Olivia Attwood series on ITV. I thought it was so excellent, though a bit squeamish-making. As an old lady who has children in their 20s, I was really surprised that so many really young women—who do not need anything—were just going for more and more treatment, spending tens of thousands of pounds. You are talking about the risks, but none of them seem to be in any way aware of the risks. Do you think we as MPs or the Government have a role in educating or targeting specifically younger people? Because obviously, like you mentioned, they are trying to keep up with influencers and stuff. Do we have a role in how we could educate them a bit more?

**Victoria Brownlie:** Yes, is the short answer. We could all be doing much more on that. The problem that we have with influencers and seeing things and wanting to emulate that, is that as young people we were all guilty of pushing the boundaries. There is an element of accessibility of our industry now that means people can potentially do things to themselves that they were not able to do several years ago. At the same time, a practitioner who has anything good about them should be talking that person through whether they feel it is necessary, the other options that are available to them, and really giving them all the information that



## HOUSE OF COMMONS

a responsible practitioner would do to move them into other areas, should they wish to do that.

Ultimately, it is about autonomy. If you are giving people all the information, they then have the autonomy to make that decision, rightly or wrongly, and then have the consequences of that. As long as they are doing that in a safe environment and they are given all the information, they should be allowed to do that because people should be able to look how they want to look. It is not for us to say what is right or wrong. As long as it is being done safely, with all the information available given to them, then that is for them.

**Lesley Blair:** Maybe if we share the risks that are out there more, because they do not understand. I have great pictures on my phone that I show to young girls who go and get lip filler done, of lips that have totally dissolved, and I show them what it is like. A few of them have now not gone to get it done. Something like that, just to educate people on what can go wrong. One of the side effects or possible complications of lip filler is blindness, because it can migrate to the eye. Do they know that? Probably not. We could have campaigns with that. That is something that I know Victoria and I would be very much wanting to get involved in and support, if we possibly could.

Social media is just crazy. How do we change that? My other favourite saying is, "Emptying the ocean with a thimble," because has it gone too far with social media, and just the reach that this all has and so on? This is the way people think they should look, and that is their idea of beauty. If you speak to other people or to oldies—I am talking about myself, I am much older—my idea of beauty is very, very different from somebody who is in their teens, who thinks that having enhanced lips, botulinum toxin, fillers and so on is attractive. I would not say that is the most attractive thing, but it seems to be in this generation that it very much is.

Q214 **Chair:** You are right. Beauty is in the eye of the beholder. That is why I asked the question around tech companies, because it used to be that we were influenced by the people around us, and now we are influenced by everybody all the time. I read recently that there was a 29-year-old woman who had a facelift. As you said, Victoria, these were the preserve of celebrities and people much older. That was obviously carried out by somebody who is a medical practitioner.

**Lesley Blair:** Not always, though. That is the problem with that as well, that that is happening without medical or surgical expertise.

**Chair:** I am just going to hand back over to David around monitoring and evaluation, and our ministerial team has come, and then we will ask you both your closing question: what would you raise with the Minister? Just one point.

Q215 **David Burton-Sampson:** What systems should be implemented to monitor adverse outcomes from non-surgical cosmetic procedures and



particular products? How do you think the Government should ensure continuous evaluation of the licensing scheme's effectiveness in improving patient safety? Perhaps we could have a quick comment from each of you. Victoria, then Lesley.

**Victoria Brownlie:** The central database is absolutely essential for recording adverse incidents and issues where we know that certain things are coming in from overseas, and we see a proliferation of things happening in the UK as a result of those things being imported. That needs to be held on a central database. In order for us to have all the information we need to deal with that correctly, it has to be held centrally.

The problem that we have within the non-medical side of the industry at the moment is that there is no central database, there is no centrally held data. It is very, very difficult to understand the length and breadth of this issue. Unfortunately, that has led to us kicking the can down the road. We were talking earlier about how the Keogh Review came out in 2013, first bringing this issue to light, and here we are now in 2025 still having conversations today.

Q216 **David Burton-Sampson:** Lesley, maybe you can answer this. Are there any examples of best practice in regulation of non-surgical procedures internationally that lawmakers here in the UK could perhaps seek to replicate?

**Lesley Blair:** I am not particularly aware of them. What I would say is that we just need to get the standards of training and education right. If we are looking to do it, we need to make sure that it is fit-for-purpose training and that the correct practitioners are actually qualified to deliver each level of the treatment. If you are doing injecting, then you are able to manage the complication if something goes wrong. It should be full circle. If we are going to be doing oversight, make sure that the person who is overseeing has the skill and the qualification to do the modality or the treatment, not just oversee it.

That is going to be really important. That is where we can make it. We can absolutely showcase the UK out there as being the best, so that people start talking about us saying who the gold standard is, who has the best practice. Let us have other countries talking about us. That would be great.

Q217 **Kirith Entwistle:** I will come to you, Victoria. How do you think the Government can mitigate undue financial impacts of the introduction of a licensing system on small business owners? Do you think that local authorities and the CQC currently have the resources and the expertise to oversee this licensing system?

**Victoria Brownlie:** Those are very good questions. There is a concern within local authorities about them being given the adequate resources to deal with this. If we think about the Botox and fillers for under 18s regulation that came in, the wide view of that is that it is not adequately



## HOUSE OF COMMONS

enforced currently. We can say the same for things like regulation on tanning beds and age restrictions on that. The difference with the licence will be because it is funded through the licence fee, it will be easier. Hopefully, the local authority will be better equipped to actually deal with the enforcement because of the funds that they will gather from that.

Can you just repeat the first half of the question? Sorry.

Q218 **Kirith Entwistle:** How do you think the Government could mitigate undue financial impacts of the introduction of the licensing system on small business owners?

**Victoria Brownlie:** What is important to remember here is that the only thing we are talking about restricting is those dangerous, high-risk red procedures, which in our opinion should not be performed by non-medical practitioners anyway. We are here because we are putting public safety first. If you are going through the correct formal qualification route, there should be a plethora of treatments and procedures that you can offer. We are not taking away your livelihood. There are still hundreds and hundreds of other procedures and treatments that you can perform safely. It is not appropriate for you to be offering, frankly, surgical-level procedures if you are not a medically trained practitioner.

**Lesley Blair:** Yes, I agree.

Q219 **Chair:** The Minister is sitting behind you. If you could ask her one question, or if you have one concern that you would raise with her, what would it be? Victoria?

**Victoria Brownlie:** It would be to move forward with the licensing element, the amber-level procedures that would require a licence, prior to the next general election. We really need movement in that space.

**Lesley Blair:** I would just like to make sure that there is parity and to make sure that it is fair; you should not be able to do all the treatments just because you are a medic. Everyone should be very much qualified in what they are doing, and we should all stay in our space of our technical expertise.

**Chair:** Thank you so, so much, Victoria and Lesley. I am really grateful, and the Committee is very grateful, for your experience, your expertise and your candour today. Thank you very much.

### Examination of witnesses

Witnesses: Karin Smyth, Gavin Larner and Professor Aidan Fowler.

Q220 **Chair:** Welcome. We have the Minister of State for Health at the Department of Health and Social Care, Minister Karin Smyth with us, Gavin Larner, the Director for Workforce at Department of Health and Social Care, and Professor Aidan Fowler, national director of patient safety at NHS England and Deputy Chief Medical Officer at the



Department of Health and Social Care. Welcome to all three of you, and thank you, Minister.

I am going to hand over to David but before I do, you heard those two concerns or questions, particularly from Victoria, around the speed at which we need to be able to bring the licencing scheme into effect, particularly with the innovation that happens within the beauty sector. What kind of timelines are we looking at for a licencing scheme?

**Karin Smyth:** First, can I say, Chair, thank you for inviting us? We made a really big announcement in August and I know it has been widely welcomed and there are a lot of questions to ask. It is complex—as I know your Committee has explored—and we are very pleased to be able to come today to share some of that, but also to hear from you and get those questions so that we can get this right. This is a really important industry and patient safety is also really important, and as you understand, and we want to make sure everyone else understands, it is really complex.

On the timing, as you have heard from your previous speakers, there are two parts to this. First, let us call them high-risk procedures that will be subject to the Care Quality Commission regulations. We want to bring this forward as soon as possible and, hold me to a date, but what we are looking to do is consult on those early in the new year, realistically. That depends on us all getting aligned as to what we are consulting and we will talk about the red, amber, green list and the other complexities as we go through this afternoon. They will then be subject to parliamentary process and as parliamentarians you will appreciate that that is way above my pay grade in terms of the timing and the scheduling and so on. But this is important to get right, so consulting early in the new year is something that I can share with the Committee.

Secondly, alongside that is the local authority licencing scheme. Again, I know some of you have previously served in local government so you will also understand that is a diverse sector. There is a range of practitioners, a range of procedures, there is the education and training, insurance requirement, premises, the fees, working with local authorities to make sure that they are able to do this, absolutely working in partnership with them, so that work will be going alongside. That will take time for more detailed consideration, so I am happy to come back to the Committee and to others; we want to make sure we bring people with us on that to make sure that we are protecting the public and striking that right balance between supporting this predominantly female-run industry and making sure it is safe.

Q221 **Chair:** It is a very female dominated inquiry both in the fact of the people who work in it, but also that 96% of the people who seek these procedures are women. With that in mind around patient safety, obviously we understand and have heard that this will be a big change when it comes forward, but is there more priority or perhaps urgency being given to some of the highest risks? We heard from Sasha about her



liquid Brazilian butt lift and the horrors that she experienced: getting sepsis, being in a coma, that the person that did that to her is still operating on the high street essentially. Why is there a need to consult on something that is that high risk? Should we not be seeing an immediate ban on some of the most dangerous procedures, as Victoria had said, that would not actually be carried out by a medical practitioner? Could we perhaps move on some of the highest risk procedures quicker?

**Karin Smyth:** I absolutely understand where the question is coming from, the need to educate the public about some of these risks and the horrors that we have seen, including deaths, and perhaps we will come on to this. But we need to get this right, and I am happy to bring in Aidan on some technicalities about what you ban and what you do not ban and what that means clinically. This is a result of consultation under the last Government. I applaud them for doing that, but we are very determined to act. The fact that we are going to move into this area is actually quite a big step for a Government to take and it is great that it has been welcomed so much, but we need to get that right and that is why it will be early in the new year. I understand behind that question is also what about in the meantime? It is incumbent on us all to highlight those risks to the public so that they are warned with that information and do not seek some of these procedures.

Q222 **David Burton-Sampson:** What recompense will consumers have under the new proposals if procedures are botched?

**Karin Smyth:** We need to get to a state of being very clear what procedures we are talking about at different times. With the high-risk areas, once we get through that then they would be subject to the usual procedures about if something goes wrong. I am struggling a bit with what is behind that question in terms of recompense. We hope that a clinical procedure at that high risk level would not go wrong, but if a medic was outside their practice or CQC regulation they would be subject to action.

Q223 **David Burton-Sampson:** Has the potential recompense for non-surgical cosmetic procedures, the amber level, that go wrong for clients been thought about?

**Gavin Larnier:** Part of what we are looking at in the scheme is what requirements we put around practitioners who are licenced, about the insurance that they take up, so that if action is taken against them subsequently they have the insurance cover that will cover recompense for those kinds of procedures. So it is ensuring there is a degree of indemnity cover in there so that there is a route for those licenced procedures to have that vehicle.

Q224 **David Burton-Sampson:** We have just heard from the last panel about practitioners who are perhaps under investigation for malpractice and the fact that if they have been found to have any sort of failures, there are currently no restrictions on them being able to continue to practice during



that investigation and even post that investigation. They can perhaps move across local authorities and start working elsewhere. How would the Department look to address some of those issues with non-surgical cosmetic procedure practitioners?

**Professor Fowler:** I recognise the concern, and I would only be able to speak to the medical point of view on that, which is, what happens with practitioners? For example we see practitioners who are under investigation while working in the NHS who leave the NHS and go and work privately. We have organisations that, when under investigation, are dissolved and then they set up under a different name. That is a challenge in regulation by both GMC and CQC. Having spent some time recently at CQC I saw exactly that: the frustration of enforcement where characters or organisations move in that way. The reality is, it is just plain difficult. We want to make sure that any loopholes we are looking at, spotting and addressing are taken into consideration with any of the increase in regulation.

Q225 **David Burton-Sampson:** Minister, we have again heard that perhaps there is not alignment across devolved Administrations on this and there is some concern that we have particular procedures in place in England that somebody could avoid by going to Scotland or Wales. How would you ensure there is regulatory alignment across the devolved nations?

**Karin Smyth:** It is a really important point, and officials working very closely with colleagues in Scotland has been really helpful in advance of us making the announcement back in August. Gavin might want to say a bit more about this, but it has been really helpful to share that and to work well together on that. Clearly health is devolved, all Departments actually, and this Government are very much committed to working with all devolved partners. The Prime Minister made that very clear when coming into office last July. That is fairly usual practice for us to work well at official level and to make those regulations work across nations, and many regulations do work well already across nations. Do you want to add anything to that?

**Gavin Larnar:** We are working closely with Scottish colleagues on this. Not just on making sure there are complementary regimes, but there are also some quite complicated internal single market issues in the UK about whether people can move across, which both Scottish and English officials and lawyers are going to have to wrestle with as we develop the regime.

**Karin Smyth:** That will also be true of some products themselves subject to what we are becoming accustomed to with regard to our role outside the European Union, and the need to work across an internal market in the United Kingdom.

Q226 **Rachel Taylor:** Thank you, Minister, and thank you for attending today. I wanted to come back on one thing about the timescale. This Committee has heard some really horrific evidence of what has happened to people who have been given liquid BBLs and it is just a really direct question:



how long are we going to have to wait before they are taken off the high street? Is the evidence not sufficient to say that that could be done more quickly? I appreciate the need for the longer timescale on consultation with the licencing scheme and the parliamentary schedule, but really how long are we going to have to wait until those dangerous procedures are taken off our high street so that we can protect our constituents?

**Karin Smyth:** I cannot add anything to what I have already said on that: we are working at pace to make sure that we get this right and we intend to have that out so that people can be clear what that looks like. In the meantime, we all need to make sure that we do as much as we can to raise awareness. This inquiry has raised a lot of publicity around a lot of this, which is really helpful, and we will continue to do that. I do not know if there is anything you want to add to that?

**Professor Fowler:** There is a mix of things happening; for example when we talk about the Brazilian butt lift, there are different approaches to doing that and there is a difference between somebody who is practicing say autologous fat transfer, which they should not be doing and are therefore already outside what is legal, and people who use a product, for example a filler that is licenced for use in 10ml volumes and they use a whole pile of them which is outside licence and therefore already outside regulatory acceptance. I know when I was here before we discussed this concern that we have to take a proportionate approach and not drive people into the hands of criminals or abroad as an alternative to get this. The Minister is quite right to say we just need to be a little cautious, that the adverse effect of what we all want, greater regulation, does not mean people go to unregulated practice more frequently. That would be a very big concern for us.

Q227 **Chair:** We understand the need for consultation and speed is of the essence in some of this, obviously. I know that the Department will work as quickly as it can do. Minister, you have said that it is on all us to kind of educate and to keep spreading the word and I think we all are, but I was just wondering if the Department of Health is running, or considering running, a public awareness campaign between now and the time that hopefully we see these really dangerous procedures come off the high street?

**Karin Smyth:** Yes, we are. Part of that was in the summer and actually the response and interest from the media was fantastic and I commend it. Largely, young female journalists have really taken this on because they can see what is happening in their own social media feeds and so on, and they have pursued some stories on behalf of those young women. We continue to do that and we are in partnership working with TikTok and influencers to get that message out. We are trying different innovative ways of trying to get that message across to particularly highlight the dangers, the need for people to inform themselves, to ask those particular questions. There is information online on the NHS website that is really good; so directing people to that information and using as many channels as we can to get that information out as there is



good information available. There are other ideas that the Committee or elsewhere thinks that we should be in different sorts of channels, but that is the approach that we have taken.

**Q228 Samantha Niblett:** I would like to talk about training and standards. I wonder what minimum training standards the Government plans to introduce for the non-surgical aesthetic sector and how would they be implemented?

**Karin Smyth:** This is really pivotal to the whole area of regulation. You probably heard the range of current training and standards out there from your practitioners, and how difficult that is to navigate as a consumer. Part of what will take some time in this is that we will have to consider the current education and training standards, the systems, who is providing those standards, what good practice looks like and so on.

As you have heard, this is an evolving industry: there are new things coming out for training people almost weekly, so it is a dynamic area to keep on top of. Then how we work to establish education standards and something that is very robust to get this across the sector; that is something that officials are used to doing but in this area, because of the nature of both the product and the qualifications and the sorts of work, getting that right will be a huge area of this work. This is maybe something Gavin wants to come in on.

**Gavin Larner:** An issue we are paying close attention to is how you arrange this in a way that new standards you consider recognise existing high quality practitioners who are well trained in non-regulated environments where people have done the right thing in reputable providers; considering those previously acquired skills in a kind of pragmatic way, while maintaining the standards that you want to see. Because of the complexity of the numbers of procedures and the different providers, just getting that right is going to take us a little while. But we want to work closely with the industry in doing that to get it pitched at the right level.

**Karin Smyth:** We should say that there are a lot of good people doing good work out there. You have heard from some of them; they want good standards because they do not want their industry to have this bad reputation. They want high standards and they do not want to be in competition with people who are cowboys, have low standards, have low hygiene. Working with them, with their expertise, to try to get that right is also critically important.

**Q229 Samantha Niblett:** That is really good to hear actually, because one of the things that we have been hearing is that many skilled practitioners—including those with level 7, so like master's level aesthetic qualifications—could be forced out of practice if they lack a formal medical background. What plans does the Department have to create accessible upskilling or transition pathways for such practitioners? You sort of alluded to it, Gavin, but I just wonder whether there is a plan



already.

**Karin Smyth:** If I take first and then I am going to bring the experts in. This adds to the complexity of the timeline about whether someone is medically qualified and what for, what those procedures are, and they are defined very closely as they are of course in usual medical regulations. Also, as Gavin said, in terms of what is already out there and then what we know is coming up stream: that is part of the severe complexity, as well as encouraging people into what is a growth industry with some good jobs for people. Getting that balance right between patient safety, clinical expertise, training expertise and safety is exactly why this takes a long time. It is very complex.

**Professor Fowler:** It is a whole spectrum, a continuous spectrum of activity. What we have to do is find a way to chunk that up in a sensible way of, what is non-medical and how you are trained in that, what is medical low risk—that is a difficult term because we have seen the effects of botulism in people recently, so I would argue that is not low risk in some ways—and making sure that when we define medical practitioner we are clear what that means. There are some surgical procedures that should not be open to all medical practitioners and we are clear on that, but you will have heard from plastic surgeons who for example say you need cosmetic surgery training specifically to do a breast implant, whereas if you had a breast surgeon here they would say, “We are very clearly trained in oncoplastic and we are very familiar with putting in breast implants and reconstructing after cancer surgery,” and so we would not want to exclude those. Or maxillofacial surgeons who do cosmetic surgery to treat lesions on the face for example. So it is just getting that bit right. But I agree you would not want a breast implant to be done by a general practitioner who has not had surgical training. We just need to get that bit right.

Q230 **Samantha Niblett:** This is a really key point because we have heard that I think 80% of practitioners are women, and lots of them will be female entrepreneurs with their own business. I just wonder if the Government are considering providing financial support or funding to assist practitioners in meeting any new regulatory requirements that may be expected of them?

**Karin Smyth:** We will need to work with the industry. We recognise, and we say in all our comms and messaging, that this is a largely female industry largely for women and is an important part of our economy, particularly in local communities and constituencies. They want to work with us and we recognise that. Obviously many of them are already working at a high level and are paying for training and premises and hygiene and so on, so they are already doing that. You heard from your last panel that we will need to keep talking with them about how that works during the sort of transitional period. All these systems are based on licencing and fees so ultimately become self-funding as a system, but that will obviously need to be part of our discussions.



Q231 **Rachel Taylor:** Minister, clearly a licencing scheme cannot come soon enough, but has the Department undertaken an assessment on the economic impact of the proposals on practitioners, particularly those operating small and independent businesses? And what steps are the Government taking to mitigate financial harm or unintended job losses in the sector? Particularly because many of our high streets are occupied by a lot of these businesses.

**Karin Smyth:** Yes, which is why, as I said to Ms Niblett, we absolutely do recognise how important many of these businesses are, so we will have to balance that transition period coming forward. As I said, many of these industries are already paying for training their staff and are in well maintained premises and so they want to make sure they are not competing with people who are not operating as well as they are. But we recognise that will need to be part of the discussion as we build up the licencing system.

**Gavin Larnner:** We will need to do formal business impact assessments as part of the development as well, to take a formal look at that at each stage.

Q232 **Rachel Taylor:** Have you carried out an assessment as to the additional resources that will be required by local authorities and the Care Quality Commission to administer and enforce the licencing scheme? It is clear that single businesses could be subject to many different parts of the licencing regime which could become complicated.

**Karin Smyth:** Those are absolutely parts of the discussion which is why we cannot do something today. That is why we want to be realistic with the Committee and the public and the industry and local authorities and talk closely with them about this. Clearly we are in conversation with them all in advance of the announcement, which is where we recognised it was welcome and are continuing to do so. But essentially, that is why we think that consulting on the high-risk procedures in the new year is a realistic timetable to have something robust enough to progress on, and in parallel with that we are having these conversations with those people for exactly these reasons.

Q233 **Rachel Taylor:** How do you think you will be able to prevent the new regime from being just too confusing, too expensive or too bureaucratic to be effective, either for the businesses themselves or for the public confidence?

**Karin Smyth:** Again, that is the challenge that we are talking to people about right now; it is really helpful to have that aired and, if I may say so, for the Committee to raise that. We recognise that it is really challenging; it is like the proverbial onion is it not? You take away one part and there are more: the nature of the procedures and the dynamic environment that we are working in, how it has evolved so quickly and grown up so quickly, what a growth industry it is and how important it is



## HOUSE OF COMMONS

to our local economy and training and jobs and opportunity and the demand from consumers.

That is why we decided to act in August and it is that complexity that means we want to put a realistic timetable about it. We want to work as quickly as possible, but we have to get it right. It also has to be, I think you have heard this from others, flexible enough to cope with what else is coming because we do not know all these procedures that are coming, so we want to make sure that we keep up with this. I think it was a parting comment from Lesley, that we want the UK to be a good beacon of growth and good governance and good regulation. As the Chancellor said, "Regulation is also part of our growth agenda," so we want to get that exactly right and it is a really good test case of how we can do that.

**Q234 Rachel Taylor:** I want to just drill down on some qualifications as well, if I may? Several stakeholders have made representations to us, including the Royal College of Surgeons, that highlighted the need for stricter regulation on who can perform surgical cosmetic procedures. Are the Government prepared to require medical practitioners, of which we do not yet have a full definition in this field, or those carrying out the procedures, hold a recognised cosmetic surgery board certification?

**Karin Smyth:** I am going to come to Aidan, but first though we worked with the college—

**Rachel Taylor:** It is a very technical question.

**Karin Smyth:** Indeed. I saw the college's submission and obviously we want to work closely with it and we welcome its co-operation with working with this and I totally understand where it is coming from on this. In fact in August, when I announced this from Southmead Hospital in Bristol, it was the surgeons that were just delighted to have us talking because they obviously see some of the worst effects of this. I know they are also very exercised about this. There are lots of demands on surgical time that we as a Government have, but I will pass over to Aidan on some of the definitions.

**Professor Fowler:** It links back to my earlier point about who is carrying out cosmetic procedures and for what purposes. I would not want to see people carrying out reconstruction after cancer surgery for example, or trauma surgery which is arguably cosmetic, excluded because they do not have that qualification by nature but do have experience. It may be in essence the same sort of procedure after skin surgery on your face or after breast reconstruction surgery, after cancer surgery. Those surgeons are highly trained through a scheme which is specific to their area of practice but is not labelled cosmetic surgery as such, so we would be putting an additional burden potentially on those who are already doing it. We just need to be careful of that bit.

**Q235 Rachel Taylor:** But you would be prepared to say that surgical procedures must be carried out by surgeons?



**Professor Fowler:** Should be carried out by surgeons, yes.

Q236 **Rosie Duffield:** I do not really mind who answers this: we have heard evidence highlighting the importance of more robust informed consent processes. Is the Department reviewing existing consent protocols for cosmetic procedures?

**Karin Smyth:** Yes. Obviously, this is a really important part of this work, and there is information available on the NHS website for people who are contemplating this. People should have all the relevant information about what the treatment involves, the benefits, the risks and where there are reasonable alternative treatments. Aidan, do you want to go through how that works currently?

Q237 **Chair:** If it is quite detailed, it would be really useful for it to be sent to us in writing. That might be the best way.

**Professor Fowler:** It might be helpful to note that there is very extensive guidance on consent, which covers informed consent about procedures, cooling-off periods, recognising where mental health capacity may be an issue, and so on. It is issued by both the Royal College of Surgeons and the General Medical Council. It is pretty extensive, and perhaps if we appended those to you, that would be useful. I have it here.

**Chair:** That would be useful. Thank you.

Q238 **Rosie Duffield:** Will the Government mandate cooling-off periods between consultation and surgery, which is something the last panel were really keen on?

**Professor Fowler:** Those are already recommended best practice. My concern with mandatory is always the exclusions to it; so if somebody requires urgent surgery and wants a reconstruction, I would not want that to be excluded because they cannot have a two-week cooling-off period, for example. But taking that into account, it is already best practice to have a two-week cooling-off period. It would be a matter for Government whether they felt that it was appropriate to make that mandatory.

**Karin Smyth:** How this works operationally for people is to be advised about. As I said, the advice is there on the NHS website and more detailed in those other guidance documents. We need to be guided by what works ordinarily, and sometimes that is not known to people. How would those who are not involved in practising medicine know the detail of it all? Therefore, we need to share that as part of this entire process so that people understand what it means. We cannot do enough to inform people that all surgery carries a degree of risk, and that they need to spend time considering and understanding those risks and feel empowered to do so. People need to do their research, and the cooling-off period is part of that general advice. The experts on the operational reality of that would guide us.



**Professor Fowler:** I hope you saw a letter that I wrote after the last attendance here about the number of hits we had on information that is already available, and very notably a huge number of people accessing choosing who will do your cosmetic surgery, as well as other sites on whether it is the right procedure and so on.

Q239 **Rosie Duffield:** We have heard evidence on the need for more thorough psychological screening, which is what you just talked about, Professor Fowler, of certain individuals seeking cosmetic procedures, particularly in relation to mental health conditions such as body dysmorphic disorder. I spoke earlier about very young women going in for cosmetic procedures—not medical—that they do not need. Is this an area that the Department is currently examining?

**Professor Fowler:** I cannot speak for the Department, but it is certainly an area that is absolutely front and centre of advice on consent for cosmetic procedures. It is something that we maintain concern about. There is a spectrum of mental health disease, with body dysmorphic syndrome, if you like, at one end, which people should be aware of. There are clear pathways for referral into the system for treatment, which is often talking therapies, such as cognitive behavioural therapy and so on, which are available widely. We are making sure that where possible those pathways are straightforward and that the advice includes looking out for that concern and making sure people are referred if it is felt that that is an issue.

**Karin Smyth:** More widely, it is not just a Department issue. You were alluding to young people; we are working closely with our colleagues across the Department for Education around mental health support in schools and so on. The advertising I referred to earlier—the linking with influencers—is an important role across government to get that right. We also need to line up with our colleagues in DSIT, with the Online Safety Act, and so on. I know the Committee has taken a great interest in the body image issue particularly, as Aidan says, in terms of practitioners recognising who is coming to them. That is part of good practice. More widely, your comment refers to something that is cross-government in terms of being very clear to people.

Q240 **Chair:** Minister, you said that we should all be encouraging people to look into the risks and do proper research, but what we have seen is a kind of striving for perfection: the “Love Island” face and body. People do not just want it; they want it now, and I am pleased that you are working with social media sites such as TikTok to get the message out. However, those sites are also among the most problematic areas for pushing these trends. You can get 60-second reels where somebody has a hugely dramatic change to their face, none of the risks are talked about, and there is no reality about the downtime. Sometimes it will be, “Here is somebody with some filler,” and almost immediately there is the result, without being honest that it is probably a week later or something like that.



Is the Department working with the Advertising Standards Authority and other regulators to strengthen oversight of advertising for both surgical and non-surgical procedures? What are you doing cross-departmentally to hold social media providers to account for the legal but harmful content on their sites around surgical procedures and non-surgical procedures?

**Karin Smyth:** I cannot speak directly on that sphere; I am afraid it is beyond my particular purview. The Department will continue to make sure it works with the Advertising Standards Authority to make sure it knows what we are doing, which will obviously be important. As I said earlier, the link across DSIT, the Department for Education, the Online Safety Act, and so on, to get this right in terms of content and to line it all up is important to the Government. In terms of this specific work, I guess it would be advised differently, but as we develop it we would need to make sure that it is part of the development of the regulations and procedures that it is in line with all those bodies.

Q241 **Chair:** We have had Ofcom in here before to talk about non-consensual intimate image abuse and the new powers that it will get. It has always talked about how it wants to encourage the online space to do better before it actually takes enforcement action. Is there any ongoing conversation with social media sites in particular about their responsibilities in terms of advertising correctly and honestly the risks of these procedures?

**Karin Smyth:** In terms of the Department of Health and Social Care, unless I am advised otherwise, I would need to come back to you on what the specific relationship is, if that is okay?

**Chair:** That is absolutely fine. Thank you very much.

Q242 **Kirith Entwistle:** What impact do you think correcting complications from cosmetic procedures is having on the NHS? Does the NHS plan to begin recording instances where it has helped patients who have suffered complications from cosmetic surgery and procedures from both the UK and abroad? I might come to you first, Aidan.

**Professor Fowler:** We have discussed this before; it is an area that we do not currently code. We potentially code complications from cosmetic surgery, but not where it was performed, which means it may not always be clear where the surgery was done. We are currently thinking about why we would collect this information and what value it would add, because we will be asking people to increase the burden of work. So essentially, we would be saying to busy clinicians, "Please record extra data about what has gone on," and give them the reasons why. I would want to explain to them the purpose, which is as a result of it what can we do about it, because it has to be useful information. We know the broad numbers of people who are seeking cosmetic surgery abroad, and they are significant; they are worryingly high. Then, what do you do about it, because it is very difficult to intervene in a way that is useful.



## HOUSE OF COMMONS

We would be recording data and at risk of, if you like, admiring the problem and creating the moral distress of knowing how many people have gone abroad for surgery and had complications, but not actually being able to act on that information.

It is about making sure we collect data in a purposeful way which we can then do something about, which is more complicated. We know anecdotally that it is a problem. We hear people say, "I am seeing people on a weekly basis with complications from having had cosmetic surgery abroad." As I said, I get this at home because my wife is a breast surgeon, and she sees these cases and tells me her clinic is seeing people every week who have sought cosmetic surgery abroad. It is about what is done with the new information collected, rather than the general information about what we are seeing, which we already know.

**Q243 Kirith Entwistle:** Do you know if the NHS is exploring how to recoup costs of these corrective procedures? Is that being done?

**Professor Fowler:** It is not, because we know it is a very difficult thing to do, and of course it starts whole debate of if you have cosmetic surgery abroad and you have problems with it, we recoup costs, whereas if you injure yourself abroad skiing and we deal with the complications, we do not recoup costs. So there is a judgment on that, and not wanting to prevent people from stepping forward with potentially dangerous infections because of the risk of costs. We would have to be very cautious about how difficult it is, the administrative burden and the cost of recouping it, and the effect on people who need to seek support because they have been harmed and are potentially at risk. We do not want to put them off doing so.

**Q244 Kirith Entwistle:** Minister, what is the Government doing to try to increase public awareness of the risks associated with cosmetic procedures being done abroad?

**Karin Smyth:** On that point, I agree with what Adian has identified. Part of the wider work will look at how much it costs and how large-scale it is, rather than on anecdote, to see whether we can build it into routine datasets. We will do that as part of the continuing work. Again, I come back to the importance of the work and announcements of this Committee in highlighting these issues to people. It is quite astonishing how many people have stopped me in these corridors, and elsewhere, to tell me what they see when they go on holiday abroad and how risky it is. It needs to be checked, and people need to be informed to ask those questions. We need to provide information to people so that it does not go wrong; we just need to raise the standard.

**Q245 Samantha Niblett:** Moving on to PIP implants in particular, do you think it was the correct decision for the UK only to remove ruptured PIP implants but not replace them, despite other countries, such as France, opting to replace all PIP implants?



**Professor Fowler:** Shall I take that one? This was a decision made some time ago, as you know. There was a review of it at the time under the leadership of Sir Bruce Keogh, the then medical director of the NHS. It looked extensively at data across Europe and the rest of the world. There were different responses across the world, but the data clearly identified that there was not sufficient risk to merit removal of all these implants; it was not just our data saying that.

It is also important to note, because this does not always come through, that if the MHRA was here, it would point out that PIP was a company that manufactured breast implants in a variety of ways over time. First, they did not all have the thin capsules that were more likely to rupture. Secondly, they did not all contain non-medical-grade silicon. It varied by lot number, and it was not always clear which were which. You would have been removing some implants that were perfectly safe, as well as those where there was a concern of rupture, but not a concern of an increase in toxicity or cancer risk, and so on. So the view was, and it is stated in the European data I have here, that there was insufficient evidence of risk to merit the potential risks of removing all these implants.

There will be people who still have PIP implants; they may be absolutely fine with no problems at all, but I should always reiterate that if they have any concerns, they can present either to the original person who implanted them or if that is not available to them to the NHS for a review. They should have annual reviews because that was the advice. A decision was made at the time that if people had concerns, we would offer removal but not replacement—a decision I was not part of—due to cost and so on.

Q246 **Samantha Niblett:** As a woman with breasts—not having a PIP implant I must say—but the very thought of thinking there is something in my body doing me harm and I am now going to have maybe one or both removed and be left with what would be a stonking reminder of an absence of breasts, or leave me disfigured because we cannot afford to get them replaced, leaves me to ask how is that an okay decision? I know we always look at cost and the bottom line, but it would then have a significant impact on a woman.

**Professor Fowler:** It was a historical decision made at the time based on the evidence available. There was an increased risk of rupture for some implants, and overall, there was an increased risk of rupture, which is usually apparent to people and is the basis for removal. There was no increased risk of other harms. That is an important point: there was no excess risk of cancer, for example, with these implants. The decision was made at the time that they would remove, not replace. I was not part of that decision.

**Samantha Niblett:** It sounds like you are talking about physical harms, whereas I cannot even begin to imagine what that would do to a woman's mental health.



Q247 **Chair:** Before you come on to your next part of your question, I really want to dig down into Samantha's point; it is a really important point. You are talking about the risk as if it were something almost external. If we were to replace this conversation about some faulty breast implants, some not, with something like a make and model of a car and some have some faulty seatbelts, you might need the seatbelt if you have an accident, or you might not. That entire make and model of car would be recalled. Yet this was a different decision made concerning the inside of a woman's body, and other countries took a much more proactive stance. As a Committee, we are trying to understand why it was that women's bodies were an acceptable risk in this case. I understand this was before your time, and it may be something that you need to write back to us about, but it goes to the heart of Samantha's question.

**Professor Fowler:** There are two separate issues. First, was it right not to remove all these implants, and on best available evidence we felt it was and that it was not necessary to remove them all. I am aware France did, others did not, and there were mixed models across the world, including for example Australia. Secondly, if you remove an implant, should you replace it at a cost to the NHS and that is a judgment of where you would then take that cost from and what it would mean we could not provide on the NHS as a result of spending money in that way. That judgment was made at the time. Is there sufficient merit to review that decision at this point where very many of those implants will have been removed or replaced? They may have been removed and replaced privately, and so on. That would be a judgment for the wider system as to how to prioritise spend.

Q248 **Samantha Niblett:** How would we press for that in light of the fact that when there was a need for other corrective surgery for botched cosmetic procedures that happened? I like the tone of maybe we should revisit this, but how do we then ensure that it is revisited? It just feels like a woman is carrying all this risk. She had something done that she thought was safe, and later found out it was not, and because it was done privately it should not be replaced on the NHS. Meanwhile, she has a potentially ticking time bomb inside her body. How would the Committee press the NHS to review this decision?

**Professor Fowler:** I do not think it would be something to do lightly, not least because we are also talking about cosmetic tourism and not wanting to encourage it. I suppose sending the message that if there is any problem at all, do not worry, because we will sort it for you, is perhaps not the right message to send. It is something you would have to give very careful thought to, and again it would have to be something balanced against other priorities, which are very significant. There is a lot of pressure on spend within the NHS, and we have to use that money as wisely as possible. It is difficult to know at this stage how many of these implants, first, are still in where people would want replacement of them and exactly how much of an issue therefore that is to merit the input into it. I cannot tell you the answer; no one can tell you the answer to, first,



how many implants remain, and secondly, how many people would want those replaced at this point.

**Q249 Chair:** In shocking news, we are running roughly on time. This question is probably fitting because it is where we started our inquiry, and that is about breast implant illness, the associated risks, the need for greater research about the safety of breast implants in general and the concerns over breast implant illness that many women have raised. Does the Government intend to make the breast implant registry mandatory because, with the PIP incident, as Professor Aidan Fowler just said, there was no knowledge as to which ones were faulty, and which ones did not hold medical-grade silicone within them? We need better understanding about the implants that are being put into women's bodies to know which ones are safe and which ones are not, Minister.

**Karin Smyth:** Unless Aidan can tell me differently about the use of the word mandatory, I am not sure how to come forward on that. This is partly an MHRA issue around devices and so on.

**Q250 Chair:** We were told by a panel of experts of surgeons that there is not currently a register for safe implants that are currently being used, and as a Committee, we have been asked whether there will be a registry of safe breast implants to use.

**Professor Fowler:** Let me try to manage what is a complex series of questions as effectively as possible; stop me if I am not answering the question. On breast implant-associated illness, there is quite a wide spectrum of symptoms that people present with that cannot be attributed to a single illness, so medically we do not recognise the term breast-associated illness. However, we also recognise that people present with a wide variety of symptoms and concerns, and we recognise that we must assess those because some have, for example, had a leak from an implant, which does need intervention. We know there are associated risks—rarely—of certain specific uncommon cancers, and we need to look for those when people present with illness. We also know anecdotally that some people who present with very difficult symptoms that may be attributable to all sorts of conditions improve when their implant is removed, but that does not necessarily confirm causality. There has been a lot of research looking at this. MHRA continue vigilance of this, but we have had 30 years of using implants. Changes have been made over time, for example, capsules can be smooth or textured, and there are pros and cons. It is always a balance of the risk of distorting effects, such as capsule formation, versus the very small risk—1 in 15,000—of cancers. There is a wealth of evidence about that and nothing at the moment says there are specific, very significant common risks from the implants.

As far as registers are concerned, there is a breast implant registry that has been increasingly used. We estimate that 80% of implants are going on that, but that does not mean that the information about them is not logged in the site they are put in, but it is a central registry. The number



of implants on that is registered and we would want all implants to be registered. There are some hygiene issues—if that is the right term—about how that registry works to make it simpler, because at the moment the feedback is that it is really very onerous; if you are trying to do a list of procedures, it is quite a thing to fill in. We have to get the balance right of wanting lots of information, while also not wanting to make it impractical to enter the information. I would want to get that right before we make it mandatory to not risk people then being inefficient.

Q251 **Chair:** There are moves to improve the registration?

**Professor Fowler:** Yes. There is a big programme around registries, which is absolutely the right direction of travel, to use scanning technology to support that. I made the point before that we do not want to be in a situation where we know more about what we buy in the supermarket than what we put into other people's bodies.

Q252 **Chair:** When it comes to the smoothness, effectiveness, improving the use of the registry, and the intake of the information—because data is obviously really key to this—are you looking at improving the take-up and use of the registry by surgeons as well?

**Professor Fowler:** It is improving all the time, and their use of it is improving, but yes, we are working on that.

Q253 **Chair:** How much is that improving in terms of numbers, in terms of percentages?

**Professor Fowler:** The latest figure I have is that we estimate that 80% of implants are put in the register, and the number on the registry at the moment is in excess of, I think, 100,000. I cannot find it; it is in here somewhere.

Q254 **Chair:** It would be really useful to have that because it is great to see improvements, but 0.1% is still an improvement on nothing so we need to be clear on that.

For the last question, I want to come back to the breast implant illness. When you talked about the mix of symptoms could also be attributed to something else, we have already carried out an inquiry into medical misogyny. Women are told this repeatedly. Whether it is the menopause, PMDD, or any kind of reproductive issues, we are constantly told that our mix of symptoms could be something else. There is a genuine frustration that women are not listened to when it comes to their bodies. When you have a group of women saying, "It is my implant that has made me ill," and they feel that they are being ignored and let down by the health system yet again, what can we do to improve that relationship and trust and make sure their views are listened to?

**Professor Fowler:** I did not want to imply that those symptoms were dismissed or were not important, but it is right that we try to identify a proper cause. I would not want to find us in a situation where we remove a breast implant and find that actually HRT would have been a better



## HOUSE OF COMMONS

option for somebody, or that they have long covid, or some other condition. I am just trying to highlight the difficulty where you do not have a clear set of symptomatology in identifying the correct condition, not just to say, "Don't worry, it is your age," or something like that, and dismiss it. We need to be as certain as possible that if we remove this implant—in which case we would not replace it because that would be counterintuitive—that, as best we can tell, we will be reducing your symptoms. When people come and they say they are adamant that they think it is related to their implant, whether we can prove that or not, they would be able to have that implant removed, and then we would have to hope that their symptoms improved.

Q255 **Chair:** Are you taking and capturing that data so if more women come forward and their symptoms improve, it would perhaps help research in this area?

**Professor Fowler:** There has been a lot of research. I was thinking through before this, how would you set up research to try to identify that and it is a really difficult area. Let us not get into the technicalities of it, but at the moment, I would not be able to say to you, "Yes, we capture that information in a particular way."

Q256 **Chair:** There may be opportunities to do that and to expand on the issue of the breast implant registry. If there were issues with particular implants, would there be a warning system or a flag?

**Professor Fowler:** The aim of the registries is to have follow-up information. This is in the world of clinical effectiveness and comes from things such as, for example, Baroness Cumberlege's report. When we implant things, in the long term, and there are failures of those devices, such as rupture or symptoms attributable to those devices, we are able to record that in a way that is practical and simple so that people are encouraged to do it, which will mean we get the best data capture we can.

**Karin Smyth:** To add to my earlier point, we are in a slightly different place because of Baroness Cumberlege's work and the intervening time. I totally take your point about medical misogyny, and many of us would absolutely recognise it. My colleague, Baroness Merron, is working on the updated women's health strategy. We are working with professional colleges and professional staff to make sure that women are heard, receive the right information, and that research is in the right place. It may be helpful for our colleagues at MHRA, who are obviously responsible for picking up many of the things Aidan is talking about, to monitor it all, including the implications of those devices. As Aidan was outlining, part of that is the need to get them fully tech-savvy in the new world and give them the support needed to make sure that they can register the products. We must make the reporting much slicker because we have been working with slightly antiquated systems. If you want us to add something on that, we are very happy to do so. I have been to MHRA to see the work it does; it does amazing work, but part of our work looking



## HOUSE OF COMMONS

at the regulation sector is to modernise it to make the best use of data and technology. It is not quite where it needs to be when compared to how we track so many other things in other parts of life.

**Professor Fowler:** We want more data, and we want to use it in real time. I should be sitting here with a laptop on which I can tell you the exact rates of things; that is the future.

**Chair:** Does anybody else have any follow-up questions? No? Then it leaves me to say thank you very much, Minister, Aidan and Gavin, for your time. We will be writing to you with some follow-up questions about the data and details. That brings this session to a close.