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Qualification requirements for

cosmetic procedures

Stakeholder consultation document

9 December 2014

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**Executive Summary**

Health Education England (HEE) exists to improve the quality of care for patients by delivering a better health and healthcare workforce for England, through the education, training and personal development of every member of staff, and by recruiting for values. The qualification requirements set out in this paper have been developed to support improvements in the quality and standards of patient and client care, safety and protection in the delivery of cosmetic procedures. They apply to all practitioners, regardless of previous training and professional background, on the basis that patient safety can only be assured if delivery of treatments is carried out by practitioners who have had specialist training in the use, application and, where applicable, operation and maintenance of the product they are using.

Stakeholder engagement has been key to developing these proposals and we have relied on the expertise of members of our Expert Reference and Advisory Groups, as well as input from other industry stakeholders and public representatives throughout the project.

The purpose of this document is to set out for stakeholder consultation the detailed qualification requirements, information on how different groups of practitioners will be able to meet these requirements, options for accreditation and recognition of qualifications and standards for practice. The consultation will be launched at a stakeholder event on 9 December 2014, and the document will also be sent out to all those on HEE’s virtual network for the project and anyone else requesting a copy. We will also seek patient and user feedback as part of the consultation. We will then revise the qualification requirements in the light of feedback received before seeking formal endorsement of the requirements from key stakeholders which will be included in our final report to the Department of Health at the completion of the project in April 2015.

Publication of this document launches a one-month consultation between 9 December 2014 and 9 January 2015. Responses should be emailed to [cosmetics@nwl.hee.nhs.uk](mailto:cosmetics@nwl.hee.nhs.uk) or posted to the Cosmetic Procedures Project Team, Health Education North West London (HENWL), Stewart House, 32 Russell Square, London WC1B 5DN.

**Consultation questions**

Section 2: Qualification requirements

1. Are these proposals clear?
2. If not, where is more detail needed?
3. Do you agree with the proposals outlined in this section?
4. If not, please provide a rationale for any alternative proposals
5. Do you have any other comments?

Section 3: What will the qualification requirements mean for individual groups of practitioners?

1. Do you agree with the proposals outlined in this section?
2. If not, please provide a rationale for any alternative proposals?
3. Where is more detail needed to clarify the proposals?
4. Do you have any other comments?

Section 4: Accreditation and recognition of qualifications

1. What changes or additional information are needed to this section of the paper to improve understanding of the options available and to inform HEE’s recommendations?
2. Do we need an additional and separate accreditation or recognition process similar to that carried out by professional regulatory bodies?
3. If your answer to the above question is yes, are there any additional options available which have been missed and if so, what are they?
4. Do you have views about the proposal to establish a new joint industry standards body/council, and if so please explain your views?
5. If you support establishment of a joint industry standards body/council, what should its responsibilities include and what organisations should be involved in its establishment and operations?

Section 5: Standards for practice

1. Is there anything missing from this section?
2. Do you have any other comments on this section?

Section 6: Next steps

1. Please give your suggestions on how implementation of these requirements can be supported
2. Do you have any further comments on these proposals, including the content of Annexes 1-6?

Glossary (Annex 6)

1. Are there any additional words or terms used in the paper which should be included in this Glossary?
2. **Introduction**
   1. This paper summarises HEE’s recommended qualification requirements for practitioners delivering cosmetic procedures developed by a group of industry and professional experts led by Health Education England (HEE), with the advice and support of an Advisory Group which includes representatives from the regulatory bodies for the health professions. See Annexes 1 and 2 for information on the membership of the Expert Reference and Advisory Groups. These requirements are based on earlier work undertaken during phase 1 of the project[[1]](#footnote-1) and have been prepared for consultation with stakeholders between 9 December 2014 and 9 January 2015.
   2. The qualification requirements have been developed to support improvements in the quality and standards of patient/client care and patient/client safety and protection – and these aims are central to our proposals. As highlighted in the review of the regulation of cosmetic interventions led by Professor Sir Bruce Keogh (the ‘Keogh Review’[[2]](#footnote-2)), “cosmetic interventions can have a profound impact on health and wellbeing”, but the clinical risk can be considerably reduced if practitioners have the appropriate skills and knowledge. Patient/client wellbeing and emotional and psychological support are essential common themes running throughout the recommended indicative curriculum content at all levels in all modalities. This recognises the importance of practitioners delivering treatments being able to recognise the needs of patients and clients and combat unrealistic expectations, use appropriate screening tools and questions to identify high risk groups who require a greater level of emotional and psychological support and understand pathways for providing support, including onward referral when necessary.
   3. The importance of patient and client protection is also recognised in the values and behaviours we would expect of practitioners delivering cosmetic procedures, which include acknowledging when treatment is not in the patient or client’s best interest and referring on or refusing treatment where appropriate, practising in a non-discriminatory manner, demonstrating ethical practice and professionalism and ongoing reflection about personal practice.
   4. There are currently no restrictions on who may perform cosmetic procedures, no qualification requirements and an absence of accredited training courses in an industry which is booming and expected to be worth £3.6 billion by 20152. The requirements presented in this report address this issue by setting out qualification requirements and associated standards for delivery of cosmetic procedures and options for accreditation.
   5. Although the procedures covered by these qualification requirements are normally purchased by members of the public for cosmetic purposes rather than free at the point of delivery as is the case with the majority of health treatments, it is important to recognise the clinical nature and risks of the treatments being delivered. For this reason the term ‘patients and clients’ has been used rather than ‘consumers’ to describe the recipients of these treatments and emphasise the importance of clinical knowledge and skills.
   6. These requirements apply to all practitioners, regardless of previous training and professional background, on the basis that patient safety can only be assured if delivery of treatments is carried out by practitioners who have had specialist training in the use, application and, where applicable, operation and maintenance of the product they are using. The requirements also take into account the Government Response to the Keogh review[[3]](#footnote-3), which accepted the majority of the review’s recommendations, including those relating to education and training, but rejected the recommendation to introduce a new regulated profession for those performing cosmetic interventions, since in its view many practitioners are already members of professional registers and therefore already subject to professional regulation. It is recognised that there will be some costs for practitioners in meeting the new requirements, but industry experts who have contributed to the production of these requirements believe that change is needed if patient/client safety is to be protected and the quality of care improved. For further information on the requirements for individual groups of practitioners, please see section 3.
   7. The qualification requirements cover five modalities:
3. Botulinum toxins (BTs)
4. Dermal fillers (DFs)
5. Chemical peels and skin rejuvenation treatments (microneedling and mesotherapy) (CPSR)
6. Laser, Intense Pulsed Light (IPL) and Light Emitting Diode (LED) treatments (LIPLED)
7. Hair Restoration Surgery (HRS)

However, one of the principles underlying the development of the qualification requirements was that the requirements should be flexible enough to be able to accommodate other ‘orphan’ treatments and new and emerging modalities. A list of treatments not addressed as part of the scope of HEE’s work is attached at Annex 3 and proposals for a new industry body which might take on the responsibility of further development and updating of the qualification requirements are outlined in Section 4.

* 1. The qualification requirements include areas of study which were highlighted as key requirements in the Keogh review, such as training on obtaining consent, information governance, informed consent and record keeping, and ensuring that practitioners have a clear understanding of the requirement to operate from safe premises, with patient safety training in topics such as infection control, treatment room safety and adverse incident reporting. They also address recommendations for training in physiology, anatomy, infection control, treatment of anaphylaxis and an understanding of existing medical conditions so that practitioners are aware of all the possible risks and complications of the procedures and are able to recognise and treat complications.
  2. At the present time there is only one cosmetic treatment which is a Prescription Only Medicine (POM) governed by legislation on prescribing: botulinum toxins. Guidance available from the Medicines and Healthcare products Regulatory Agency (MHRA) on the supply and administration of botulinum toxins for cosmetic purposes[[4]](#footnote-4) does not place restrictions on the groups able to administer this product, however it does make it clear that responsibility for administration lies with a qualified and designated prescriber who is accountable to their regulatory body and responsible for undertaking a physical examination of patients and ensuring that any practitioner to whom they delegate responsibility to administer is appropriately trained and competent to deliver the prescribed treatment. The following groups are able to prescribe botulinum toxins for cosmetic treatments:
* Doctors and dentists
* Pharmacist independent prescribers
* Nurse and midwife independent prescribers
  1. Dermal fillers are medical devices and do not require a prescription. However there are plans to introduce legislation which would require practitioners without a clinical training to be subject to clinical oversight from clinical professionals when they deliver dermal filler treatments.
  2. Stakeholder engagement has been key to developing these proposals. This has included:

a) establishing a network of contacts who receive regular updates on the project

b) carrying out a call for evidence in early 2014 which included two stakeholder events in February

c) establishing Expert Reference and Advisory Groups to develop the qualification requirements

d) sharing the outcome of phase 1 of the project at a stakeholder event in May 2014 and in a report on phase 1 which was published in September 2014

e) further developing the qualification requirements between June and end November for consultation with stakeholders between 9 December and 9 January 2015

f) consulting with professional regulatory bodies and other stakeholder groups on their scope of practice and qualification requirements for individual groups of practitioners

**2 Qualification requirements**

Aims and learning outcomes

* 1. The aims of any training and education programmes delivered to meet the HEE qualification requirements should be to prepare practitioners to provide high standards of proficient patient/client-centred care and deliver cosmetic interventions safely and appropriately, adhering to the principles of ‘do no harm’ and promoting public health at all times, with skills and proficiency underpinned by person-centeredness and appropriate theoretical knowledge.
  2. The learning outcomes of any education programmes delivered to meet the qualification requirements should enable the practitioner to:

1. communicate effectively and openly with patients/clients
2. accurately assess an individual patient/client’s needs
3. identify and explain the relevant risks of the proposed treatment and how to mitigate them
4. undertake a thorough history, including relevant past medical history and current medication, to inform the management plan
5. identify instances when treatment is not in the patient/client’s best interests
6. provide a rationale for decisions to treat and not treat, and for choice of modality
7. understand and describe the influences that can affect the choices made by patients/clients and practitioners about cosmetic interventions to be used
8. appraise and use appropriate sources of emotional support/information/advice and decision support systems
9. apply the principles of evidence-based practice
10. understand and describe the possible interactions between different treatments and demonstrate how to apply that knowledge
11. use knowledge and skills to achieve optimal results and minimise the risk of complications
12. recognise their own professional accountability and responsibility for treatment delivery and manage their practice in an ethical way
13. understand and demonstrate insight into the limitations of their own competences and scope of practice
14. understand and explain the roles and relationships of others involved in the prescription, delivery and supervision of cosmetic interventions
15. understand and describe the most appropriate ways to deal with duty of candour, complaints and escalation of concerns and problems
16. deliver treatments safely and appropriately:

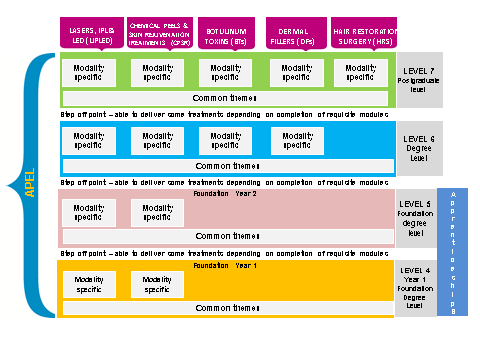
Table 1

|  |  |  |
| --- | --- | --- |
| **Level** | **Modality** | **Treatments able to be delivered on successful completion of training:** |
| 7 | LIPLED | 1. Fully ablative skin treatments (ie non-fractional resurfacing) (GMC-registered practitioners only) 2. Treatments within the periorbital rim (subject to oversight of clinical professional) |
| CPSR | 1. Full face phenol peels and injection lipolysis into superficial fat (GMC-registered practitioners only) 2. Mesotherapy with pharmaceutical strength topical agents (subject to oversight of independent prescriber) 3. Medium depth chemical peels and localised phenol peels (subject to oversight of independent prescriber) |
| BTs | 1. Botulinum toxins (subject to oversight of independent prescriber) |
| DFs | 1. Permanent fillers (GMC-registered practitioners only) 2. Dermal fillers (temporary/semi-permanent) (subject to oversight of independent prescriber) |
| HRS | 1. Hair restoration surgery (GMC-registered practitioners only) |
| 6 | LIPLED | 1. Ablative fractional laser treatments (excluding treatments within the periorbital rim) 2. Laser and IPL for generalised and discrete pigmented lesions (excluding treatments within the periorbital rim) |
| CPSR | 1. Up to 1.5 mm microneedling with manual device or ≤1.0mm power assisted microneedling (subject to oversight of clinical professional) 2. Superficial chemical peels to Grenz zone (subject to oversight of clinical professional) 3. Mesotherapy with/without homeopathic topical treatment (subject to oversight of clinical professional) |
| 5 | LIPLED | 1. Laser treatments for tattoo removal (excluding treatments within the periorbital rim) 2. Laser and IPL treatments for benign vascular lesions (excluding treatments within the periorbital rim) |
| CPSR | 1. 0.5-1.0 mm microneedling with manual device |
| 4 | LIPLED | 1. Lasers and IPL for hair removal/reduction (excluding treatments within the periorbital rim) 2. Non ablative lasers, IPL and LED for photorejuvenation, including sun induced benign dyschromia (excluding treatments within the periorbital rim) 3. LED for clinically diagnosed acne vulgaris |
| CPSR | 1. ≤0.5mm microneedling with manual device 2. Very superficial chemical peels to stratum corneum |

* 1. The treatments able to be delivered following training at each level for each modality, and supervision requirements following qualification (also summarised in Annex 4) have been determined by the potential risk associated with each treatment as set out in Annex 5.

Qualification levels

Figure 1



Notes:

1. DF and BT treatments: training will be at both levels 6 and 7, and practitioners will normally have to complete the modules common to all modalities at levels 4 and 5 (items 1a-f, 2a, 3 and 4 on pages 14 to 19) before entering the modality specific training (items 2d and 2e on page 18) at levels 6 and 7. However there are some exemptions from these training requirements – see Section 3 for further information.
2. HRS: training will only be at level 7 and is restricted to GMC-registered practitioners only.
3. Oversight arrangements are summarised in para 2.32-2.34.

2.4 There have been some modifications to the requirements since the report on phase 1 of this project was published1:

a) The qualification requirements no longer address the education and training needs of HRS Assistants. This decision was taken because the majority of the content at levels 4 and 5 was not relevant for this group of practitioners.

b) A number of treatments deemed as high risk medical treatments have been moved from level 8 to level 7 on the basis that following successful completion of training, these treatments will be delivered by GMC-registered practitioners only.

c) The qualification requirements for BT treatments to the upper face and non-permanent DFs for lines and folds (precluding complex zones) have been moved to level 7 and will require the oversight of an independent prescriber who meets the requirements set out in paras 2.32 and 2.33 of this document. This recognises the need to deal holistically with a patient/client who may require a range or combination of treatments over time, with the benefit of continuity of care from the same practitioner. In addition, it underscores the complexity of treatments and risk of potential complications and the need for practitioners to be able to recognise and manage medical emergency situations and minimise the risk of complications. It also recognises that there is a difference between administering injections for drug delivery, eg vaccinations or intramuscular injections, and administering injections into the face to modify appearance and, in the case of BTs, alter the function of a specific muscle. A practitioner who has successfully completed a qualification at level 7 will have demonstrated the application of critical thinking to their practice and to the clinical decisions they make.

* 1. The qualification requirements correspond with different levels of learning, which, as already mentioned above, reflect the complexity and risk level of different treatments and the corresponding knowledge and skills requirements which have been identified to ensure patient/client safety and high standards of care. A brief summary of the differences between each level of study is set out below. The requirements will not necessarily equate to the requirements to achieve an academic award (ie an undergraduate or postgraduate degree, certificate or diploma offered by a university or other awarding organisation) although opportunities should be available for practitioners to build up credits towards such awards.

Table 2

|  |  |  |  |
| --- | --- | --- | --- |
| **Level of award** | **Example of award** | **Holders of the qualification will be able to:** | **Holders of the qualification will have:** |
| 4 | Foundation Degree Year One/  Apprenticeship | * evaluate the appropriateness of different approaches to solving problems related to their area(s) of study and/or work * communicate the results of their study/work accurately and reliably, and with structured and coherent arguments * undertake further training and develop new skills within a structured and managed environment | the qualities and transferable skills necessary for employment requiring the exercise of some personal responsibility |
| 5 | Foundation Degree/Higher Apprenticeship | * use a range of established techniques to initiate and undertake critical analysis of information, and to propose solutions to problems arising from that analysis * effectively communicate information, arguments and analysis in a variety of forms to specialist and non-specialist audiences, and deploy key techniques of the discipline effectively * undertake further training, develop existing skills and acquire new competences that will enable them to assume significant responsibility within organisations | the qualities and transferable skills necessary for employment requiring the exercise of personal responsibility and decision-making |

|  |  |  |  |
| --- | --- | --- | --- |
| **Level of award** | **Example of award** | **Holders of the qualification will be able to:** | **Holders of the qualification will have:** |
| 6 | Graduate or degree level | * apply the methods and techniques that they have learned to review, consolidate, extend and apply their knowledge and understanding, and to initiate and carry out projects * critically evaluate arguments, assumptions, abstract concepts and data (that may be incomplete), to make judgements, and to frame appropriate questions to achieve a solution – or identify a range of solutions – to a problem * communicate information, ideas, problems and solutions to both specialist and non-specialist audiences | the qualities and transferable skills necessary for employment requiring:   * the exercise of initiative and personal responsibility * decision-making in complex and unpredictable contexts * the learning ability needed to undertake appropriate further training of a professional or equivalent nature |
| 7 | Postgraduate level | * deal with complex issues both systematically and creatively, make sound judgements in the absence of complete data, and communicate their conclusions clearly to specialist and non-specialist audiences * demonstrate self-direction and originality in tackling and solving problems, and act autonomously in planning and implementing tasks at a professional or equivalent level * continue to advance their knowledge and understanding, and to develop new skills to a high level | The qualities and transferable skills necessary for employment requiring:   * the exercise of initiative and personal responsibility * decision-making in complex and unpredictable situations * the independent learning ability required for continuing professional development |

Adapted from QAA (2008) *The framework for higher education qualifications in England, Wales and Northern Ireland*.[[5]](#footnote-5)

* 1. Training for some healthcare practitioners who have a degree-level qualification will be at postgraduate level, but will include some learning from levels 4, 5 and 6. This acknowledges the level of clinical knowledge and skills they have already acquired and the additional skills and knowledge needed to extend their scope of practice to include cosmetic procedures.

Areas of study/indicative content

* 1. In order to meet the learning outcomes and ensure that practitioners are able to deliver safe, appropriate and patient-centred treatments, the areas of study which must be incorporated into a detailed curriculum to enable practitioners to develop knowledge and competence appropriate to the cosmetic interventions they are delivering is set out on pages 14-19. These areas of study are grouped into the following four themes:

1. Generic knowledge and skills
2. Specialty specific knowledge and skills
3. Law, policy and ethics
4. Facilities, premises, health and safety
   1. These themes should be represented at all levels of training as part of a spiral curriculum, with iterative revisiting of themes throughout the programme, deepening and integrating learning by reinforcing and building on knowledge and skills from previous levels and dealing with issues in an increasingly complex way.

Figure 2

Cognition

Attitudes

Level 7

Level 6

Level 5

Level 4

Skills

Practitioner

Source: Adapted from Harden R M and Stamper N (1999) What is a spiral curriculum? *Medical Teacher* 21:141-3

* 1. It is for education providers to determine the detailed learning outcomes for individual courses or modules of study and the number and size of required modules based on the indicative content on the following pages and the practical skills training requirements set out in para 2.21.

Table 3

|  |
| --- |
| Areas of Study: Indicative Content |
| **1. GENERIC KNOWLEDGE AND SKILLS** |
| **a. Evidence-based Practice**   1. understanding of basic principles of research methodology 2. ability to critically appraise evidence-based literature 3. understanding of systematic review 4. adherence to evidence-based practice and ability to rationalise deviation from evidence base 5. ability to undertake a literature search 6. utilisation of information technology and health informatics   **b. Working in a Team Context**   1. effective multidisciplinary team working 2. effective communication with colleagues 3. respect for and appreciation of other team members 4. understanding of principles of leadership and management 5. skills in supervision, mentoring and training 6. equality and diversity training 7. conflict resolution 8. understanding of pitfalls of lone-working; working in isolation   **c. Professionalism**   1. show respect for patients/clients 2. treat patients/clients fairly without discrimination 3. act with honesty and integrity 4. do not abuse patient/client trust 5. probity 6. recognise and work within levels of competence 7. work in partnership with patient/client to support shared decision making, informed consent and shared agreement on outcome expectations 8. strive to ensure patient/client receives good care and treatment 9. maintain competence, keep skills up to date   **d. Clinical Governance & Accountability**   1. appreciation of the value of audit and ability to undertake routine audit of outcomes 2. take part in quality assurance and quality improvement to promote patient/client safety 3. ability to record work clearly and accurately 4. improve performance through reflective practice and peer review 5. contribute to systems which protect patients/clients, eg adverse event recognition and reporting 6. accountability to employers   **e. Clinical**   1. basic understanding of anatomy and physiology, pathology, microbiology, biochemistry, pharmacology, biophysics and hygiene 2. ability to examine the patient/client, take a relevant history and assess needs to develop a care plan 3. ability to monitor and record progress against the care plan and modify appropriately if required 4. ability to assess, evaluate and interpret risk indicators, balance risk against benefits and communicate potential risks and benefits to patients/clients and others 5. ability to deal appropriately with sudden deterioration in patient’s/client’s physical or psychological condition or with emergency situations 6. numeracy skills, drug calculations required to administer medicines safely via appropriate routes 7. understanding of drug pathways and how medicines act 8. understanding of impacts of physiological state of patients on drug responses and safety 9. understanding of pharmaco-dynamics, pharmaco-therapeutics and pharmaco-kinetics 10. knowledge of management of adverse drug events/reactions 11. management, preparation and administration of medicines   **f. Emotional and Psychological Support**   1. use appropriate screening tools and questions to identify high risk groups who require emotional and psychological support 2. recognise emotional/psychological needs of patient/client 3. recognise mental health issues and body dysmorphic disorder 4. ability to appropriately manage patient/client expectations 5. understanding of and ability to manage long and short term psychological reactions post procedure, eg heightened emotional arousal, unmet expectations 6. understanding clear pathways for providing emotional and psychological support, including onward referral when necessary |

|  |
| --- |
| **2. COSMETIC PROCEDURE SPECIALTY SPECIFIC KNOWLEDGE AND SKILLS**  ***[Including patient/client consultation and assessment, treatment plan development and delivery, understanding and mitigation of risks, recognition and management of complications]*** |
| **2a. ALL MODALITIES (NB: \* indicates HRS excluded):** |
| 1. understanding of the structure and function of the skin and hair 2. \*understanding of skin ageing and preventative measures 3. \*understanding of the morphology of facial ageing 4. \*understanding of relevant dermatological conditions/diseases, eg cherry angioma, spider naevus, actinic lentigo, melasma, benign dyschromias related to sun damage, acne, hirsutism, rosacea 5. understanding of the hair growth cycle 6. ability to perform appropriate consultation and assessment of patient/client 7. ability to take relevant past medical history and utilise appropriate breadth of knowledge as a basis for sound clinical judgement 8. understanding of psychosocial impact of presenting complaint and potential impact of specific treatment 9. understanding of common health conditions which may affect treatment, eg diabetes, hypertension, cardiovascular disease/stroke, autoimmune disease, immunocompromised patients, those with transmissible infections, alcohol/drug abuse 10. recognition that each patient/client is an individual and may require or respond differently to standard treatments (eg depending on age, facial morphology, skin quality, baseline asymmetry etc) and ability to tailor treatment appropriately 11. understanding of relevant anatomy and physiology throughout the lifespan 12. understanding of skin microbiology/microbiome 13. decision-making skills to develop appropriate and effective treatment plan 14. understanding of a breadth of treatment options and offer alternatives and/or refer on 15. understanding of use of combination treatments to maximise outcomes 16. understanding of relative and absolute contraindications of relevant procedure 17. ability to deliver relevant procedure safely, effectively and proficiently 18. understanding of limitations of relevant procedure 19. development of appropriate pre-procedure and post-procedure/after care plans 20. understanding of relevant interactions with concomitant medications 21. recognition of common side effects/complications of relevant procedure 22. recognition of serious adverse events/complications of relevant procedure 23. ability to mitigate risk 24. ability to effectively treat complications and/or refer on if appropriate 25. understanding of needle-stick injury and appropriate measures 26. adequate numeracy skills to dilute and/or dose agents appropriately 27. understanding of appropriate storage of products 28. ability to utilise clean and/or sterile technique when appropriate 29. recognition of differential diagnosis and signs associated with vasovagal response and management 30. appropriate use of topical or local anaesthetic, understanding of risks/benefits, and recognition and treatment of adverse reactions 31. ability to take photographs both pre and post-treatment photography and understand how they should be used |

|  |  |  |  |
| --- | --- | --- | --- |
| **MODALITY SPECIFIC KNOWLEDGE AND SKILLS** | | |  |
| **2b. CPSR**   1. evidence base and mechanistic understanding of common skin rejuvenation techniques 2. understanding of skin anatomy—epidermis (stratum corneum and viable epidermis), dermis (papillary and reticular), hypodermis 3. understanding of skin appendages (hair follicle, sebaceous gland, sweat gland/duct) 4. understanding of depth of penetration of peel 5. understanding of wound healing mechanisms 6. ability to accurately assess Fitzpatrick skin type 7. recognitions of comedonal vs inflammatory and cystic acne and step-ladder algorithms of appropriate treatment 8. understanding of cutaneous wrinkling vs skin folds secondary to deeper anatomical changes 9. biochemistry and pharmacological or physiological actions of specific peeling agents, agents used with mesotherapy and microneedling 10. understanding of pharmacological actions of lipolytic agents used with injection and mechanism of action of tissue response 11. understanding of microneedling including efficacy and risks associated with needle depth 12. understanding of appropriate clinical indications for various chemical peels, microneedling and mesotherapy 13. understanding of appropriate clinical indications for injection lipolysis 14. ability to inform patient/client of expected consequences and timescales (eg bleeding, erythema, peeling, induration/oedema, pain) 15. ability to inform patient/client of common or mild complications (eg reactivation of HSV, superficial infection) and mitigate risks 16. ability to inform patient/client of moderate, serious or permanent complications (eg hyper or hypo pigmentation, cellulitis, scarring, textural changes and nodules, cardiotoxicity, sedation risks) 17. recognition of high risk areas of treatment and danger zones | **2c. LIPLED**   1. understanding of basic principles of physics which underpin clinical application of lasers, IPL and LED treatment 2. strict adherence to safety protocols including eye protection 3. understanding of maximum permissible exposure and nominal ocular hazard distance 4. awareness of hazards to eye and skin from accidental exposure and reflection 5. knowledge that various wavelengths will penetrate skin and eye tissue differently, depending on diffusion properties 6. familiarity with various laser, IPL and LED delivery systems and optical radiation-tissue interactions 7. optimisation of clinical outcomes using appropriate devices and treatment parameters 8. ability to recognise common benign skin lesions and conditions such as cherry angioma, spider naevus, rosacea, actinic lentigo, melasma, acne vulgaris, sun damage and benign dyschromias 9. understanding the limitations of laser, IPL and LED in the treatment of common benign skin lesions and conditions and when to refer on 10. contraindications for the use of laser, IPL and LED treatments 11. appropriate patient selection including skin type, indication and treatment choice 12. appropriate skin preparation and role of test patch 13. knowledge of various tattoo types, inks and pigments 14. appropriate wavelength selection for specific pigments 15. awareness of alternative methods of tattoo removal 16. knowledge of alternative methods of hair removal 17. knowledge of alternative treatments for common benign skin lesions and conditions 18. knowledge of Q-switched laser technology and difference between active and passive 19. knowledge of fractional and non-fractional delivery 20. ablative laser wavelengths and pulse durations vs nonablative wavelengths 21. provision of appropriate postoperative instructions including wound care and sun protection 22. knowledge of manufacturer device manuals and protocols 23. knowledge of manufacturer/supplier guidelines and device training | |  |
| **2d. BTs**   1. in depth understanding of facial and neck anatomy including relevant vessels, nerves and muscles 2. understanding of static and dynamic wrinkling 3. familiarity with the concepts of youth and attractiveness with regards to eyebrow shape and facial contours and symmetry which can be modified or enhanced using botulinum toxin 4. understanding of age-related changes which may impact appropriate use of botulinum toxins 5. identification of contraindications for use, eg pregnancy, breast feeding, history of neuromuscular disorder 6. understanding of biochemistry and pharmacology (eg dilution, diffusion, onset and duration of action, metabolism, toxicity) of various botulinum toxins 7. understanding of mechanism of action of botulinum toxins, effects at neuromuscular junction and acetylcholine blockade 8. ability to reconstitute and store various botulinum toxins appropriately 9. knowledge of manufacturers’ guidelines and ability to justify deviation from 10. accurate and appropriate injection technique and product placement (eg dose and site) 11. ability to adjust toxin dose and placement for individualised treatment 12. understanding of potential risks including facial asymmetry, ptosis, dry eyes, drooling, lip drooping, difficulty speaking or swallowing, dry mouth, respiratory distress 13. understanding of patient/client’s occupation and how this may affect management options 14. knowledge of common treatment areas, danger zones and high risk areas 15. ability to recognise and correct suboptimal outcomes using knowledge of facial muscle interactions | **2e. DFs**   1. in depth understanding of facial anatomy including relevant vessels, nerves, muscles and fat pads 2. understanding of volume changes associated with ageing and impact on appearance 3. understanding of conventional concepts of youth, beauty and attractiveness in relationship to facial shape, balance and proportion, skin folds and wrinkles 4. appropriate patient assessment with in depth analysis of wrinkles, folds, facial shape and contour and development of appropriate treatment plan 5. understanding of biochemistry, pharmacology of various types of dermal filler: permanent, semi-permanent and temporary; replacement vs stimulatory; with or without local anaesthetic 6. ability to choose best product for individual need 7. familiarity with mechanistic action of stimulatory fillers 8. knowledge of the skin microbiome and need for sterile technique to mitigate risk of infection or biofilm formation, eg particularly with permanent fillers or deep placement using cannula 9. knowledge of various injection techniques eg threading, depot, fanning 10. dosage placement of product at appropriate anatomical site (eg nasolabial folds, marionette lines, lips, tear trough) 11. placement of product at appropriate tissue depth (eg intradermal, sub dermal, periosteal) 12. knowledge of needle vs cannula technique, understanding of pros/cons and ability to use appropriately 13. knowledge of common treatment areas, danger zones and high risk areas (eg periorbital, temple) 14. relative risks of common treatment areas (eg glaballa, nasolabial folds and vascular compromise) 15. recognition of specific severe adverse events including vascular occlusion/embolisation (which can lead to skin necrosis and scarring or permanent blindness) and expedient delivery of required emergency treatment 16. understanding and recognition of specific adverse events including hypersensitivity, biofilm, granuloma, nodule formation with suppuration and abscess formation and treat or refer on appropriately 17. ability to use hyaluronidase if appropriate eg recognition of appropriate indication, accurate dilution and administration, knowledge of complications and adverse events with hyaluronidase use | |  |
| **2f. Hair Restoration Surgery**   1. understanding of epidemiology and demographics of hair loss, including ethnic variation 2. recognition of common causes of scarring and non-scarring alopecia for appropriate patient/client selection 3. appropriate patient/client assessment with accurate identification of aetiology of hair loss - androgenetic, non-androgenetic or a combination 4. ability to offer treatment options for androgenetic, non-androgenetic or combination hair loss 5. ability to assess current hair loss and anticipate future pattern development for aesthetically pleasing placement of grafts 6. understanding graft preparation techniques 7. ability to dissect and trim follicular unit grafts derived from strip or follicular unit extraction (FUE) methods 8. ability to extract grafts incised for FUE by a doctor or doctor-directed robot 9. ability to place follicular unit grafts appropriately and accurately 10. knowledge of principles of good surgical practice/technique 11. in depth knowledge of medical and surgical management of hair loss and reconstruction techniques 12. understanding risks and benefits of hair restoration surgery 13. knowledge of pre-operative preparation, and appropriate intra- and post-operative care 14. recognition and management of hair restoration surgery complications 15. recognition and management of emergency situations in hair restoration surgery 16. safe, effective delivery of primary and reconstructive hair restoration surgery | | | |
| **3. LAW, POLICY AND ETHICS** | | **4. FACILTIES, PREMISES, HEALTH & SAFETY** | |
| 1. Equality, diversity and human rights 2. Legal basis for practice, liability and indemnity 3. Principles of medical negligence 4. Information governance, confidentiality and data protection 5. Manufacturer and NICE guidance 6. Understanding of principles of informed consent and mental capacity 7. Awareness of vulnerable patient/client groups: children, learning disability, mental health, emergency situations 8. Role of statutory regulation for health professionals 9. GMC, NMC, GDC, HCPC, GPhC, GOC standards, competence to deliver treatments and insight into scope of practice 10. Prescribing legislation and guidance relating to cosmetics and to prescribing off-label or unlicensed use of medicines, and regulation around remote prescribing 11. Management of patient complaints 12. Legislation and regulatory controls impacting on cosmetic practice, eg local Authority, CQC, MHRA, GMC, GDC 13. Knowledge of professional standards of practice relating to nonsurgical cosmetic practice RCS, BAD, NMC 14. Commercial aspects of cosmetic practice and regulatory standards, eg marketing, advertising, financial inducements (with particular reference to CAP advice and training services) | | 1. Health, safety and welfare of patients/clients and staff 2. Infection prevention and control 3. Fire safety regulation 4. Health and safety regulation 5. Principles of risk assessment and management 6. Moving and handling 7. Instrument and equipment safety, servicing and record-keeping 8. Emission characteristics of various equipment 9. Appropriate laser safety management including role of Laser Protection Advisor (LPA) and Supervisor (LPS) 10. Understanding of relevant hazard control, eg electrical fire, explosion, plume emission 11. Management of operating theatre if required 12. Product safety, appropriate storage and expiry date 13. Safe storage, handling and disposal of treatment products, equipment and waste 14. Insight into risks of preparation and administration of treatment in non-clinical setting 15. Understanding of warning label signage | |

European standards

* 1. The draft European standard for beauty care services (currently under development) will provide guidance on requirements for the provision of the types of treatments able to be delivered following completion of training at levels 4 and 5. The draft European standard for aesthetic medical services (due to be published for public consultation in early 2015) will provide guidance on requirements for the types of treatments able to be delivered following completion of training at levels 6 and 7.

National Occupational Standards

* 1. National Occupational Standards already exist for some of the treatments able to be delivered following training at levels 4, 5 and 6 and these are listed below. Those practitioners who have a qualification which meets these standards will be able to seek recognition of this qualification against HEE’s requirements at the appropriate level of study.

Table 4

|  |  |  |
| --- | --- | --- |
| **NOS** | **Title** | **Performance criteria** |
| SKAB34 | Reduction of hair growth using intense pulsed light (IPL) or laser systems | * Maintain safe and effective methods of working when reducing hair growth using IPL or laser systems * Consult, plan and prepare for treatments * Carry out hair reduction using IPL or laser treatments * Provide aftercare advice * Organisational and legal requirements * How to work safely and effectively when providing laser hair reduction treatments * Client consultation * Anatomy and physiology * Contra-indications and contra-actions * Equipment and materials * Treatment specific knowledge * Aftercare advice for clients |
| SKAB35 | Photo rejuvenation of the skin using IPL or laser systems | As above for reduction of hair growth |
| SKAB37 | Cosmetic skin peel treatments (Alpha Hydroxy Acids, Beta Hydroxy Acids) | As above for reduction of hair growth plus   * Applied chemistry |
| SKAB38 | Cosmetic skin needling treatments (up to 1mm on face and up to 1.5mm body areas only) | As above for IPL or laser systems |

Entry requirements

* 1. There will be a range of entry points to training for different groups, and Recognition of Prior Learning (RPL) and Accreditation of Prior Learning (APL) will be used to recognise previous certificated or uncertificated learning and determine modules to be completed to meet qualification requirements.
  2. For entry to level 4 programmes, education providers will set their own entry and admission requirements to ensure that candidates meet their eligibility criteria and have the right skills, knowledge and values to successfully complete their programmes of study, with the appropriate competencies to provide high quality and safe services. However it is recommended that the following requirements form the basis of the standards set for entry to training at level 4:

1. 5 GCSEs at grade C and above including Maths, English and Core Science
2. Plus one of the following, recognising the value of non-traditional vocational qualifications in this field:

One A-Level or equivalent

A level 3 accredited qualification from an Awarding Organisation in relevant subject, eg Beauty Therapy

Access course

Skills for Health bridging programme

1. For candidates who have not achieved secondary education-level qualifications, work experience may count towards entry, eg through submission of a portfolio of evidence, but prior work experience should not be a requirement for entry
2. Applicants must demonstrate ability to study at level 4
3. Applicants must complete an enhanced Disclosure and Barring Service (DBS) application form and receive a DBS certificate
4. If English is not the applicant’s first language, an English language level of IELTS 6.5 or 7.0 (depending on the education provider’s requirements) in all components or equivalent will be required

A key objective for HEE is to widen access to educational opportunities and provide opportunities for progression of individuals without formal school qualifications, eg through the development and provision of apprenticeship opportunities.

Recruitment and selection

* 1. Education providers will be expected to ensure that the individual values and behaviour of students/trainees selected for entry support the delivery of excellent client/patient care and experience, eg through demonstrating openness, candour, compassion, integrity and honesty.
  2. The application process for those entering the programme at level 4 should include an interview, and recruitment processes must involve industry or clinical experts who understand the treatments being delivered and the needs of patients/clients. In the case of regulated health professionals, the recruitment and selection process should include a registration check to ensure that there are no outstanding fitness to practice issues.

Length of programme

2.16In order to practice at different levels, a practitioner will need to demonstrate that they meet the learning outcomes for that level. It will be for the education provider to determine the appropriate length of time required by practitioners to demonstrate that they have met these learning outcomes and to ensure that the programme meets national standards for notional student workload.

Balance between practice-based learning and theory

* 1. Training should be competence-based not time-based, and should include supervised practice as well as theoretical and practice-based assessment. Outcome assessments should be proficiency and competence based. It is important that practice-based learning is integral to the programme so that the student is provided with the opportunity to observe and practice delivery of the relevant treatments.

2.18 A minimum of 50% of the curriculum must be devoted to the development of practical skills, and 80% should normally be in a practice learning environment, although the value of simulated practical learning, particularly when high fidelity simulation models are available for teaching, is recognised as a suitable alternative in some cases. Students/trainees must have protected learning time in practice and the educational programme must include the opportunity for students/trainees to develop proficient practical skills under supervision and for their proficiency to be assessed as to whether they have mastered the skill to a high standard and are able to provide an excellent standard of patient care and safety. All practical training experience should be education-led with students having supernumerary status and not being paid to deliver the treatments which they are being trained to deliver.

2.19 Students/trainees should be required to record their progress in a portfolio of evidence to monitor the acquisition of practical skills and theoretical knowledge and understanding and skills and values-based-behaviours. The portfolio will provide a mechanism for recording all assessments and for sign off of achievement of learning outcomes. It will be owned by trainees and be accessible to educational tutors, practice-based supervisors/assessors and internal/external verifiers. Evidence may include:

1. Observation of procedures
2. Directly observed practice
3. Simulation
4. Case based discussions, including looking at the emotional and psychological needs of patients/clients
5. Case studies
6. Audit (clinical records)
7. Feedback from supervisor/assessor or other members of team
8. Feedback from clients/patients
9. e-learning, tutorial/discussion or lecture attendance
10. Audio-visual media
11. Assignments
12. Work-based learning assessments
13. Reflection
14. Critical incident recording, analysis and reporting
15. Evidence of prior learning or attainment

Practical skills training and practice-based learning requirements

* 1. Practice-based learning must enable student/trainees to acquire proficiency in the skills that they will be able to deliver following completion of the education programme either independently or under clinical supervision/oversight. Learning outcomes may vary by work placement, and good practice in designing the educational programme would incorporate a requirement for more than one workplace learning attachment/experience. It is anticipated that some clinics or salons will wish to establish their facility as a recognised training environment and advertise some treatments to be delivered by trainees at a reduced price.

2.21 Recommendations are made below as to the minimum number and range of treatment opportunities which must be available for students/trainees to practice under supervision. These numbers are to be considered as a minimum, and it is acknowledged that some students/trainees will need additional opportunities to develop their proficiency over and above these minimum requirements. The assessment of learner proficiency at sign off is essential.

Table 5

|  |  |
| --- | --- |
| **Treatments** | **Practical skill requirements**  Notes:   1. Each treatment undertaken should include a full clinical consultation and selection of appropriate treatment parameters. 2. Assessment of proficiency in delivery of treatments will be undertaken by the supervisor/assessor. |
| **LIPLED** | Level 4   * Use lasers and IPL for hair removal/reduction   + A minimum of **20** hair removal treatments on **at least 3** different areas of the body * Use non ablative lasers, IPL and LED for photorejuvenation including sun induced dyschromia   + A minimum of **10** photorejuvenation treatments   Level 5   * Use laser treatments for tattoo removal   + A minimum of **20** tattoo removal treatments which must include tattoos of **more than one colour** and in **at least 3** different areas of the body * Use laser and IPL treatments for benign vascular lesions   + A minimum of **20** treatments which must include at least **3 different types** of vascular lesion in **at least 2** different areas of the body.   Level 6   * Use laser and IPL treatments for benign pigmented lesions   + A minimum of twenty **20** treatments which must include **at least 3** different types of pigmented lesion in **at least 2** different areas of the body. * Deliver ablative fractional laser treatments   + A minimum of **10** treatments   Level 7   * Deliver fully ablative skin treatments (ie non-fractional resurfacing)   + A minimum of **4** treatments   For LIPLED, a patient may have treatments to different parts of their body and this will count as separate treatments |
| **CPSR** | **10** treatments for 10 different patients/clients (observation), **10** treatments for 10 different patients/clients (delivered under supervision) for each treatment type at each level |
| **BTs** | **10** botulinum injections for 10 different patients/clients (observation), **10** botulinum injections for 10 different patients/clients (under supervision) for each treatment type at each level |
| **DFs** | **10** treatments for 10 different patients/clients (observation), **10** treatments for 10 different patients/clients (delivered under supervision) for each treatment type at each level |
| **Treatments** | **Practical skill requirements** |
| **HRS** |  |
| Currently practicing HRS Surgeons | Each skill would only need to be demonstrated by the Hair Transplant Surgeon once, or a number of times on one occasion, by the supervisor/assessor to make a decision on competence |
| Trainee Hair Transplant Surgeons | * Patient consultation/selection for medical treatment of hair loss – **50** cases * Uncomplicated patient consultation/selection for surgery – **50** cases * Complicated patient consultation/selection for surgery (eg scar reconstruction or revision hair transplant) – **10** cases * Hair line design – **50** cases * Strip FUT harvest (incision, dissection and closure) – **50** cases * Strip FUT slivering – minimum **10** slivers in **50** cases = minimum 500 slivers. The entire strip should be slivered in at least 5 of the cases. * Graft cutting – minimum **50** grafts in **50** cases = minimum 2500 grafts. In at least five of the cases grafts will be cut for the duration of the whole case taking rest breaks as appropriate. * Incision making – minimum **100** incisions in **50** cases (in varied locations and of varied sizes) - minimum 5000 incisions. In at least 5 cases all the incisions required will be made. * Graft Placing (forceps and implanter) – minimum **100** grafts implanted with forceps in **25** cases and minimum **100** grafts implanted with implanters in **25** cases = minimum 5000 grafts placed. In at least 5 cases of each type, grafts will be placed for the whole case taking rest breaks as appropriate. * Follicular Unit Extraction (manual non-motorised and manual mechanised) incision making – minimum **100** successful (ie follicle/follicular unit extracted intact) manual non-motorised incisions in **25** patients and minimum **100** successful manual mechanised incisions = minimum 5000 FUE incisions. In at least 5 cases all the incisions required will be made. * Follicular Unit Extraction graft extraction – minimum **100** successful extractions in **50** cases = 5000 FUE graft extractions. In at least 5 cases all the grafts will be extracted.   *Notes:*   * *The list is not exhaustive and the numbers listed are representative but not definitive.* * *It is assumed that trainees learning strip follicular unit transplant (strip FUT) technique have had previous general surgical experience. If not, the relevant surgical skills required to be taught may be more extensive.* |

Student support and supervision and assessment during training

2.22 Students/trainees will require support in both academic and practice learning environments. Trainees must have a named, designated lecturer or tutor, responsible for the totality of their learning experience, who must have a teaching qualification. It is important that lecturers or tutors have the appropriate technical and clinical or scientific knowledge in the subject they are teaching, eg by using Laser Protection Advisers (LPAs) to deliver teaching to deliver LIPLED treatments.

* 1. In the practice placement(s), trainees may have multiple supervisors who will help the student/trainee develop their practical skills throughout the learning programme through observation and practice under supervision on patients/clients. The supervisor may also have an assessor role, taking responsibility for assessing proficiency and achievement of learning outcomes. Supervisors/assessors must:
     + 1. have due regard and proficiency within the specific area of practice under assessment and be able to provide a role model for the student/trainee
       2. be trained as a supervisor/assessor - requirements to be determined by education provider
       3. meet the qualification requirements for the treatment being supervised/assessed
       4. have a minimum of 3 years of post-qualification experience delivering the treatments for which they will be supervising delivery and post-qualification delivery of a minimum of 150 of the same treatments
       5. be able to take direct responsibility for the consequences of treatment and clinical management of complications, including the ability to prescribe where appropriate
       6. be able to provide evidence of contemporaneous proficiency in the treatment/s being delivered, and evidence of annual updating and of meeting any requirements for Continuing Professional Development (CPD) and revalidation
       7. have appropriate indemnity insurance
       8. for those procedures which can only be delivered under supervision following training, be able to produce evidence of completion of pre-registration clinical training, registration with a statutory regulatory body and, where appropriate, an independent prescribing qualification

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2.24 Verifiers are responsible for verifying the quality of assessment: internal verifiers support and work with teams of assessors to develop assessment procedures and facilitate good practice. External verifiers work with education providers to quality assure qualifications on behalf of awarding bodies and should have formal training, higher than that for supervisors. The training will be determined by the education provider or awarding body.

2.25 The trainee to educator ratio should be as follows:

* 1. Demonstration: maximum of 10 trainees to one demonstrator
  2. Practice placement: maximum of 4 trainees to one supervisor/assessor, but this will depend on the nature of the supervision/assessment. In some cases, eg for injectable treatments, a 1:1 ratio will be required.

Accreditation or auditing of practice learning environments

* 1. Education providers will be responsible for the ‘accreditation’ or auditing of practice learning environments to ensure that:

1. student/trainees practitioners have access to the necessary facilities, range of treatments, and support in order to develop proficiency in delivering the relevant treatments for that level of study in the relevant modality
2. Patient/client care is evidence based
3. Patients and clients are aware that students are being trained and that they can refuse the involvement of students in their treatment
4. supervisors/assessors are appropriately trained and updated annually to meet the needs of their students/trainees
5. there are an adequate number of supervisors/assessors to provide a safe environment for students and patients/clients
6. students/trainees receive the appropriate level of supervision
7. verifiers (both internal and external) are independent of the assessor
8. adequate learning and teaching resources, including IT resources, are available to support learning
9. they can be assured that the practice learning environment has the appropriate mechanisms in place to ensure that the practice based element of their training is of high quality and fit for purpose, that it provides value for money
10. placement providers have an understanding of the requirements of the education provider and of student/trainees
11. the practice learning provider operates a safe and effective system of care and complies with clinical and information governance requirements, with appropriate policies and procedures in place to maintain confidentiality, both related to patients and clients, staff and students/trainees
12. there are up-to-date health and safety policies and procedures to maintain patient/client, student, staff and visitor safety at all times
13. the placement provider receives timely feedback from student evaluations and any actions taken

Assessment

2.27 All education and training programmes must be assessed and certificated. Course documentation must include the learning outcomes and details of knowledge and skills assessed, to support recognition and accreditation of learning.

2.28 A range of assessment methods should be used to assess whether a student/trainee has met the required learning outcomes, testing knowledge, decision-making and the application of theory to practice. These will be determined by the education provider but should include:

1. a portfolio of evidence
2. a summative examination of practice in a simulated learning environment or setting relevant to the student/trainee’s area of practice which takes into account the total client/patient experience, supported by a ‘final sign off’ of competence to meet the requisite standard of proficiency
3. satisfactory demonstration of proficiency in required skills, taking into account the student/trainee’s value-based behaviours, empathy and compassion, respect for client/patients and reflection on learning
4. written assessments and examinations

Interruption to study

* 1. Training to meet requirements at each level of training for each modality (including satisfactory completion of assessments) must be completed within five years following commencement. Education providers must ensure that the trainee’s acquired knowledge and skills remain valid to achieve the required proficiencies and, where appropriate, to progress to the next level of training.

Delivery of treatments following qualification

* 1. In supporting the Keogh review recommendations, it is not HEE’s intention to exclude any practitioners from delivering cosmetic procedures or to deny training to any industry sectors, as this might encourage practitioners to practice without training or with training which does not meet the standards recommended by HEE which could consequently undermine patient safety. Rather than seeking to exclude practitioners who do not have clinical training, Keogh sought to address the patient safety aspect by requiring professional/clinical oversight of non-healthcare practitioners for some more complex procedures.
  2. The qualification requirements are based on the premise that a number of treatments will be delivered under the oversight of a clinical professional, in some cases an independent prescriber – see below. These requirements recognise the risks associated with certain treatments and the need for practitioners to have access to and support from experienced clinicians who are able to deal with medical emergency situations and complications. Where the requirement is for an independent prescriber to have oversight, this recognises that practitioners are often working independently away from hospital and clinical settings, and there may be a need to be able to deal with complications without recourse to the NHS, eg to prescribe antibiotics in case of infection.

Table 6

(Extract from Table 1, page 10 & Annex 4)

|  |  |  |
| --- | --- | --- |
| **Level** | **Modality** | **Treatments able to be delivered on successful completion of training:** |
| 7 | LIPLED | Treatments within the periorbital rim (subject to oversight of **clinical professional**) |
| CPSR | Mesotherapy with pharmaceutical strength topical agents, medium depth chemical peels and localised phenol peels (subject to oversight of **independent prescriber**) |
| BTs | Botulinum toxins (subject to oversight of **independent prescriber**) |
| DFs | Dermal fillers (temporary/semi-permanent) (subject to oversight of **independent prescriber**) |
| 6 | CPSR | Up to 1.5 mm microneedling with manual device or ≤1.0mm power assisted microneedling, superficial chemical peels to Grenz zone and Mesotherapy with/without homeopathic topical treatment (subject to oversight of **clinical professional**) |

2.32 The following table sets out which groups of health professionals would be eligible to provide oversight. Further information on the training requirements for individual groups of practitioners is set out in section 3:

Table 7

|  |  |  |
| --- | --- | --- |
| **Able to provide oversight as independent prescriber and as clinical professional (subject to meeting all of criteria in para 2.33 below)** | **Able to provide oversight as clinical professional (subject to meeting the additional requirements set out below in para 2.33)** | **Excluded from being able to provide clinical oversight** |
| Doctors  Dentists  Independent Pharmacist Prescribers Independent Nurse and Midwife Prescribers | Pharmacists  Nurses and Midwives  Optometrists  Dispensing Opticians  Dental Hygienists  Dental Therapists  Clinical Scientists\* (LIPLED treatments) | Physiotherapists\*  Podiatrists\*  Dental Nurses  Orthodontic Therapists  Dental Technicians  Pharmacy Technicians  Pharmacy Assistants  Optical Assistants  Beauty therapists  Laser Protection Advisors  Laser Protection Supervisors |

\* Cosmetic treatments are outside of the scope of practice for physiotherapists and podiatrists (although they can of course complete training to deliver these treatments). They would not therefore meet the requirements below for providing oversight. Further work is required to establish whether any other groups regulated by HCPC would be able to provide oversight.

* 1. Practitioners must also meet all of the following criteria to be eligible to provide clinical oversight of treatment delivery:

1. successful completion of the training programme at the required level for the treatment for which they are providing oversight
2. a minimum of 3 years of post-qualification experience delivering the treatments for which they will be supervising delivery and post-qualification delivery of a minimum of 150 of the same treatments
3. completion of pre-registration clinical training and registration with a statutory regulatory body which regulates the clinical practice being delivered
4. ability to take direct responsibility for consequences of treatment and clinical management of complications, including the ability to prescribe for level 7 CPSR, BT and DF treatments
5. evidence of contemporaneous proficiency in the treatment/s being delivered through meeting the regulator’s CPD and revalidation requirements
6. appropriate indemnity insurance

2.34 In cases where the treatment is delivered with clinical oversight, the independent prescriber or clinical professional will retain responsibility and accountability for any treatments being delivered. It will be up to the clinician to ensure that the practitioner administering the treatment meets the qualification requirements for the treatments being delivered and to decide on the level of oversight required, working within the spirit and boundaries set down by their professional codes of conduct and ethical practice as mandated by their statutory bodies, and the prescribing policies of their employers. Their decision will be determined by their knowledge of the practitioner’s skills proficiency and experience and their assessment of their ability to intervene in an emergency which may require prescription medication. The role of the independent prescriber is described in the Keogh Review Call for Evidence[[6]](#footnote-6):

*“Botulinum toxin injection can be administered by a physician or other appropriate practitioner; or administered by anyone acting in accordance with the directions of an appropriate practitioner. On the latter point, the responsibility lies with the appropriate practitioner even if the product is administered by a third party. If the individual administering the product is a doctor, nurse, dentist or pharmacist, then they need to follow their appropriate professional standards. If the product is administered by an individual who is not a health professional, then the individual is not covered by professional standards.”*

2.35 There are a number of medicinal products containing botulinum toxin, for example Botox and Vistabel, licensed for specific medical conditions. Some of these products are for the temporary improvement in the appearance of moderate to severe glabellar and crow’s feet lines, when the severity of these lines has an important psychological impact in adult patients.  MHRA has not licensed these products for purely cosmetic purposes (ie, to improve the physical appearance where there is no psychological impact).  MHRA’s guidance covers the law and MHRA views in relation to the legality of using these medicines and other injectable products outside their licensed indications. The guidance is not an endorsement of such use and does not cover appropriate clinical practice in these circumstances.

2.36 MHRA provides guidance[[7]](#footnote-7) on off-label or unlicensed use of medicines which makes it clear that all healthcare professionals are responsible for their practice in accordance with the tenets laid down by their relevant professional statutory regulatory body. Responsibility for administration of botulinum toxins for cosmetic use lies with the prescriber who possesses a qualification for prescribing recorded with their regulatory body. Such prescribers must provide evidence of their individual clinical competence and work within the spirit and boundaries set down by their professional codes of conduct and ethical practice as mandated by their statutory bodies, and the prescribing policies of their employers. It also states that:

*“The responsibility that falls on healthcare professionals when prescribing ..... a medicine off-label may be greater than when prescribing a licensed medicine within the terms of its license. Prescribers should pay particular attention to the risks associated with using unlicensed medicines or using a licensed medicine off-label. These risks may include: adverse reactions; product quality; or discrepant product information or labelling (eg ... potential confusion for patients or carers when the Patient Information Leaflet is inconsistent with a medicine’s off-label use.)*

* 1. When delivering cosmetic treatments, practitioners have a responsibility for explaining that botulinum toxin is not licensed for general cosmetic use and ensuring that the patient understands this.
  2. Additional guidance on prescribing which is of relevance to cosmetic procedures is available for some health professions. The General Medical Council (GMC) has published guidance which supplements its Good Medical Practice[[8]](#footnote-8) on Good Practice in Prescribing and managing medicines and device[[9]](#footnote-9) which includes guidance on delegating responsibility for administering medicines, prescribing at the recommendation of a professional colleague and recommending medicines for prescription by colleagues. The GMC guidance also makes it clear that doctors:

are “*responsible for the prescriptions you sign and your decisions and actions when you supply and administer medicine and devices or authorise or instruct others to do so. You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicines*.”

must “*make sure that anyone to whom you delegate responsibility for administering medicines is competent to do what you ask of them*.”

2.39 The GMC guidance also states that doctors must undertake a physical examination of patients before prescribing non-surgical cosmetic medicinal products such as Botox®, Dysport® or Vistabel® or other injectable cosmetic medicines, and that they must not prescribe these medicines by telephone, video-link, or online. When prescribing at the recommendation of another doctor, nurse or other healthcare professional, doctors must satisfy themselves that the prescription is needed, is appropriate for the patient and within the limits of his/her competence, and that when delegating assessment of a patient’s suitability for a medicine, the person to whom s/he delegates has the qualifications, experience, knowledge and skills to make the assessment. In both cases the doctor will be responsible for any prescription s/he signs.

* 1. Similarly to the GMC, the General Dental Council (GDC) has published supplementary Guidance on prescribing medicines[[10]](#footnote-10), which specifies that dentists must not remote prescribe (eg via telephone, email or a website) for non-surgical cosmetic procedures such as the prescription or administration of Botox® or injectable cosmetic medicinal products.

2.41 The Nursing and Midwifery Council (NMC) also provides guidance on Standards for medicines management[[11]](#footnote-11), Remote assessment and prescribing[[12]](#footnote-12), Remote prescribing and injectable cosmetic medicinal products[[13]](#footnote-13) and Cosmetic Practice[[14]](#footnote-14) which make it clear that any nurse or midwife administering injectable cosmetic medicinal products must follow the NMC standards for medicines management, that remote prescriptions or directions to administer should only be used in exceptional circumstances and that a physical examination of patients must be undertaken before prescribing non-surgical cosmetic medicinal products. Nurse independent prescribers can legally prescribe and administer licensed parenteral medicines such as Botox® in cosmetic procedures on their own initiative. However when prescribing medicines independently for uses outside their licensed indications, as is the case when using botulinum toxins for cosmetic purposes, nurse prescribers must accept professional, clinical and legal responsibility for that prescribing. Nurse independent prescribers cannot order and receive wholesale supplies of Botox® etc. This is based on the principle that a prescriber prescribes and that his/her prescription is then dispensed by a pharmacist. Nurse independent prescribers can administer drugs themselves and authorise others to do so under their patient specific direction.

**Consultation questions**

1. **Are these proposals clear?**
2. **Where is more detail needed?**
3. **Do you agree with the proposals outlined in this section?**
4. **If not, please provide a rationale for any alternative proposals**
5. **Do you have any other comments**
6. **What will the qualification requirements mean for individual groups of practitioners**
   1. As indicated previously, these requirements apply to all practitioners, regardless of previous training and professional background, on the basis that patient safety can only be assured if delivery of treatments is carried out by practitioners who have had specialist training in the use, application and, where applicable, operation and maintenance of the product they are using. The qualification requirements will provide an opportunity for practitioners, whether clinically trained or not, to attain the necessary skills and expertise to safely deliver cosmetic treatments in five defined modalities.
   2. The qualification requirements have been designed to provide step off points following completion of training at each level (at which point practitioners will be able to deliver specific treatments) and opportunities for career progression. For the LIPLED and CPSR treatments, there are step off points following training at levels 4, 5, 6 and 7. For the BT, DF and HRS treatments there is only one step off point following training at level 7, although practitioners will need to complete training at levels 6 and 7 to deliver BT and DF treatments. Some generic knowledge and skills which are common to all cosmetic treatments will be shared across modalities and some will be modality specific. Delivery of treatments in each modality will be dependent on completion of the requisite compulsory modules for that modality, but there should be opportunities for practitioners to study to deliver treatments in more than one modality.
   3. There will be a range of entry points to training for different groups. Those without any previous training to deliver cosmetic procedures, including some groups of health professionals, will be required to start with level 4 training, selecting modules to reflect the modalities in which they wish to practice. Other groups of health professionals will be able to enter training at levels 6 and 7, depending on their previous qualifications – para 3.8, Table 8 and the accompanying notes set out the training requirements for each group of practitioners. In all cases, those already delivering cosmetic procedures will be able to apply for Recognition of Prior Learning (RPL) and Accreditation of Prior Learning (APL) to recognise previous certificated or uncertificated learning and determine modules to be completed to meet qualification requirements.

Accreditation or Recognition of Prior Learning (APL/RPL)

* 1. Only previous studies taken at the same level as (or higher than) the course for which the applicant is requesting partial exemption will be considered for APL. Applicants must also demonstrate that prior learning is valid, matching the level and content of study of the module for which they are seeking exemption, and current (qualifications more than five years old are unlikely to be considered). There is normally a limit to the amount of credit which can be imported into an award via APL. This varies between one half and two thirds.
  2. A typical process for recognising prior learning and experience will include submission of a portfolio of evidence and/or a description of how the individual already meets the learning outcomes of a course or module through their experience, background reading and research and courses which they have attended. The education provider may also wish to carry out a practical skills assessment.
  3. Very short courses, eg 1-2 days in duration, will not met the requirements for APL/RPL.
  4. The process for transition is as follows:

Figure 3

Practitioners already delivering cosmetic treatments:

New practitioners wishing to start delivering cosmetic treatments:

See Table 8 and accompanying notes for information on exemptions for some groups of regulated health professionals

Apply to an education providers for accreditation or recognition of prior learning (both certificated and uncertificated)

Apply to membership organisations or voluntary registration organisations for recognition of existing knowledge and skills

Complete appropriate education and training programme to meet qualification requirements for modalities and treatments which practitioner wishes to deliver

Arrange indemnity insurance

Requirements for different groups of practitioners

3.8 Table 8 and the notes below the table describe training requirements for different groups of practitioners. All groups will be able to apply for APL/RPL to recognise existing knowledge and skills.

Table 8

|  |  |
| --- | --- |
| **The following groups of registered health professionals will be exempt from parts of the training programme (1)** | **The following groups will have to complete a structured and accredited or recognised programme of education and training** |
| Doctors (2)  Dentists, Dental Hygienists and Dental Therapists  Pharmacists  Nurses and Midwives  Optometrists and Dispensing Opticians  Podiatrists/Chiropodists (3) (5)  Physiotherapists (4) (5) | Dental Nurses  Orthodontic Therapists  Dental Technicians  Pharmacy Technicians  Pharmacy Assistants  Optical Assistants  Beauty therapists (6)  Laser Protection Advisors (7)  Laser Protection Supervisors |

Notes:

1. Groups in the first column will not be required to complete generic areas of study 1a-e and non-cosmetic specific parts of areas of study 3 and 4 (see Table 3 on pages 14 to 19) and will be able to apply for accreditation or recognition of prior learning (APL/RPL) for other areas of study (subject to education provider criteria for recognition – see paras 3.4 to 3.6)
2. Dermatologists and Plastic surgeons will normally only require training in the modality specific areas 2b to 2f (pages 17 to 19), unless they can demonstrate through APL/RPL that they already meet the knowledge and skills proficiency in these areas
3. Podiatrists/Chiropodists use botulinum toxins and dermal fillers for clinical purposes. Although the MHRA guidance indicates that podiatrist independent prescribers are excluded from the groups of ‘appropriate practitioners’ able to prescribe botulinum toxins for cosmetic purposes, since they can prescribe only those medicines which are relevant to the treatment of disorders affecting the foot, ankle and associated structures, this guidance will need to be revisited, since botulinum toxins could be used for cosmetic purposes for these parts of the body, eg to address hyperhydrosis. Delivery of cosmetic treatments to any other part of the body would be out of scope of practice of a practitioner delivering treatments as a podiatrist, and for this reason they have been excluded from the groups of health professionals able to provide oversight of treatments (see Table 7, para 2.32)
4. Physiotherapists use botulinum toxins and dermal fillers for clinical purposes. However physiotherapist independent prescribers are excluded from the groups of ‘appropriate practitioners’ able to prescribe botulinum toxins for cosmetic purposes, and delivery of cosmetic treatments would be out of scope of practice for a physiotherapist. For this reason they have been excluded from the groups of health professionals able to provide oversight of treatments (see Table 7, para 2.32).
5. Requirements for other health professions regulated by HCPC have not yet been determined: Paramedics, Radiographers, Prosthetists/Orthotists, Dieticians, Biomedical Scientists, Clinical Scientists, Arts Therapists, Orthoptists, Hearing Aid Dispensers, Practitioner Psychologists, Occupational Therapists, Speech and Language Therapists
6. Beauty therapists wishing to deliver cosmetic treatments will need additional training in all areas. However it is likely that practitioners who have undertaken a vocational qualification which meets the relevant national occupational standards will already meet the requirements at the level of the qualification, although the organisation being asked to recognise the qualification may wish to check that all key areas/themes have been covered as part of the qualification.
7. Laser Protection Advisers (LPAs) would require training in all generic and LIPLED specific areas with the exception of 2c i – vi , xviii – xx, xxii and xxiiii, 3k where relevant to LIPLED and 4 (Table 3, pages 14-19).

Transition

3.9 It is recognised that there will need to be a phased implementation and transition period to avoid any dislocation of services to the public while the education and training requirements are being implemented. It is recommended that from September 2018 all practitioners delivering the specific treatments addressed within this document should meet the HEE qualification requirements for those treatments. This will allow time for practitioners to validate their existing knowledge and skills and meet any gaps in learning. Until new qualifications are available which meet the requirements outlined in this paper, there should not be any restrictions to practitioners in accessing existing training courses in order to meet CPD requirements as this would not be in the interest of public safety.

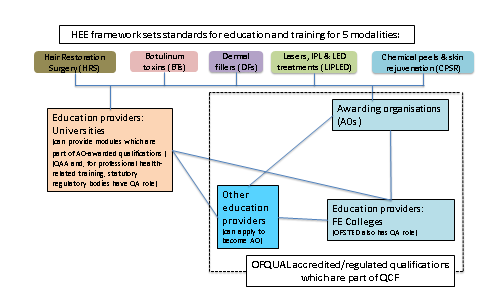
3.10 Although some individuals will wish to study for a formal qualification and will therefore apply for APL/RPL to recognise existing and learning and skills, other practitioners may not choose this option. Statutory professional regulators will require evidence from practitioners to demonstrate that they are meeting CPD and revalidation requirements and that they are working within their scope of practice. Voluntary registration bodies[[15]](#footnote-15) and membership organisations will also have a key role in validation and may already have procedures in place to review an individual practitioner’s portfolio of evidence to determine whether they already meet the qualification requirements. Priority would need to be given to those who may be eligible and willing to supervise individuals during training or immediately following completion of training for those treatments which will continue to require clinical oversight. Voluntary registration bodies and membership organisations may also wish to offer a service for those practitioners who are not members of a voluntary registration or membership body, and assessment centres may want to develop and provide services to the industry to provide independent evaluation of an individual’s portfolio of evidence and provide an assessment of clinical skills/proficiency

* 1. One of the options which may be used as part of the process to recognise the skills proficiency and knowledge of existing practitioners would be the ‘grandparenting’ approach used within health to enable established practitioner registration within newly formed professions or specialties. For example, when new GMC specialities were approved (eg in Plastic Surgery and Vascular Surgery) and when new requirements for Dispensing Staff were introduced as part of the Dispensary Services Quality Scheme in 2006. In this case new practitioners in a dispensing practice were required to have completed or be working towards a Pharmacy Services S/NVQ Level 2 qualification. For experienced practitioners in dispensing practices, it was permissible for those with over 1000 hours experience, and whose employer had signed a competency certificate, to be exempt from this qualification requirement.
  2. If a ‘grandparenting’ approach is needed, there would need to be agreement on how it might be implemented within a limited timeframe, with guidance on how much time practitioners will have to meet any shortfall in education and training and which organisations would take a lead on implementation.

**Consultation questions**

1. **Do you agree with the proposals outlined in this section?**
2. **If not, please provide a rationale for any alternative proposals**
3. **Where is more detail needed to clarify the proposals?**
4. **Do you have any other comments?**
5. **Accreditation and recognition of qualifications**
   1. As part of its Mandate for 2014/15[[16]](#footnote-16), HEE is required to make recommendations on accreditation or recognition of qualifications and course delivery.
   2. The current landscape of education, training and workforce development is diffuse and in most cases aimed at specific groups of practitioners currently engaged in practice, for example one-day courses provided to regulated health professionals to deliver specific treatments. Vocational courses and qualifications are also available for those working in the hair and beauty industry. Training providers include manufacturers, professional associations, further education (FE) colleges, higher education institutions (HEIs), professional associations and royal colleges and private training organisations, and the size of the potential education market is significant – for example OFQUAL data indicates that between June 2012 and June 2014 163,000 learners were certificated against regulated qualifications in the beauty industry.
   3. The range of education providers delivering training to deliver cosmetic treatments is summarised below:

Figure 4



HEE would not wish to exclude any training companies and education providers currently offering courses from continuing to contribute to qualifications for practitioners delivering cosmetic procedures. It is recognised that delivery of qualifications to meet the requirements set out in this document will require collaboration and partnerships between education providers and industry experts and trainers for provision of specialist training in the use of different cosmetic products, equipment and devices. It will also be important for those education providers providing foundation level training to collaborate with those providing degree and postgraduate degree level training. However it is recommended that all organisations wishing to develop and provide qualifications which meet HEE’s requirements should be regulated by OFQUAL or have their own degree awarding powers or should work in partnership with these organisations.

* 1. In the case of OFQUAL regulated qualifications, awarding organisations are responsible for every aspect of the qualification, from design through to awards, and must meet rigorous requirements to ensure qualifications maintain appropriate standards and quality, including evidence of engagement with employers, stakeholders and professional associations and fitness for purpose of qualifications. On the other hand, those organisations which have degree awarding powers are responsible for the academic standards and quality of learning opportunities of the programme they offer and the qualifications and credits they award, but they must also meet standards set by the QAA which monitors and advises on standards that all providers of UK higher education are required to meet. In both cases, the awarding organisations are required to demonstrate that there is industry and public involvement in the design, management and ongoing development of educational programmes and that:

1. students/trainees are able to access all the necessary specialist facilities and resources, including academic and appropriately qualified clinical and technical support, to meet the required learning outcomes
2. students/trainees, employers and other key stakeholders can be assured that education providers have the appropriate robust governance and QA to support programme delivery, including engagement with employers and specialists in programme design and delivery

For health related programmes of education and training which lead to a registerable qualification, there is an additional and separate accreditation process which is carried out by professional regulatory bodies (GMC, GDC, GPHC, GOC, NMC, HCPC). This process is designed to ensure that education and training standards are met and that:

1. qualifications prepare practitioners with the necessary knowledge and level of skills proficiency to ensure high standards of patient care and satisfaction
2. assessments are fit for purpose and assess whether a student/trainee has met the required learning outcomes relevant to their scope of practice
3. stakeholders know which qualifications meet the regulatory body’s standards for education and training
4. there is consistency of standards across qualifications and education provision
   1. In its response to the Keogh review[[17]](#footnote-17), the Government rejected proposals to introduce statutory regulation for those performing cosmetic interventions, suggesting instead that clinical involvement in certain non-surgical cosmetic interventions is key in improving standards amongst practitioners who are not members of a regulated profession. However this decision means that there is a lack of clarity about where responsibility for recognition of qualifications might sit to ensure they meet the education and training standards. There are a number of possible options available:

|  |  |
| --- | --- |
| a)  Professional membership bodies, eg British Association of Cosmetic Nurses (BACN), British Association of Dermatology (BAD), Federation of Holistic Therapies (FHT) | Pros  Some membership organisations already have a role in recognising or accrediting qualifications (eg FHT) or are considering taking on this role (eg BACN)  Some membership organisations already have Professional Standards Authority (PSA) Accredited Voluntary Register (AVR) status (eg FHT)  Cons  Not all practitioners are members of membership bodies  Not all organisations have sufficient membership numbers to make it cost effective to take on a role in recognition and accreditation of qualifications, albeit that it would be a potential source of income through charging a validation fee to be paid by the education provider  Different organisations might adopt different approaches to recognition and accreditation with different results which might result in a lack of standardisation across the industry  These organisations would need to sign up to HEE’s qualification requirements as their standards for education and training to deliver cosmetic procedures |
| b)  Voluntary registration organisations: eg [Save Face Limited](http://www.saveface.co.uk/), [TYCT](http://www.treatmentsyoucantrust.org.uk/) and [FHT](http://www.fht.org.uk/home/) | Pros  If an additional requirement is that only those voluntary registration organisations which have AVR status should be able to recognise or accredit courses, the requirement to meet HEE qualification requirements could be one of the criteria set by PSA for AVR status  Cons  These registration organisations limit their membership to restricted groups of practitioners. This would therefore be a piecemeal approach which would not result in standardisation across the industry  Recognition and accreditation of qualifications may not be seen as core business and organisations may not wish to invest in resources to support this activity |
| c)  Statutory professional regulators | Pros  The GMC’s work on credentialing of qualifications may provide an assurance of quality for some qualifications  Cons  The GMC may not see this as a priority area for credentialing  The credentialing process would only look at qualifications for doctors |
| d)  Joint industry standards body/council (see para 4.8) | Pros  Industry representatives take ownership for industry standards  This option meets government requirements for ‘right touch’ regulation which recognises the role of regulation to protect people but advocates the minimum regulatory force required to achieve the desired results  If this body is seen to be independent without a financial stake in the industry, it is more likely to be seen as a credible body in standards-setting and taking a lead role in public protection.  Cons  There would be initial resource implications if this body takes on a recognition and accreditation role, although this activity would be able to generate future income. This option may therefore require some start-up funding which is unlikely to be available for some time due to the May 2015 election and a possible change in administration – any delay will impact on the current momentum and partnerships achieved through HEE’s project  This option would address the need to further develop the qualification requirements to address ‘orphan’ and emergent treatments (see para 1.7 and Annex 3) and ensure the future proofing and continuing validating of the qualification requirements |

4.8 It has been proposed by some of the professional membership organisations that a new organisation be established building on the collaborative work carried out by members of HEE’s Expert Reference Group members. This joint industry standards body or council would be funded through fees charged to those organisations supporting its establishment and contributing to its leadership and management. With an independent Chair, the body would be able to take responsibility for setting industry standards centred around the welfare and safety of well-informed patients/clients, and this might include managing implementation and further development of HEE’s qualification requirements after the project ends in April 2015 and developing an evidence base for cosmetic procedures. The body might also take on responsibility for accrediting or recognising qualifications or might subcontract delivery of this activity, but retain overall responsibility.

4.9 In the absence of a statutory regulator, HEE’s preferred option would be to establish a joint industry body or council, if this has the support of industry, and to explore the financial and legislative implications of such a move. It is envisaged that responses to this consultation will inform further development of this proposal.

* 1. Recognition of overseas qualifications will also need to be addressed and HEE is currently exploring options with the Department of Health.

**Consultation questions**

**What changes or additional information are needed to this section of the paper to improve understanding of the options available and to inform HEE’s recommendations?**

**Do we need an additional and separate accreditation or recognition process similar to that carried out by professional regulatory bodies?**

**If your answer to the above question is yes, are there any additional options available which have been missed and if so, what are they?**

**Do you have views about the proposal to establish a new joint industry standards body/council, and if so, please explain your views?**

**If you support establishment of a joint industry standards body/council, what should its responsibilities include and what organisations should be involved in its establishment and operations?**

**5 Standards for practice**

5.1 Practitioners are accountable for their practice and should only ever deliver treatments within their level and scope of experience and competence, meeting the requirements of their regulatory bodies if appropriate. If practitioners wish to move to another area of practice, they must recognise the limits of their existing knowledge and skills and ensure they meet the qualification requirements for any additional treatments they will be delivering.

5.2 Practitioners are expected to demonstrate the following values and behaviours:

1. acknowledging when treatment is not in patient/client’s best interest and referring on or refusing treatment where appropriate
2. actively seeking out and participating in CPD opportunities
3. promoting an open culture of transparency and learning
4. demonstrating ethical practice and professionalism
5. practising in a non-discriminatory manner
6. reflecting on own personal practice
   1. Following completion of training, practitioners are encouraged to identify a mentor with whom they can discuss complex clinical or ethical developments.
   2. Practitioners will be expected to ensure that they update their practice and education regularly in accordance with contemporaneous practice standards, the CPD requirements set by professional statutory or voluntary regulatory and membership bodies, if applicable, and the appraisal and revalidation requirements of employers. It is particularly important that practitioners who do not offer regular treatments take steps to update and refresh their skills and that they invite peer review as part of this process.
   3. The education and training provision which meets the HEE qualification requirements for cosmetic procedures will introduce practitioners to a range of different brands and types of devices and other products. However in recognition of the wide range of current, new and emerging technologies and products, there will be an expectation that practitioners will continue to develop their professional knowledge and competencies following qualification and ensure that they have received specific training for devices, products or equipment they are using in contemporaneous practice.
   4. When prescribing a particular treatment for a patient/client, practitioners must satisfy themselves that they have undertaken a full assessment of the patient/client, including psychological assessment and risk assessment, and that they have offered the appropriate level of support and an explanation of the risks associated with preferred treatments to help patients/clients reach an informed decision on whether or not to go ahead. Practitioners should refer the patient/client on when it is necessary to do so. They should also offer the appropriate follow-up and after-care.
   5. As already highlighted in paras 2.34 to 2.41, the responsibility for administering a prescription medicine remains with the prescriber who must only prescribe within their scope of practice and competence and work within the spirit and boundaries set down by their professional regulatory codes of conduct and ethical practice as mandated by their statutory bodies and the prescribing policies of their employers, if appropriate. Additional requirements are in place for prescribing a medicine ‘off-label’, with the practitioner having responsibility for explaining that botulinum toxin is not licensed for general cosmetic use and for ensuring that the patient understands that this is so.

5.8 Practitioners will be expected to ensure that they meet any employer, education provider or regulatory body requirements to declare any changes, eg as a result of convictions, cautions or health conditions, which might impact on their practice and to meet Disclosure and Barring Service (DBS) requirements.

* 1. Practitioners must ensure that they have adequate professional indemnity insurance which covers the full range of treatments they are delivering.
  2. A range of standards set by professional membership bodies and regulatory bodies also exist The following are of particular relevance:

1. MHRA *Guidance on the safe use of lasers, IPL systems and LEDs[[18]](#footnote-18)*
2. MHRA guidance on the supply and administration of Botox®, Vistabel®, Dysport® and other injectable medicines outside their licensed medicinal uses such as cosmetic procedures[[19]](#footnote-19)
3. Royal College of Surgeons Professional Standards for Cosmetic Practice[[20]](#footnote-20)
4. GMC’s guidance on Good Practice in prescribing and managing medicines and devices[[21]](#footnote-21),[[22]](#footnote-22)
5. GDC guidance on remote prescribing[[23]](#footnote-23)
6. NMC’s guidance on cosmetic practice[[24]](#footnote-24)
7. IHAS Good Medical Practice in Cosmetic Surgery[[25]](#footnote-25) (which includes standards which are also applicable to non-surgical procedures)
8. TYCT Injectable Cosmetic Treatments Training Principles[[26]](#footnote-26)
9. Committee of Advertising Practice (CAP) and Broadcast Committee of Advertising Practice’s Help Note on Marketing of Cosmetic Interventions[[27]](#footnote-27)

See paras 2.35 and 2.36 for further information on the MHRA guidance relating to the prescribing of BTs for cosmetic purposes.

A range of other standards documents and guidance are also available from professional membership organisations.

* 1. Cosmetic treatments that do not involve surgery and are not undertaken by healthcare professionals are not normally treated as being within the scope of CQC registration requirements. This includes laser treatments with the exception of those procedures that are deemed to cut or cause oblation to the skin, such as ablative skin resurfacing, which are seen as surgical when carried out by a health care professional and are regulated by CQC. The use of botulinum toxins by a health care professional to treat a disease, disorder or injury is also within CQC’s scope because it constitutes a regulated activity.
  2. Businesses offering cosmetic treatments are affected by a wide range of laws and duties relating to public health, occupational health and safety, environmental protection, and in some parts of the UK to public control licensing. Most of this law is administered by local authorities, often through their environmental health departments. However there is uneven regional coverage. There are two areas of legislation open to local authorities: the general provisions of the Health and Safety at Work etc. Act 1974 and adoptive licensing/registration powers in the Local Government (Miscellaneous provisions) Act 1982 and the London Local Authorities Act 1991 which only applies in the London boroughs. In addition, many local authorities have local licensing legislation applying to their particular area.
  3. The Health and Safety at Work Act, 1974, is the legal enforcement used by local authority officers to ensure health and safety standards are maintained, so far as reasonably practicable, in commercial premises.
  4. If the local authority formally resolves that the provisions of the Local Government (Miscellaneous Provisions) Act 1982 apply within its district, then the authority can register electrolysis procedures which involve actual, or risk of, skin piercing. By-laws are made by the council to bring the Act into effect locally and both the person undertaking the activity, as well as the premises, must be registered with the local authority.
  5. The London Local Authorities Act 1991 enables the London borough councils to license premises intended to be used for ‘special treatment’ provided they adopt the provisions included within the Act. This has latterly been amended by the London Local Authorities Act, 2000. ‘Special treatment’ now includes light, electric or other special treatment ‘of a like kind’. The powers cover any premises used, intended to be used, or represented as being used, for the reception or treatment of persons. Premises which are under the supervision of a medical practitioner registered by the GMC or health practitioners (defined as a person who uses his skills with a view to curing or alleviating of bodily diseases or ailments’) are excluded from the requirements. The Act is adoptive, meaning that the London borough council must resolve to adopt its powers before it can come into effect in that London borough. A London borough may grant or renew a license on any such terms and conditions as it specifies and the conditions for the granting of a license may include the qualifications of the person giving the special treatment[[28]](#footnote-28).

**Consultation questions**

1. **Is there anything missing from this section?**
2. **Do you have any other comments on this section?**
3. **Next steps**

6.1 Between January and April 2015, the main focus of the project team will be to seek endorsement from the regulatory bodies and industry representatives, including membership organisations, insurers, service providers, manufacturers and education and training providers, and regulatory bodies and explore how implementation of the qualification requirements can be supported. We will continue to work to raise the profile of this project with stakeholder groups, including members of the public.

6.2 Publication of this document launches a one-month consultation between 9 December 2014 and 9 January 2015. Responses should be emailed to [cosmetics@nwl.hee.nhs.uk](mailto:cosmetics@nwl.hee.nhs.uk) or posted to Cosmetic Procedures Project Team, Health Education North West London, Stewart House, 32 Russell Square, London WC1B 5DN no later than 9 January 2015.

**Consultation questions**

1. **Please give your suggestions on how implementation of these requirements can be supported.**
2. **Do you have any further comments on these proposals, including the content of Annexes 1-6?**

Carol Jollie

27 November 2014

Annex 1

**Non-surgical Cosmetic Interventions & Hair Restoration Surgery**

**Expert Reference Group (ERG) Membership**

|  |  |
| --- | --- |
| Health Education England | Prof David Sines CBE (Chair)  Carol Jollie, Performance and Delivery Manager  Patrick Spicer/Filmawit Kiros, Project Support Officer |
| Cosmetic Non-surgical Interventions Advisory Group | David Ward, Royal College of Surgeons (RCS) and RCS Cosmetic Surgery Interspecialty Committee (CSIC)  Jane Pierce, General Dental Council (GDC) |
| CSIC Standards for Training & Certification Sub Group | Simon Withey, Chair and Member of Keogh Review Committee |
| Beauty therapy | Sharon Preston, British Association of Beauty Therapy and Cosmetology (BABTAC)  Chris Wade, Association of Aesthetics, Injectables and Cosmetics (AAIC)  Cheryl Cole, Federation of Holistic Therapists (FHT) |
| Dentistry | Mike Mulcahy, Faculty of General Dental Practice (UK) (FGDP)  Brian Franks, Clinical Lead, MSc Non-surgical Facial Aesthetics, School of Medicine and Dentistry, University of Central Lancashire; Visiting Senior Lecturer, MClinDent Programmes, BPP University/City of London Dental School |
| Medicine | Tamara Griffiths, British Association of Dermatologists (BAD)  Kam Singh, British College of Aesthetic Medicine (BCAM)  Greg Williams, British Association of Hair Restoration Surgery (BAHRS)  Nilofer Farjo, British Association of Hair Restoration Surgery (BAHRS) |
| Environmental Health Practitioner | Ian Gray, Chartered Institute of Environmental Health (CIEH) |
| Laser therapy | Harry Moseley or Jonathan Exley, British Medical Laser Association (BMLA)  Stan Batchelor, Society of Radiological Protection (SRP) |
| Nursing | Andrew Rankin, British Association of Cosmetic Nurses (BACN)  Yvonne Senior, Private Independent Aesthetic Practices Association (PIAPA) |

|  |  |
| --- | --- |
| Pharmacy | Nazia Hussain  Gary Fletcher or Gurj Bhella |
| Plastic surgery | Ash Mosahebi, British Association of Aesthetic Plastic Surgeons (BAAPS)  Sarah Pape, British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) |
| Aesthetic Research | Dr Alex Clarke, Clinical Research Psychologist & Visiting Professor, Centre for Appearance Research, University of West of England  Prof Diana Harcourt, Co-Director of the Centre for Appearance Research, University of the West of England, Bristol |
| Users | Deborah Sandler, www.cosmeticsupport.com (Psychotherapist, user and independent patient support service provider)  Catherine Kydd, Campaigner on PIP implants and Member of Keogh Review Committee |
| Sector Skills Council | Tiffany Tarrant, Development Manager, Hair & Beauty Industry Authority (HABIA) |
| Industry representative | Sally Taber, Director, Independent Healthcare Advisory Services (IHAS), a Division of the Association of Independent Healthcare Organisations (AIHO) |
| Ex Officio Member | Julie Screaton, Director for London & South East, HEE & SRO for project |

Annex 2

**Non-surgical Cosmetic Interventions & Hair Restoration Surgery Advisory Group Membership**

|  |  |
| --- | --- |
| Health Education England | Julie Screaton, Director for London and South East (Chair)  Carol Jollie, Performance and Delivery Manager  Filmawit Kiros/Patrick Spicer, Project Support Officers |
| General Dental Council | Janet Collins, Head of Standards  Jane Pierce, Head of Education Policy and Quality Assurance |
| General Medical Council | Paula Robblee, Policy Manager, Education Directorate |
| General Optical Council | Kiran Gill, Head of Legal Compliance |
| General Pharmaceutical Council | Joanne Martin, Quality Assurance Manager (Education) |
| Health & Care Professions Council | Edward Tynan, Policy Officer |
| Nursing & Midwifery Council | Aditi Chowdhary-Gandhi, Standards Development Officer, Continued Practice |
| Hair & Beauty Industry Authority (HABIA) | Tiffany Tarrant, Development Manager |
| Royal College of Surgeons | Mr David Ward, Vice-President, Vice-Chair of Cosmetic Surgery Interspecialty Committee & Consultant Plastic Surgeon  Claire Flatt, Policy and Implementation Manager |
| British Association of Dermatologists (BAD) & Royal College of Physicians Dermatologist lead | Dr Tamara Griffiths |
| Royal Pharmaceutical Society | Ruth Wakeman, Head of Professional Support |
| National Institute for Health & Care Excellence | Prof Neal Maskrey, Consultant Clinical Adviser |
| Department of Health | Noel Griffin, Team Leader, Public Health Policy and Strategy Unit |
| Ex Officio Member | Prof David Sines CBE, Chair of ERG |
| **In attendance**  NHS Education for Scotland  Wales | Prof D Stewart Irvine, Director of Medicine  Darren Ormond, Healthcare Quality Division  Mr Richard Karoo, Consultant Plastic Surgeon |

Annex 3

**Out of scope treatments**

A range of treatments were deemed to be out of scope when designing the qualification requirements described in this paper, although a key principle underlying development of the requirements was that they should be flexible enough to accommodate other treatments, including new and emerging treatments at a later date. During the call for evidence carried out during phase 1 of HEE’s project a wide range of treatments were identified and these are listed below, with an indication of whether they are ‘orphan’ treatments which might potentially need to be addressed as part of the future development of the qualifications requirements or whether they would be out of scope.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surgical (part of activities regulated by CQC)** |  | **‘Orphan’ non-surgical treatments** |  | **Out of scope** |
| Liposuction treatments (see below) which require the skin to be broken with any device larger than a needle, and those which require a device, eg a probe or cannula, to be used underneath the skin |  | Non-surgical lipomodification treatments (see below) |  | Tattooing and micropigmentation for the scalp |
| Threadlifting (surgical sutures or threads designed to lift the skin) | Body piercing |
| Sclerothapy which involves injections with a very fine needle to remove surface and thread veins | Branding and scarification |
| Autologous fat transplant or lipofilling |  | Radio frequency treatments deliver an electrical current via electrodes to the skin to treat skin laxity |  | Ear stapling |
|  |  | Growth factor facial injections (also known as vampire face lifts) |  | Tongue splitting |
|  |  |  |  | Cautery |
|  |  |  |  | Electrolysis – using a direct electric current to permanently remove hair |
|  |  |  |  | Carboxytherapy – cutaneous and subcutaneous administration of carbo dioxide gas to treat stretch marks, cellulite and hypertrophic scars |

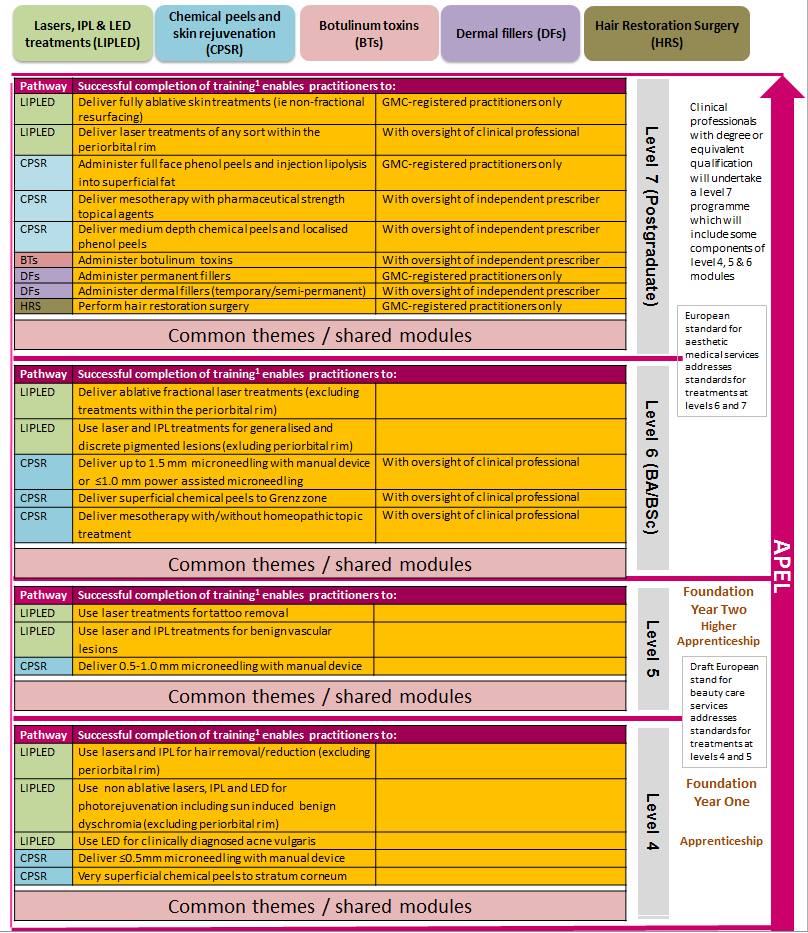
**Notes:**

1. Lipomodification removes fat from the body and the process may be undertaken surgically or by using non-surgical techniques. It can be delivered by:

* injection (non-surgical)
* freezing (can be surgical or non-surgical) – also known as crytherapy, cryolipolysis, cryogenic neuromodulation, lipocryolysis
* the use of ultrasonic devices (surgical or non-surgical)
* liquification (surgical or non-surgical)
* the use of a probe inserted inside the body (surgical)

1. Many patients are misled, either unintentionally or deliberately by the range of names used for different treatments. Moving forward, an attempt to try to harmonise the language used is critical.

Annex 4

Summary of qualification and supervision requirements

Annex 5

Risk & Hazard Stratification

Note: All treatments have the potential to be high risks, for example a client may suffer an unexpected allergic reaction, even though there is very low or no reported incidence. For this reason we have defined a level of training which will help to ensure that a practitioner is appropriately skilled to mitigate any potential risks.

|  |  |  |
| --- | --- | --- |
| **Level** | **Treatment** | **Potential risks and hazards\*** |
| **LIPLED** | | |
| 7 | Fully ablative skin treatments (ie non-fractional resurfacing) | * Severe pain, poor cosmetic outcome, permanent hyper or hypo pigmentation, risks of sedation * Depth and large area of injury results in risk of scarring, infection - impetigo, erysipelas, cellulitis, keloid scarring * Systemic fluid imbalance |
| 7 | Laser treatments of any sort within the periorbilal rim | Pain, infection, hyper or hypopigmentation, poor outcome, eye damage or blindness |
| 6 | Ablative fractional laser treatments (excluding treatments within the periorbital rim) | * Pain, infection, poor outcome, prolonged erythema * Reactivation of HSV, acne or millia * Hyper or hypopigmentation, |
| 6 | Laser and IPL treatments for generalised and discrete pigmented lesions (excluding treatments within the periorbital rim) | * Inappropriate treatment * Missed diagnoses eg melanoma * Hyper or hypopigmentation, scarring |
| 5 | Laser treatments for tattoo removal (excluding treatments within the periorbital rim) | * Pain * hyper or hypo pigmentation * paradoxical permanent hyperpigmentation, scarring |
| 5 | Laser and IPL treatments for benign vascular lesions  (excluding treatments within the periorbital rim) | * Pain, poor outcome * Infection * Reactivation of HSV |
| 4 | Lasers and IPL for hair removal  (excluding treatments within the periorbital rim) | * Discomfort, * Absence of effect * Hyper or hypo pigmentation, scarring |
| 4 | Non ablative lasers, IPL and LED for photorejuvenation, including sun induced dyschromia (excluding treatments within the periorbital rim) | * Discomfort, * Absence of effect, * Hyper or hypo pigmentation, scarring |
| 4 | LED for clinically diagnosed acne vulgaris | Unsuitable or inappropriate treatment of disease |

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| --- | --- | --- |
| **CPSR** | | |
| 7 | Full face phenol peels | Requires cardiac monitoring due to cardiotoxic effects; depth and large area of injury results in high risk of scarring, infection--impetigo, erysipelas, cellulitis, severe pain, poor cosmetic outcome, permanent hyper or hypo pigmentation, keloidal scarring, risks of sedation, systemic fluid imbalance. |
| 7 | Injection lipolysis into superficial fat | Pain, oedema, neurological adverse events, drooping, asymmetry, irregular skin texture and subcutaneous nodules. Off license use of PCDC in periorbital fat has resulted in reports of blindness. |
| 7 | Mesotherapy with pharmaceutical strength topical agents | * Pharmacological agents will be required using a prescription and the risks are those associated with the specific agent, though may be magnified when used in conjunction with mesotherapy due to increased penetration * Risk of pain, bleeding, infection, bruising * Autoimmune and hypersensitivity reactions; granuloma and biofilm formation |
| 7 | Medium depth chemical peels | * Pain, permanent scarring, permanent hyper or hypo pigmentation, impetigo, cellulitis, erysipelas. Risk of spills can result in unintended tissue destruction. * Systemic fluid imbalance (depending on total body surface area treated) |
| 7 | Localised phenol peels | Severe pain, risks of sedation, permanent scarring, poor cosmetic outcome with permanent hyper or hypo pigmentation, permanent skin textural irregularities, impetigo, cellulitis, risk of spills will result in unintended and severe tissue destruction. |
| 6 | Up to 1.5 mm microneedling with manual device or ≤1.0 mm power assisted microneedling | * Pain, bleeding, infection eg impetigo, cellulitis * Blood borne infection eg HIV, hepatitis * Systemic fluid imbalance (depending on surface area treated); |
| 6 | Superficial chemical peels to Grenz zone | * Erythema, scaling, allergic reaction or hypersensitivity * Hyper or hypopigmentation, unsatisfactory outcome/absence of response |
| 6 | Mesotherapy with/without homeopathic topical treatment | * Pain, bleeding, swelling, bruising; hypersensitivity and allergic reactions, persistent erythema, textural irregularities/lumpiness * Risk of blood borne infection (eg hepatitis, HIV), impetigo, erysipelas, cellulitis, |
| 5 | 0.5-1.0 mm microneedling with manual device | Pain, bleeding, infection, inadequate response |
| 4 | ≤0.5 mm microneedling with manual device | Discomfort, absence of effect, aggravation of underlying skin disease |
| 4 | Very superficial chemical peels to stratum corneum | Discomfort, absence of effect, aggravation of underlying skin disease |

|  |  |  |
| --- | --- | --- |
| **BTs** | | |
| 7 | Botulinum toxin | Prescription drug; risks are injection related (pain, bruising, bleeding, impetigo, cellulitis and blood-borne infection); reactivation of HSV; ptosisis, asymmetry, inappropriate muscle paralysis impairing function (especially lower face/neck); dry eyes, dry mouth. Pain and vasovagal response. |
| **DFs** | | |
| 7 | Permanent fillers | * Requires fully sterile conditions due to permanent nature of implant and risk for biofilm formation; this type of filler is associated with higher risk of long term adverse events in addition to all risks associated with temporary/semi-permanent fillers * Granuloma formation, hypersensitivity risk, risk for permanent disfigurement; vascular occlusion with necrosis and scarring, blindness |
| 7 | Dermal fillers (temporary / semi-permanent) | * Bleeding, infection, bruising; poor cosmetic outcome, overcorrection and facial disfigurement. Reactivation of HSV. Pain and vasovagal response. * Autoimmune and hypersensitivity reactions; permanent blindness, vascular occlusion with resultant skin necrosis and permanent scarring. Granuloma and biofilm formation |
| **HRS** | | |
| 7 | Hair restoration surgery | Permanent and disfiguring scarring from donor site or as a result of poor graft placement; cellulitis/infection; risks of sedation |

Annex 6

Glossary

**Accreditation of Prior Learning (APL)**

This is an umbrella term for the process by which Higher Education Institutions (HEIs) give credit against learning achieved by an individual before entry to a programme of study. This takes into account current knowledge from formal study and qualifications or through experience gained, eg in a job, and compares it with the learning required on the programme to be studied. Some of this prior learning may be counted towards the programme of study and result in exemptions from studying one or more courses. The term encompasses both Accreditation of Prior Certificated Learning (AP(C)L) and Accreditation of Prior Experiential Learning (AP(E)L).

**Assessors**

A person who undertakes marking or the review of marking on behalf of the Awarding Organisation. This involves using a particular set of criteria to make judgements as to the level of attainment a Learner has demonstrated in an assessment.

**Awarding Organisations**

Awarding Organisationsare organisations recognised by OFQUAL to provide specific qualification types, for example from GCSEs and A levels to specialised vocational qualifications. All awarding organisations have to comply with OFQUAL’s General Conditions of Recognition.

**Botulinum toxins**

Botulinum toxin is a neurotoxin produced by the bacteria Clostridium botulinum. By preventing nerve endings from releasing acetylcholine, a chemical essential for nerve to communicate with muscle cell, it prevents muscles from receiving nerve stimulation.

It is used for cosmetic purposes to address dynamic wrinkles which occur with facial expression. Signal from nerve ending to muscle is blocked, therefore dynamic wrinkle does not form. Untreated facial muscles work normally. Brands include Botox(R), Vistabel(R) (UK brand name for Botox(R)), Dysport(F), Azzalure(R) (UK brand name for Dysport(R)), Bocouture(R). As a prescription-only medicine, botulinum toxin must be prescribed by a healthcare professional.

**Chemical peels**

Chemical peels involve the controlled, chemical destruction of skin at varying depth for cosmetic or medical indications. The depth of the peel is proportional to the risk and potential benefit. The types of peel are broken down as:

* Very superficial: destruction of surface dead skin cell layer
* Superficial: destruction into viable epidermis—series of ongoing treatments required
* Medium depth: full thickness destruction of entire epidermis into upper dermis
* Deep: destruction into reticular dermis--full ablative treatment, requires sedation, cardiac monitoring, performed in theatre

**Competence**

Competence is task oriented and can be achieved through non direct patient contact, eg simulation. (Also see proficiency)

**Dermal fillers**

Dermal fillers are used to plump lines, wrinkles, folds and some scarring, and augment the lips (and facial contours) by restoring volume and definition – the practitioner injects the filler in a series of small injections or using a cannula. Some treatments require the application of a local anaesthetic cream, others may be performed using nerve block anaesthesia, and treatment time can vary between 30 minutes to an hour. Dermal fillers are made from a variety of materials and the effects can be either temporary or permanent, depending on the filler.

**Hair Restoration Surgery**

Hair restoration surgery is of the commonest male cosmetic surgical procedures and can be used to treat many causes of alopecia (hair loss), including eyebrows and beards and scars and dermatological conditions. It is almost exclusively transplant based, and there are two main methods of extracting donor hair. The first is Strip Follicular Unit Transplant (Strip FUT), which involves surgical wound closure, producing a linear donor scar, and Follicular Unit Extraction (FUE), which involves multiple punch biopsies, producing small round scars. Strip FUE can be conducted either manually, or using automated robotics. The method of implantation is the same for both, involving incision and the placement of grafts with forceps and implanters.

**Independent prescriber**

After successful completion of an approved education programme, nurses, pharmacists, optometrists, physiotherapists and podiatrists/chiropodists can become *independent* prescribers. All non-medical prescribing (ie not including doctors and dentists who are able to prescribe on registration) is underpinned by legislation and regulatory standards. Accordingly, all non-medical prescribers must record their qualification with their professional regulator and have a responsibility to remain up to date with the knowledge and skills that enable them to prescribe competently and safely.

**Lasers, Intense Pulsed Light (IPL) and Light Emitting Diode (LED) treatments**

This group of treatments involve the use of certain optical radiation devices to change the appearance, colour, texture, or structure of the skin or hair, for cosmetic purposes. **Lasers** emit light at a single wavelength at high energy, generating heat within targeted site in tissue. When laser light is delivered to tissue, it is absorbed (predominantly in specific target) which generates a reaction – in skin treatments this is most commonly a thermal affect but it can be mechanical or ablative. These treatments may take 15 minutes to over an hour**. IPL treatments** differ from laser treatments by emitting a broad spectrum of non-coherent light, although the interaction between the light and tissue is largely the same as laser light and results in thermal effects in the skin. They are typically used in hair reduction and other skin procedures, such as photo-rejuvenation, and as with lasers, the treatments are typically 4-6 weeks apart. **LED** devices are non-thermal devices that emit incoherent light over a range of wavelengths. They are commonly used in the treatment of photo damage, inflammatory acne, sebaceous gland disorders, and oily skin.

**Laser Protection Advisers (LPAs)** are responsible for overseeing laser safety, and employers must appoint or consult a certified LPA where Class 3B and Class 4 lasers or IPL systems are being used. In order to achieve the minimum competency level and as part of their initial safety training, staff must attend a Care of Knowledge course which should include practical exercises on undertaking risk assessments, administration of safety and equipment management.

**Laser Protection Supervisors (LPSs)** work within the department, clinic or healthcare establishment with responsibility for supervising the work of personnel who operate optical radiation equipment, supervising the optical radiation equipment and supervising the local rules to ensure that they are followed on a day-to-day basis. The LPS would be expected to have achieved a certain level of equipment understanding, practical experience and knowledge of the optical radiation field that they are working in which they would normally learn from the LPA.

**Mesotherapy**

Mesotherapy involves multiple injections of pharmaceutical and homeopathic medications, plant extracts, vitamins and other ingredients into subcutaneous skin for skin rejuvenation. It has been extended to subcutaneous injection into fat for lipolysis (cell rupture and death of fat cells)

**Microneedling**

Micro/skin needling (also known as skin rolling) Involves repeatedly puncturing the skin with tiny, sterile needles and is purported to induce endogenous production of cutaneous collagen in the upper dermis, though evidence is modest. Typically the procedure involves a specialised microneedling device which may consist of up to 200 super fine needles, eg Dermaroller®.

**Oversight**

For some more complex treatments, HEE is recommending that delivery of treatments following successful completion of training is carried out with the oversight of a health professional, with that health professional retaining responsibility for carrying out the patient or client assessment, ‘prescribing’ a particular treatment and being able to deal with emergency situations and complications. If they delegate administration of a treatment they must ensure that the practitioner has the appropriate training and skills.

**Proficiency**

This paper refers to proficiency rather than competency to reflect the higher level of skills required by practitioners. Whereas competency is associated with standardised and routinized procedures, proficiency requires a practitioner to see systems holistically, receive deviations from the normal pattern and have a higher level of decision-making.

**Recognition of Prior Learning (RPL)**

RPL is a similar scheme to the APL, to provide the opportunity to claim credits for relevant exams and qualifications awarded through awarding bodies.

**Supervisor**

For the purposes of this paper, a supervisor is the person who helps the student/trainee develop their practical skills throughout the learning programme through observation and practice under supervision on patients/clients. The supervisor may also have an assessor role, taking responsibility for assessing proficiency and achievement of learning outcomes.

**Verifier**

Verifiers are responsible for verifying the quality of assessment on behalf of the awarding organisation. Internal verifiers support and work with teams of assessors to develop assessment procedures and facilitate good practice. External verifiers work with education providers to quality assure qualifications on behalf of awarding bodies and should have formal training, which will be determined by the education provider or awarding organisation.

**Consultation questions**

1. **Are there any additional words or terms used in the paper which should be included in this Glossary?**

1. <http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/09/Non-surgical-cosmetic-interventions-Report-on-Phase-11.pdf> [↑](#footnote-ref-1)
2. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf> [↑](#footnote-ref-2)
3. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf> [↑](#footnote-ref-3)
4. <http://www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingsellingandsupplyingofmedicines/Frequentlyraisedissues/BotoxVistabelDysportandotherinjectablemedicinesincosmeticprocedures/> [↑](#footnote-ref-4)
5. <http://www.qaa.ac.uk/publications/information-and-guidance/publication?PubID=2718> [↑](#footnote-ref-5)
6. <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions-call-for-evidence> [↑](#footnote-ref-6)
7. <http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087990> [↑](#footnote-ref-7)
8. <http://www.gmc-uk.org/guidance/good_medical_practice.asp> [↑](#footnote-ref-8)
9. <http://www.gmc-uk.org/Prescribing_guidance.pdf_52548623.pdf> [↑](#footnote-ref-9)
10. [http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Guidance%20Sheet%20Guidance%20on%20Prescribing%20Medicines%20September%202013%20v2.pdf](http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Guidance%2520Sheet%2520Guidance%2520on%2520Prescribing%2520Medicines%2520September%25202013%2520v2.pdf) [↑](#footnote-ref-10)
11. <http://www.nmc-uk.org/Documents/NMC-Publications/238747_NMC_Standards_for_medicines_management.pdf> [↑](#footnote-ref-11)
12. [http://www.nmc-uk.org/Documents/Circulars/2008circulars/NMC%20circular%2016\_2008.pdf](http://www.nmc-uk.org/Documents/Circulars/2008circulars/NMC%2520circular%252016_2008.pdf) [↑](#footnote-ref-12)
13. <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Remote-prescribing-and-injectable-cosmetic-medicinal-products/> [↑](#footnote-ref-13)
14. <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/Cosmetic-injectables/> [↑](#footnote-ref-14)
15. Voluntary registration organisations: e.g. ‘[Save Face Limited](http://www.saveface.co.uk/)’, ‘[Treatments You Can Trust’ (TYCT)](http://www.treatmentsyoucantrust.org.uk/) - which was formerly operated by the Independent Healthcare Advisory Services, a trade association for private healthcare and cosmetic surgery providers and is now operated by Cosmetic Quality-Assurance Ltd (CQAL) and the ‘[Federation of Holistic Therapists’ (FHT)](http://www.fht.org.uk/home/), which is the only organisation which currently has Professional Standards Authority (PSA) Accredited Voluntary Register (AVR) status [↑](#footnote-ref-15)
16. DH (May 2014) *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values - A mandate from the Government to Health Education England: April 2014 to March 2015*. <https://www.gov.uk/government/publications/health-education-england-mandate-april-2014-to-march-2015> [↑](#footnote-ref-16)
17. DH (February 2014) *Government response to the review of the regulation of cosmetic interventions*. <https://www.gov.uk/government/publications/regulation-of-cosmetic-interventions-government-response> [↑](#footnote-ref-17)
18. <http://www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON014775> [↑](#footnote-ref-18)
19. <http://www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingsellingandsupplyingofmedicines/Frequentlyraisedissues/BotoxVistabelDysportandotherinjectablemedicinesincosmeticprocedures/> [↑](#footnote-ref-19)
20. <http://www.rcseng.ac.uk/publications/docs/professional-standards-for-cosmetic-practice/> [↑](#footnote-ref-20)
21. <http://www.gmc-uk.org/Prescribing_guidance.pdf_56002831.pdf> [↑](#footnote-ref-21)
22. The GMC is also developing a code of ethics relating to cosmetic procedures (due for completion in 2015) [↑](#footnote-ref-22)
23. [http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Remote%20prescribing.pdf](http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Remote%2520prescribing.pdf) [↑](#footnote-ref-23)
24. <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/Cosmetic-injectables/> [↑](#footnote-ref-24)
25. <http://www.independenthealthcare.org.uk/cat_view/85-workstreams/103-cosmetic-surgery-treatments-workstream/menu-id-571> [↑](#footnote-ref-25)
26. <http://www.independenthealthcare.org.uk/cat_view/85-workstreams/103-cosmetic-surgery-treatments-workstream/menu-id-571> [↑](#footnote-ref-26)
27. <http://www.cap.org.uk/Advice-Training-on-the-rules/Help-Notes/Cosmetics-interventions-marketing.aspx> [↑](#footnote-ref-27)
28. The information on legislation in paras 5.12 to 5.15 has been taken from evidence submitted by the Chartered Institute of Environmental Health [↑](#footnote-ref-28)